How to apply for participation
If you are interested in participating in our network, please send a letter of intent along with a W-9 to nv1-providerservices@anthem.com or call a Provider Relations representative at 1-702-228-1308.
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1 INTRODUCTION

Welcome to the Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) network! We’re pleased you’ve joined our network, which represents some of the finest health care providers in the state.

Anthem is a licensed managed care organization (MCO). We bring national expertise in operating local, community-based health care plans with experienced local staff to complement our operations. We’re committed to assisting you in providing quality health care.

We believe hospitals, physicians and other providers play pivotal roles in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining our stable, high-quality provider network. All network providers are contracted with us through a Participating Provider Agreement.

If you are interested in participating in any of our quality improvement committees or learning more about specific policies, please contact us. Most committee meetings are scheduled at times and locations intended to be convenient for you. Please call Provider Services at 1-844-396-2330 with any suggestions, comments or questions. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members and your patients.

We retain the right to add to, delete from and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials we provide as proprietary and confidential.

Please note: Material in this provider manual is subject to change. Please go to https://mediproviders.anthem.com/nv for the most up-to-date information.
2 OVERVIEW

Who is Anthem Blue Cross and Blue Shield Healthcare Solutions?
Community Care Heath Plan of Nevada, Inc., doing business as Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem), is a leader in managed health care services for the public sector. We provide health care coverage exclusively to low-income families, children, pregnant women and the expansion population.

We operate a community-focused managed care company with an emphasis on the public sector health care market. We coordinate our members’ physical and behavioral health care, offering a continuum of education, access, care and outcome programs, resulting in lower cost, improved quality and better health status for Americans.

Strategy
Our strategy is to:
- Improve access to preventive primary care services by ensuring the selection of a primary care provider (PCP) who will serve as provider, care manager and coordinator for all basic medical services.
- Improve health status of and outcomes for members.
- Educate members about their benefits, responsibilities and the appropriate use of health care services.
- Encourage stable, long-term relationships between providers and members.
- Encourage medically appropriate use of specialists and emergency rooms.
- Commit to community-based enterprises and community outreach.
- Facilitate the integration of physical and behavioral health care.
- Foster quality improvement mechanisms that actively involve providers in re-engineering health care delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.

Summary
Escalating health care costs are driven in part by a pattern of fragmented episodic care and, quite often, unmanaged health problems of members. We strive to educate members to encourage the appropriate use of the managed care system and to be involved in all aspects of their health care.
3 QUICK REFERENCE INFORMATION

Our Website
Our website contains a full complement of provider resources, including an online provider inquiry tool for real-time eligibility, claims status and authorization status. In addition, the website provides helpful information such as forms, the Preferred Drug List, drugs requiring prior authorization, provider manuals, referral directories, provider newsletters, claims status, electronic remittance advice and electronic funds transfer information, updates, clinical guidelines, and other information to help you work with us. Visit our site at https://mediproviders.anthem.com/nv.

Call Provider Services for precertification/notification, health plan network information, member eligibility, claims information, inquiries and recommendations you may have about improving our processes and managed care program.

Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) Phone Numbers
Provider Services:
- Telephone: 1-844-396-2330
- Fax: 1-800-964-3627
- Availity Client Services:* 1-800-282-4548

TTY: 711

Automated Provider Inquiry Line for Member Eligibility: 1-844-396-2330

24/7 NurseLine: 1-844-396-2329 (TTY 711)

Member Services: 1-844-396-2329 (TTY 711)

Pharmacy Services: 1-844-396-2330

Vision Services — EyeQuest*: 1-888-696-9551

Radiology Services — AIM Specialty Health®*: 1-800-714-0040

Electronic Data Interchange (EDI) Hotline: 1-800-590-5745

Nonemergency Transportation — MTM*: 1-844-879-7341 (for Medicaid members only; see Section 9.4 for additional details)

Nevada Phone Numbers
Nevada Department of Health Care and Financing Policy Medicaid Office: 1-775-684-3600

Nevada Department of Health Care and Financing Policy Nevada Check-Up Office: 1-775-684-3777

HP Enterprise Services: 1-877-638-3472
Keeping the Door Open with Ongoing Communications
To make sure you have the information you need to work effectively with us and our members, we’ll send you broadcast faxes, notify you of provider manual updates, mail you quarterly newsletters and post information on our website. Keep reading for more information to help you in your day-to-day interaction with us.

<table>
<thead>
<tr>
<th>Additional Information</th>
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<tbody>
<tr>
<td><strong>Member Eligibility</strong></td>
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<tr>
<td>Contact the Provider Inquiry Line at 1-844-396-2330 or log in to the provider portal at <a href="https://mediproviders.anthem.com/nv">https://mediproviders.anthem.com/nv</a>.</td>
</tr>
<tr>
<td><strong>Notification/Precertification</strong></td>
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<tr>
<td>• May be submitted via the following methods:</td>
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<tr>
<td>o Website: <a href="https://mediproviders.anthem.com/nv">https://mediproviders.anthem.com/nv</a></td>
</tr>
<tr>
<td>o Telephone: 1-844-396-2330</td>
</tr>
<tr>
<td>o Fax: 1-800-964-3627</td>
</tr>
<tr>
<td>• Data required for complete notification/precertification:</td>
</tr>
<tr>
<td>o Member ID number</td>
</tr>
<tr>
<td>o Legible name of referring provider (provider’s name)</td>
</tr>
<tr>
<td>o Legible name of individual referred to provider (member’s name)</td>
</tr>
<tr>
<td>o Number of visits/services</td>
</tr>
<tr>
<td>o Date(s) of service</td>
</tr>
<tr>
<td>o Diagnosis</td>
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<tr>
<td>o CPT code</td>
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<tr>
<td>• In addition, clinical information is required for precertification.</td>
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<tr>
<td>Referral and certification forms are located at <a href="https://mediproviders.anthem.com/nv">https://mediproviders.anthem.com/nv</a>.</td>
</tr>
<tr>
<td><strong>Medicaid ID</strong></td>
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<tr>
<td>Anthem requires providers to hold a valid Nevada Medicaid ID.</td>
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<tr>
<td><strong>National Provider Identifier</strong></td>
</tr>
<tr>
<td>National Provider Identifier (NPI) — The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique provider identifier for health care providers.</td>
</tr>
<tr>
<td>All participating providers must have an NPI number.</td>
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<tr>
<td>An NPI is a 10-digit, intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about health care providers, such as the states in which they practice or their specialties.</td>
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<tr>
<td>You can apply for an NPI by:</td>
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<tr>
<td>• Completing the application online at <a href="https://nppes.cms.hhs.gov">https://nppes.cms.hhs.gov</a>; estimated time to complete the NPI application is 20 minutes.</td>
</tr>
<tr>
<td>• Completing a paper copy by downloading it at <a href="https://nppes.cms.hhs.gov">https://nppes.cms.hhs.gov</a>.</td>
</tr>
<tr>
<td>• Calling 1-800-465-3203 and requesting an application.</td>
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</table>
### Claims Information

- **Submit paper claims to:**
  Anthem Blue Cross and Blue Shield Healthcare Solutions
  Nevada Claims
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

- **Electronic claims payer IDs:**
  - Institutional, Professional, Dental and Electronic Remittance Advice 837
  - EMR Attachments 275
  - SDS — please contact the clearinghouse.

- Timely filing is within 180 days of the date of service or per the terms of the provider agreement. Non-network and emergency transportation providers have 365 days from the last date of service.
- If other health insurance exists, the claim for services may be submitted up to 180 days from the date on the Explanation of Payment (EOP) for network providers. For non-network providers, the claim may be filed up to 365 days from the date on the EOP.
- Verify eligibility and check claims status and precertification status quickly and easily at [https://mediproviders.anthem.com/nv](https://mediproviders.anthem.com/nv).
- You may also receive claims, eligibility and precertification status over the phone any time by calling our toll-free, automated Provider Inquiry Line at **1-844-396-2330**.

### Medical Necessity Appeal Information

- Medical necessity appeals must be filed within 90 calendar days from the date on the notice of action/denial.
- You may pursue an appeal on behalf of the member with the member’s written authorization.
- We’ll send a determination letter within 30 calendar days of receiving the appeal request.
- Medical necessity appeals are eligible for one level of appeal.
- Submit a medical necessity appeal to:
  - Anthem Blue Cross and Blue Shield Healthcare Solutions
  - Medical Appeals
  - P.O. Box 62429
  - Virginia Beach, VA 23466-2429

  Medical necessity appeals can be submitted through the Availity Portal [https://www.availity.com](https://www.availity.com).

### Administrative Denials and Administrative Appeals

- An administrative denial is a denial of services that is based on reasons other than medical necessity.
- Administrative denials are made when a contractual requirement is not met, such as late notification of admissions or lack of precertification.
- If you are dissatisfied with an administrative denial decision, you may file an administrative appeal by submitting a written request with supporting documentation as to why the administrative requirements were met.
- An administrative appeal must be filed within 90 calendar days of the date on the administrative denial notice.
- We’ll render a decision and send a determination letter within 30 calendar days of receiving the administrative appeal.
- Administrative appeals are eligible for one level of appeal.
- Submit an administrative appeal to:
  - Anthem Blue Cross and Blue Shield Healthcare Solutions
  - Appeals Department
  - P.O. Box 62429
  - Virginia Beach, VA 23466-2429

  Administrative appeals can be submitted through the Availity Portal [https://www.availity.com](https://www.availity.com).
<table>
<thead>
<tr>
<th>Claims Payment Appeals</th>
<th>Our Provider Experience program helps you with claims payments and issue resolution.</th>
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<tbody>
<tr>
<td></td>
<td><strong>Just call 1-844-396-2330 and select the Claims prompt when you hear it.</strong></td>
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<tr>
<td></td>
<td>We connect you with a dedicated resource team, called the Provider Services Unit (PSU), to ensure:</td>
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<tr>
<td></td>
<td>- Availability of helpful, knowledgeable representatives to assist you.</td>
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<td></td>
<td>- Increased first-contact, issue resolution.</td>
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<td></td>
<td>- Significantly improved turnaround time of inquiry resolution.</td>
</tr>
<tr>
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<td>- Increased outreach communications to keep you informed of your inquiry status.</td>
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<td></td>
<td><strong>Claims Payment Appeals</strong></td>
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<tr>
<td></td>
<td>If after speaking with the PSU your claim issue remains unresolved, you may file a formal payment appeal. Verbal and written appeals are accepted. There are specific guidelines outlined in the <strong>Claim Payment Appeal</strong> section of this manual that explain situations where verbal appeals are not accepted. The PSU agent will assist you in determining this.</td>
</tr>
<tr>
<td></td>
<td>Whether filed verbally or in writing, we must receive your payment appeal within 90 calendar days from the date of the <em>EOP</em>. We will send a determination to you within 30 calendar days of receiving the appeal.</td>
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<td></td>
<td>If you are dissatisfied, you may submit a request for a second-level review. Verbal appeals for second-level reviews are not accepted. We must receive your written request within 30 calendar days of receipt of first-level decision/resolution letter.</td>
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<td><strong>Submit a written payment appeal to:</strong></td>
</tr>
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<td></td>
<td>Anthem Blue Cross and Blue Shield Healthcare Solutions</td>
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<tr>
<td></td>
<td>Payment Appeal Unit</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 61599</td>
</tr>
<tr>
<td></td>
<td>Virginia Beach, VA 23466-1599</td>
</tr>
<tr>
<td></td>
<td>Claims payment appeals can be filed through the Availity Portal: <a href="https://www.availity.com">https://www.availity.com</a></td>
</tr>
<tr>
<td>Grievances</td>
<td>Grievance is an expression of dissatisfaction about any matter or aspect of the health plan or its operations (excluding payment disputes or adverse medical actions). Provider grievances should be submitted to:</td>
</tr>
<tr>
<td></td>
<td>Anthem Blue Cross and Blue Shield Healthcare Solutions</td>
</tr>
<tr>
<td></td>
<td>9133 W. Russell Road</td>
</tr>
<tr>
<td></td>
<td>Las Vegas, NV 89148</td>
</tr>
<tr>
<td>Provider Services</td>
<td>For more information, contact Provider Services at <strong>1-844-396-2330.</strong></td>
</tr>
<tr>
<td>Representatives</td>
<td><strong>Grievances</strong></td>
</tr>
<tr>
<td></td>
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<td>Las Vegas, NV 89148</td>
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<tr>
<td></td>
<td><strong>Provider Services Representatives</strong></td>
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<tr>
<td></td>
<td>For more information, contact Provider Services at <strong>1-844-396-2330.</strong></td>
</tr>
</tbody>
</table>
4 PRIMARY CARE PROVIDERS

4.1 Primary Care Providers/Primary Care Sites

Members will be assigned to a PCP or primary care site (PCS) within five business days of the effective date of enrollment. Members can choose either a PCP or a PCS for their primary health care. We may auto-assign a PCP or PCS that has traditionally served the Medicaid population to an enrolled member who does not make a selection at the time of enrollment.

The PCP is a network provider responsible for the complete care of his or her patient, our member. The PCP serves as the entry point into the health care system for the member. The PCP is responsible for the complete care of his or her patient, including but not limited to providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining the continuity of care. PCP responsibilities include at a minimum:

- Managing the medical and health care needs of members to ensure all medically necessary services are made available in a timely manner.
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment to include services available under fee-for-service Medicaid.
- Providing the coordination necessary for the referral of patients to specialists and to services that may be available through fee-for-service Medicaid.
- Maintaining a medical record of all services rendered by the PCP and other referral providers.
- Freely communicating with members about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

A PCP must be a participating physician or network provider/subcontractor who provides or arranges for the delivery of medical services, including case management, to ensure all services that are found to be medically necessary are made available in a timely manner. The PCP may practice in a solo or group setting or may practice in a clinic (for example, a federally qualified health center [FQHC], rural health center [RHC]) or outpatient clinic).

A PCS is a location, usually a clinic, where a member chooses to access primary health care. The member’s medical record is maintained at this location, and a rotating staff of physicians manages and coordinates the member’s medical needs.

We encourage members to select a PCP/PCS who provides preventive and primary medical care as well as precertification and coordination of all medically necessary specialty services. We encourage our members to make an appointment with their PCPs/PCSs within 90 calendar days of their effective dates of enrollment.

FQHCs and RHCs may function as PCPs/PCSs. Providers must arrange for coverage of services to assigned members 24 hours a day, 7 days a week, in person or by an on-call physician. Providers must also answer emergency telephone calls from members within 30 minutes. Finally, each PCP/PCS must provide a minimum of 20 office hours per week of personal availability as a PCP/PCS.
4.2 Provider Specialties

Providers with the following specialties can apply for enrollment with us as a PCP/PCS:
- Advanced nurse practitioner
- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Nurse practitioner certified as specialist in family practice or pediatrics
- Obstetrician/gynecologist (OB/GYN)

To be a PCP, you must be enrolled in the Nevada Medicaid program at the service location where you wish to practice as a PCP/PCS before contracting with us.

4.3 PCP/PCS Onsite Availability

We’re dedicated to ensuring access to care for our members, and this depends upon the accessibility of network providers. Our network providers are required to abide by the following standards:
- The PCP/PCS must offer telephone access for members 24 hours a day, 7 days a week.
- A 24-hour telephone service may be utilized. The service may be answered by a designee such as an on-call physician or nurse practitioner with physician backup, an answering service or a pager system; however, this must be a confidential line for member information and/or questions. An answering machine is not acceptable. If an answering service or pager system is used, the call must be returned within 30 minutes.
- The PCP/PCS or another physician/nurse practitioner must be available to provide medically necessary services.
- Covering physicians are required to follow the referral/precertification guidelines.
- It is not acceptable to automatically direct the member to the emergency room when the PCP/PCS is not available.
- We encourage our PCPs/PCSs to offer after-hours office care in the evenings and on weekends.

4.4 Provider Disenrollment Process

You may cease participating with us for either mandatory or voluntary reasons.

Mandatory disenrollment occurs in the event you become unavailable due to immediate, unforeseen reasons. Examples of this include death and loss of license. Members are auto-assigned to another PCP/PCS to ensure continuous access to our covered services as appropriate. We’ll notify members of any termination for PCPs/PCSs or other providers from whom they receive ongoing care.

We’ll also notify affected members if you disenroll for voluntary reasons such as retirement. You must give written notice to us within the time frames specified in your Participating Provider Agreement with us. Members linked to a PCP/PCS who have disenrolled for voluntary reasons will be notified to self-select a new PCP/PCS.
Members’ medical information must be sent to the new PCP/PCS in order to provide continuity of care, regardless of whether you had mandatory or voluntary reasons for disenrollment.

4.5 Members Eligibility Listing

As a PCP/PCS, you’ll receive a monthly listing of your panel of assigned members. If a member calls to change his or her PCP/PCS, the change will be effective the next business day. You should verify each Anthem member receiving treatment in your office is on our membership listing. If you don’t receive the lists in a timely manner, contact a Provider Relations representative. For questions regarding a member’s eligibility, visit our website at https://mediproviders.anthem.com/nv or call our automated Provider Inquiry Line at 1-844-396-2330.

4.6 Member Enrollment

Eligibility of Medicaid members is determined by the Division of Welfare and Supportive Services (DWSS). DWSS notifies the state’s fiscal agent, who enrolls members.

Medicaid and Nevada Check Up members who meet the state’s eligibility requirements for participation in managed care are eligible to join our health care plan.

Members are enrolled for a period of 12 months contingent upon continued Medicaid or Nevada Check Up eligibility.

We do not on the basis of health status or need for health services discriminate against members eligible to enroll. We will not deny the enrollment of or discriminate against any Medicaid or Nevada Check Up member eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color or national origin. If the member was previously disenrolled from Anthem as the result of a grievance we filed, the member will not be re-enrolled with us unless the member wins an appeal of the disenrollment.

Anthem does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Anthem does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Anthem does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Anthem may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Anthem provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Anthem representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the
incident and is assisted in doing so if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: 1-800-368-1019 (TTY/TTD: 1-800-537-7697)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Anthem provides free tools and services to people with disabilities to communicate effectively with us. Anthem also provides free language services to people whose primary language isn’t English (for example, qualified interpreters and information written in other languages). These services can be obtained by calling the customer service number on their member ID card.

If you or your patient believe Anthem has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our grievance coordinator via:

- Mail: 9133 W. Russell Road, Las Vegas, NV 89148
- Phone: 1-888-235-9334

**Equal Program Access on the Basis of Gender**

Anthem provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Anthem must also treat individuals in a manner consistent with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (that is, race, color, national origin, gender, gender identity, age or disability).

Anthem may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

### 4.7 Medicaid Enrollment of Pregnant Women

Letters are sent to new Medicaid members requiring them to select a managed care organization (MCO) or have an MCO automatically assigned. We’re responsible for all covered medically necessary obstetrical services and pregnancy-related care commencing at the time of enrollment.

### 4.8 Medicaid Newborn Enrollment

We’re responsible for all covered medically necessary services to the qualified newborn. All eligible newborns born to our members are enrolled effective the date of birth if the mother of the newborn was
enrolled with us as of the newborn’s date of birth. The newborn will remain enrolled with us for as long as Medicaid eligibility is maintained.

4.9 Nevada Check Up Newborn Enrollment

The head of household/mother must notify Division of Health Care Financing and Policy (DHCFP) of the newborn within 14 days of delivery in order to qualify to receive coverage from the date of birth. If the notification is not received in time, the newborn will be enrolled on the first day of the next administrative month from the date of notification. If the mother has other health insurance that provides 30 days of coverage to the newborn, the newborn will be enrolled as of the first day of the next administrative month. If the coverage extends beyond that 30-day period, the child will not be eligible for Nevada Check Up enrollment until after the insurance expires and the child’s eligibility is determined under Nevada Check Up eligibility rules.

4.10 Member Identification Cards

Within five business days of notification of enrollment into Anthem, each of our members will be mailed an identification card, which identifies the member as a participant in our program. To ensure immediate access to services, visit our website to verify eligibility. The state will not issue a state Medicaid ID card for those members enrolled in managed care. The holder of the member identification card we issue is a member or guardian of the member. The identification card will include:

- The member’s identification number.
- The member’s name.
- The member’s date of birth.
- The member’s enrollment effective date.
- Toll-free phone numbers for information and/or authorizations.
- Toll-free 24/7 NurseLine — available 24 hours a day, 7 days a week.
- Descriptions of procedures to be followed for emergency or special services.
- Our address and telephone number.
- PCP/PCS name and telephone number.

Our members also have access to:

- Print-on-demand ID cards — by logging in to our website, members can download and print their ID cards from home.
- Mobile ID card smartphone app — via our new app, available for both iOS and Android users, members can download an image of their current ID cards and fax or email you a copy.
Our member identification card sample:

4.11 Americans with Disabilities Act Requirements

Our policies and procedures are designed to promote compliance with the Americans with Disabilities Act of 1990. You’re required to take actions to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

- Street-level access.
- Elevator or accessible ramp into facilities.
- Access to lavatory that accommodates a wheelchair.
- Access to examination room that accommodates a wheelchair.
- Handicap parking clearly marked unless there is street side parking.

4.12 Medically Necessary Services

To be considered a medical necessity (medically necessary), items and services must have been established as safe and effective as determined by Nevada Medicaid service manuals and Nevada Check Up. The items and services must be:

- Consistent with the symptoms or diagnosis of the illness or injury under treatment.
- Necessary and consistent with generally accepted professional medical standards.
- Not furnished for the convenience of the member, the attending physician, the caregiver or the physician supplier.
- Furnished at the most appropriate level that can be provided safely and effectively to the member; Medicaid will only cover items and services that are appropriate and necessary for the diagnosis or treatment of an illness or an injury or to improve the functioning of a malformed body part.

We will only cover items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or that improve the functioning of a malformed body part. We do **not** cover the use of any experimental procedures or experimental medications except under certain circumstances.
## 5 ANTHEM HEALTH CARE BENEFITS

### 5.1 Anthem Covered Services

The following list shows the health care services and benefits we cover for Medicaid and Nevada Check Up members. The services covered will be administered up to the limits/guidance as outlined in the appropriate Nevada Medicaid service manuals.

Some services are limited by number of visits or supply/equipment items. We have a process to review these requests for extra visits or extra supplies. We also have a process to review requests for noncovered services when they are medically necessary.

Some of the services listed below may need preapproval; Please contact us or visit our website at [https://mediproviders.anthem.com/nv](https://mediproviders.anthem.com/nv) for more information.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Inclusions, Limitations or Exclusions</th>
</tr>
</thead>
</table>
| Applied Behavioral Analysis (ABA)     | ABA is a behavior intervention model to treat children with autism spectrum disorder (ASD). ABA is rendered to Medicaid-eligible individuals under age 21 in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. ABA services include:  
  • Assessment  
  • Evaluation/re-evaluation  
  • Treatment intervention plan with measureable objective goals  
  • Data-driven, targeted goals  
  • Functional communication training  
  • Self-monitoring skills  
  • Adaptive living skills  
  • Cognitive skills  
  • Speech, occupational and physical therapy  
  • Durable medical equipment (DME)  
  • Speech generating device (SGD)  
  • Verbal skills  
  • Language skills  
  • Peer play  
  • Social skills  
  • Prevocational and vocational skills  
  • Parent training  
  • Family education  
  • Family counseling  
  • Case management                                                                                                                                                                                                 |
| Abortions                             | Excluded except where the life of the mother is endangered; for sexual assault (rape) or incest; and for treatment of incomplete, missed or septic abortions.  

To save the life of the mother, a *Certification Statement for Abortion to Save the Life of the Mother* must be included. |
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Inclusions, Limitations or Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergy Services</strong></td>
<td>In the case of rape and/or incest, a <em>Certification Statement for Abortion due to Sexual Assault (Rape) or Incest</em> must be included. Standard allergy testing and treatment are covered benefits. We do not cover allergy testing that is investigational in nature and not proven to be effective. Examples of allergy tests not covered include but are not limited to the following:</td>
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<td>• Advanced Cell Test (ACT) by ELISA methodology</td>
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<td>• Applied kinesiology test</td>
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<td>• Bronchial challenge test</td>
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<td>• Candida hypersensitivity test</td>
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<td>• Chemical analysis of body tissues</td>
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<td>• Chlorinated pesticides (serum)</td>
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<td>• Conjunctival or nasal challenge test</td>
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<td>• Cytokine or cytokine receptor assays for multiple chemical sensitivities (MCS)</td>
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<td></td>
<td>• Cytotoxic food testing (Bryan’s test, leukocytotoxic test, ACT)</td>
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<tr>
<td></td>
<td>• Electrodermal acupuncture</td>
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<td></td>
<td>• Environmental challenge testing</td>
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<td>• Food challenge testing/food immune complex assays (FICA)</td>
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<td>• Leukocyte histamine release test or lymphocyte proliferation test</td>
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<td></td>
<td>• Lymphocytes (B or T subsets); may be appropriate for collagen vascular disease, immune deficiency syndromes, leukemia, lymphomas</td>
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<td></td>
<td>• Mediator release test (MRT)</td>
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<td></td>
<td>• Multiple chemical or environmental sensitivity testing</td>
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<td></td>
<td>• Neutralization testing</td>
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<tr>
<td></td>
<td>• Prausnitz-Kustner (P-K) testing – passive cutaneous transfer test</td>
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<tr>
<td></td>
<td>• Provocation-neutralization testing (Rinkel test), either subcutaneously or sublingually</td>
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<td>• Pulse test (pulse response test, reaginic pulse test)</td>
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<td></td>
<td>• Rebuck skin window test</td>
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<td>• Specific IgG subclass IV testing</td>
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<td>• Spinal manipulation</td>
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<td>• Sublingual provocative testing</td>
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<td>• Urine autoinjection</td>
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<td>• Venom blocking antibodies</td>
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<tr>
<td><strong>Ambulatory Surgery Centers</strong></td>
<td>These services are covered.</td>
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<tr>
<td><strong>Anesthesia</strong></td>
<td>These services are covered.</td>
</tr>
<tr>
<td><strong>Assistant Surgeon</strong></td>
<td>These services are covered for qualifying procedures.</td>
</tr>
<tr>
<td><strong>Assistive/Augmentative Communication Devices</strong></td>
<td>These services are covered.</td>
</tr>
<tr>
<td><strong>Audiology Services</strong></td>
<td>• Medically needed audiology services including audiology testing, hearing aids and supplies are covered. Certain restrictions apply.</td>
</tr>
</tbody>
</table>

18
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Inclusions, Limitations or Exclusions</th>
</tr>
</thead>
</table>
| Behavioral Health Services | We cover the following services up to the service limit/guidance in the appropriate Nevada Medicaid services manual:  
  - Inpatient mental health and substance abuse services  
  - Outpatient mental health and substance abuse services  
  - Mental health rehabilitative treatment services  
  - Residential treatment center (RTC) for members under 21 years of age |
| Behavioral Health — Crisis Intervention | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Crisis Stabilization | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Electroconvulsive Therapy (ECT) | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Home Health Care Services | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Hospital Based Detoxification Services/Chemical Dependency Services | We cover admission to substance abuse units of general hospitals or freestanding psychiatric and substance abuse hospitals. |
| Behavioral Health — Intensive Outpatient Program (IOP), Psychiatric and Chemical Dependency | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Methadone Maintenance Program | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Neurotherapy (Including Biofeedback) | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Observation | Observation cannot exceed 48 hours up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Outpatient/Ambulatory Detoxification Services | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Partial Hospital, Psychiatric and Chemical Dependency | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Psychological and Neuropsychological Testing | Includes:  
  - Neuropsychological testing  
  - Neurobehavioral testing  
  - Psychological testing  
  These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| Behavioral Health — Residential Treatment Center (RTC) — Medicaid Members Under 21 Years of Age | Medicaid  
  We’re responsible for all services covered until the member is properly disenrolled from managed care, per the Nevada Medicaid services manual.  
  Anthem must notify DHCFP of a member’s admission to an RTC within five days of admission. The member will be disenrolled from Anthem effective the first day of the next administratively possible month following the RTC admission, and services will be reimbursed by FFS thereafter.  
  Nevada Check Up |
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Inclusions, Limitations or Exclusions</th>
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<tbody>
<tr>
<td><strong>Biofeedback</strong></td>
<td>Limited to codes 90875 and 90876.</td>
</tr>
<tr>
<td><strong>Blood Administration and Other Blood Products</strong></td>
<td>These services are covered.</td>
</tr>
</tbody>
</table>
| **Botox Injections** | Covered services include the following:  
  - Treatment for spasticity of limbs as a result of brain or spinal cord injury including cerebral palsy  
  - Treatment for eye conditions to stop twitching  
  Services:  
  - May be covered for other medically necessary treatment.  
  - Are not covered for cosmetic purposes. |
| **Cardiac Rehabilitation Services** | These services are not covered. |
| **Chemotherapy/Radiation** | These services are covered. |
| **Chiropractic Services** | Covered for when a diagnosis of spinal subluxation is made by the referring doctor or under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Medicaid members under 21 years of age. |
| **Circumcisions** | Routine circumcisions are covered. Certain restrictions apply for nonroutine circumcisions. :  
  - |
| **Clinic Services** | **Federally qualified health centers (FQHCs)** provide preventive services or services to treat an illness or chronic disease.  
  **Rural health clinics (RHCs)** provide preventive services.  
  Members can receive covered services at these facilities from the following providers:  
  - Physicians  
  - Nurse practitioners  
  - Physician assistants  
  - Certified nurse-midwives  
  - Visiting nurses  
  - Clinical psychologists  
  - Clinical social workers  
  - Registered dietitians  
  - Nutritional professionals  
  Members can self-refer to a federally qualified provider (in- or out-of-network). |
<p>| <strong>Cochlear Implants</strong> | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. |
| <strong>Cosmetic/Plastics/Reconstructive Procedures</strong> | Services are covered only for prompt repair of an accidental injury or the improvement of a malformed body part in order to improve function. Cosmetic surgery directed at improving appearance is not covered. |</p>
<table>
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<tr>
<th>Covered Services</th>
<th>Inclusions, Limitations or Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental — Oral/Maxillofacial Surgical</td>
<td>Medicaid Members Age 21 and Older&lt;br&gt;Adult Medicaid members receive emergency extractions and palliative care under certain guidelines and limitations.</td>
</tr>
<tr>
<td></td>
<td>Medicaid Members under Age 21 and Nevada Check Up Members under Age 19&lt;br&gt;Surgery to correct a wide range of diseases, injuries and defects to the head, neck, face, jaws, and hard and soft tissues of the lower jaw and face region is covered.</td>
</tr>
<tr>
<td>Dental — Preventive/Restorative</td>
<td>Effective July 1, 2017, Anthem no longer covers the dental benefit for members. This benefit is delivered directly through the State Medicaid FFS program.</td>
</tr>
<tr>
<td>Refer to FFS NV Medicaid</td>
<td>Call Liberty Dental* at <strong>1-866-609-0418</strong> or visit <a href="http://LibertyDental.com/nvmedicaid">LibertyDental.com/nvmedicaid</a> for information about receiving dental services.</td>
</tr>
<tr>
<td>Dermatology</td>
<td>These services are covered.</td>
</tr>
<tr>
<td>Diabetic Services — Self-Management Training</td>
<td>These services are covered.</td>
</tr>
<tr>
<td>Diabetic Services — Supplies</td>
<td>These services are covered.</td>
</tr>
<tr>
<td>Diagnostic Testing (Laboratory and Radiology)</td>
<td>These services are covered.</td>
</tr>
<tr>
<td>Diagnostic Testing — Nuclear Medicine</td>
<td>These services are covered.</td>
</tr>
<tr>
<td>Dialysis Services</td>
<td>These services are covered.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.</td>
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<tr>
<td></td>
<td>Durable medical equipment is equipment:&lt;br&gt;• Used to serve a medical purpose&lt;br&gt;• Fitted for use in the home&lt;br&gt;• Able to withstand repeated use</td>
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<tr>
<td></td>
<td>The following DME and medical supplies are examples of services not covered:&lt;br&gt;• Physical fitness or personal recreation equipment&lt;br&gt;• Personal care or hygiene products&lt;br&gt;• Household items, such as air conditioners or ceiling fans&lt;br&gt;• Environmental products&lt;br&gt;• Telecommunications devices for the deaf</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>EPSDT services are covered services for Medicaid Members under age 21 and Nevada Check Up Members through their 19th birthday.</td>
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<tr>
<td></td>
<td>Complete medical screens include the following:&lt;br&gt;• Comprehensive health and developmental history, including an assessment of both physical and mental health development&lt;br&gt;• Comprehensive physical exam&lt;br&gt;• Appropriate immunizations, according to age and health history, unless medically contraindicated at the time</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Inclusions, Limitations or Exclusions</td>
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</table>
| Laboratory tests, including an appropriate blood-lead level assessment | • Laboratory tests, including an appropriate blood-lead level assessment  
• Health education  
• Vision screening  
• Hearing screening  
• Dental screening  
• Vision, hearing and dental exams may be performed at other intervals  
• Other necessary health care or diagnostic screens or examinations  

A member under the age of 21 whose eligibility status is pregnancy-related is not eligible.  

The state Medicaid plan requires that EPSDT screenings are billed using appropriate coding, 99381-99385 or 99391-99395, with modifier EP or TS.  
• Use Modifier EP for routine screening.  
• Use Modifier TS if referral or follow-up indicated. Also complete field 21 on the CMS-1500 claim form with the ICD-10 code for the condition requiring follow up. |
| Early Childhood Intervention (ECI) Services            | These services are covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Educational Consults/Health Promotion                 | Coverage includes educational consultations for diabetes self-management.  

Also includes publications, presentations, classroom instruction and preventive services. This is not a separately billable service. |
| Emergency Services                                      | These services are covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Emergency Transportation                                | These services are covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Enteral Nutrition                                       | These services are covered. Certain restrictions apply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Family Planning Services and Supplies                  | Family planning services include counseling, information, education and communication activities, and delivery of contraceptives/birth control. Family planning services are covered without precertification at any qualified family planning provider, regardless of whether or not the provider is participating in our network.  

Members can self-refer to a qualified provider (in or out of network).  

The following services are not covered:  
• Tubal ligations and vasectomies are not covered for:  
  o Members under 21 years of age.  
  o Members adjudged to be mentally incompetent.  
  o Members who are institutionalized.  
• Sterilization reversals are not covered.  
• Abortions and/or hysterectomies are excluded from family planning.  

Sterilization and hysterectomy forms are to be completed by the physician and submitted with claim form for payment. Sterilization forms are not required for anesthesiology providers only. Hysterectomy consent forms are required for all provider types. |
<p>| Obesity Surgery/Bariatrics                              | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.                                                                                                                                                                                                                                                                                                                                                                                                 |
| Gastroenterology Services                               | These services are covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |</p>
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<tr>
<th>Covered Services</th>
<th>Inclusions, Limitations or Exclusions</th>
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<tr>
<td>Gender Reassignment Services</td>
<td>These services are covered up to the service limit guidelines in the appropriate Nevada Medicaid services manual to individuals eligible for Medicaid in accordance with Nevada Medicaid coverage. Please make sure to review Section 607 of the Nevada Medicaid Services Manual, as well as the Nevada Billing Guidelines, which includes specific language regarding coverage and limitations. The Nevada Billing Guidelines also offers providers additional guidelines and a list of surgical codes for gender reassignment services that may be billed in conjunction with the KX modifier (CMS1500 claim form) or Condition Code 45 (UB04 claim form).</td>
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</tbody>
</table>
| Genetic Testing and DNA Testing        | These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. Genetic and DNA testing is considered medically necessary to establish a diagnosis of inherited diseases when certain conditions are met. Certain restrictions apply. For example, we do not reimburse:  
  - Prenatal diagnosis for sex determination of the fetus without implications for genetic disease.  
  - Self-testing home kits.  
  - Genetic testing for cleft disorders.  
  - Blood-typing for paternity testing.  
  - Experimental or investigational genetic testing, including but not limited to:  
    - Hair analysis.  
    - Preimplantation genetic diagnosis.  
    - Tumor marker screenings. |
| Habilitative Services                  | Habilitative services include services and devices provided for a person to prevent deterioration or attain or maintain a skill or function never learned or acquired due to a disabling condition.  
  Maintenance therapy is covered under habilitative services and includes the skilled therapy necessary for maintenance and development of a safety therapy plan.  
  Requirements include but not limited to:  
  - A plan of care addressing a condition for which therapy is an accepted method of treatment as defined by standards of medical practice.  
  - A plan of care for a condition that establishes a safe and effective skilled maintenance program.  
  Prior authorization may be required; please contact us for additional information |
<p>| Home Health — Rehabilitation (OT, PT, ST, RT) | Home health agency visits are covered. Certain restrictions apply for services other than skilled nursing (below). |
| Home Health Skilled Nursing Care       | These services are covered.                                                                                                                                                                                                                             |
| Home Infusion/Total Parenteral Nutrition | These services are covered.                                                                                                                                                                                                                            |
| Hyperbaric Oxygen Therapy              | Topical hyperbaric oxygen therapy is not covered.                                                                                                                                                                                                       |
| Hysterectomies                         | Hysterectomies are not covered for the sole purpose of sterilization.                                                                                                                                                                                     |</p>
<table>
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<tr>
<th>Covered Services</th>
<th>Inclusions, Limitations or Exclusions</th>
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<tr>
<td>Whenever a hysterectomy is performed, abortion/sterilization/hysterectomy (ASH) forms must be completed by the physician and submitted with claim form for payment. Please complete the Sterilization Consent Form at <a href="https://www.medicaid.nv.gov/Downloads/provider/FA-56.pdf">https://www.medicaid.nv.gov/Downloads/provider/FA-56.pdf</a>.</td>
<td>Sterilization forms are not required for anesthesiology providers only. Hysterectomy consent forms are required for all provider types.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>See section 5.5 – Immunizations.</td>
</tr>
<tr>
<td>Inpatient Medical and Surgical</td>
<td>These services are covered.</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual.</td>
</tr>
<tr>
<td>Medical Nutrition Therapy</td>
<td>Anthem reimburses participating registered dieticians for medical nutrition therapy (MNT) services rendered to eligible Nevada Medicaid members.</td>
</tr>
<tr>
<td>To receive nutrition/dietician related services members must have written orders of a physician, physician’s assistant (PA) or advanced practice registered nurse (APRN). The treatment must also be designed and approved by a registered dietitian. Certain limitations apply.</td>
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<tr>
<td>Coverage includes:*</td>
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<tr>
<td>• Initial nutrition and lifestyle assessment.</td>
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<td>• One-on-one or group nutrition counseling.</td>
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<td>• Follow-up intervention visits to monitor progress in diet management.</td>
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<td>• Reassessment as necessary to ensure compliance with the dietary plan.</td>
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<tr>
<td>Mammograms (Screening and Diagnostic)</td>
<td>Limited to one per year.</td>
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<tr>
<td>Nebulizers</td>
<td>These services are covered. Certain restrictions apply.</td>
</tr>
<tr>
<td>Neurology Services</td>
<td>These services are covered.</td>
</tr>
<tr>
<td>Observation — Medical</td>
<td>Observation services are provided by the hospital and supervising physician to member held but not admitted into an acute hospital bed for observation. Consistent with federal Medicare regulations, the HCFP reimburses hospital observation status for a period up to but no more than 48 hours.</td>
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<tr>
<td><strong>Notification is NOT required unless the member converts/admits as inpatient.</strong></td>
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<tr>
<td>Obstetrical Care</td>
<td>Obstetrical ultrasound of a pregnant uterus is a covered benefit when it is determined to be medically necessary, up to the service limit guidance in the appropriate Nevada Medicaid services manual.</td>
</tr>
<tr>
<td>Please refer to the Nevada Medicaid Billing Manual for information regarding delivery claims</td>
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<tr>
<td>When possible, a pregnant woman can remain in the care of a non-network provider.</td>
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<tr>
<td>Covered Services</td>
<td>Inclusions, Limitations or Exclusions</td>
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<tr>
<td>Professional delivery claims with dates of service January 1, 2018, or after with gestational ages of 37 and 38 weeks will require a supporting medically necessary diagnosis code for the early delivery. If a professional delivery claim is submitted without evidence of medical necessity, we’ll deny the claim with the explanation code k34 — Delivery is not medically indicated. You may resubmit the claim with the appropriate supporting diagnosis code or submit an appeal with the relevant medical records.</td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>These services are covered.</td>
</tr>
<tr>
<td>Spinal Manipulation</td>
<td>Osteopathic manipulation services are limited to codes 98925 through 98929. These services are covered per the Nevada Medicaid service manual.</td>
</tr>
<tr>
<td>Otolaryngology (ENT)</td>
<td>These services are covered.</td>
</tr>
<tr>
<td>Out-of-Area Care</td>
<td>Out-of-area or out-of-state emergency care does not require a prior authorization. Generally, post-stabilization procedures do require prior approval. However, if post-stabilization services are administered to maintain the member’s stabilized condition within one hour of the request for authorization, such services will still be covered. Also, if post-stabilization care — administered to maintain, improve or resolve the member’s stabilized condition — requires prior approval and we don’t respond within one hour, we’ll pay the provider for that stabilization care. We will not pay the provider an amount any greater than what would pay a network provider for those services. Nonemergency, care requires prior authorization. If our network is unable to provide medically needed services in the member service area (or state), we’ll cover these services adequately and in a timely manner for as long as the services are not available in our network. Native Americans may access and receive medically necessary services at an Indian Health Service (IHS) facility or tribal clinic.</td>
</tr>
<tr>
<td>Pain Management</td>
<td>These services are covered. Medical necessity review may be required for prior authorization.</td>
</tr>
<tr>
<td>Perinatology (Maternal/Fetal Care)</td>
<td>These services are covered.</td>
</tr>
</tbody>
</table>
| Personal Care Services including Assistants | These services are covered under certain circumstances as outlined in the Medicaid Service Manual (MSM), including but not limited to:  
• Assistance with bathing, grooming and dressing (one service).  
• Assistance with toileting needs.  
• Assistance with transferring and positioning nonambulatory members.  
• Assistance with ambulation.  
• Assistance with eating.  
• Assistance with medications. Prior authorization is required. The following services are not covered:  
• Tasks that can be performed by member  
• Services provided by willing caregiver  
• Tasks not on approved service plan  
• Services to maintain household, such as cleaning areas not used by member  
• Services provided to someone other than member |
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Inclusions, Limitations or Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Care required to be performed by health care professional licensed by state</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Pharmacy coverage includes:</td>
</tr>
<tr>
<td></td>
<td>• Prescription drugs approved by the United States Food and Drug Administration (FDA)</td>
</tr>
<tr>
<td></td>
<td>• Over-the-counter (OTC) items approved by the FDA and covered by Fee-For-Service (FFS) program (prescription required)</td>
</tr>
<tr>
<td></td>
<td>• Self-injectable drugs (including insulin)</td>
</tr>
<tr>
<td></td>
<td>• Smoking cessation drugs</td>
</tr>
<tr>
<td></td>
<td>• Various supplies (diabetic testing supplies, spacers)</td>
</tr>
<tr>
<td></td>
<td>• Vaccines: limited to adults only for flu and pneumococcal</td>
</tr>
<tr>
<td></td>
<td>We don’t cover the following:</td>
</tr>
<tr>
<td></td>
<td>• Drugs not approved by the FDA</td>
</tr>
<tr>
<td></td>
<td>• Drugs from manufacturers that do not participate in a rebate agreement with the Centers for Medicare and Medicaid Services (CMS)</td>
</tr>
<tr>
<td></td>
<td>• Drugs not on the FFS OTC Drug Formulary</td>
</tr>
<tr>
<td></td>
<td>• Drugs to help members get pregnant</td>
</tr>
<tr>
<td></td>
<td>• Drugs used for cosmetic reasons</td>
</tr>
<tr>
<td></td>
<td>• Drugs for hair growth</td>
</tr>
<tr>
<td></td>
<td>• Drugs used to treat erectile problems</td>
</tr>
<tr>
<td></td>
<td>• Drugs used for weight loss</td>
</tr>
<tr>
<td></td>
<td>• Experimental or investigational drugs</td>
</tr>
<tr>
<td></td>
<td>Coverage for most drugs is limited to a 30-day supply unless the drug is considered maintenance pharmaceutical for a chronic condition. See Section 5.8 — Pharmacy Services for more information.</td>
</tr>
<tr>
<td>Physician Services</td>
<td>All symptomatic and general preventive health visits to physicians or physician extenders within the scope of their licenses are covered benefits. Physician services covered include services received while admitted in the hospital, outpatient hospital department, in a clinic setting or in a physician’s office.</td>
</tr>
<tr>
<td>Podiatric Services</td>
<td>Please make sure to consult the Medicaid Services Manual section 603.7 to review additional limitations including covered and noncovered services.</td>
</tr>
<tr>
<td></td>
<td>We don’t cover preventive care including the cleaning and soaking of feet, application of creams to ensure skin tone, and routine foot care such as trimming of nails and cutting or removal of corns or calluses in the absence of infection or inflammation.</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>We cover the following preventive health services for Medicaid members:</td>
</tr>
<tr>
<td>Wellness Visit</td>
<td>• Every three years for members ages 21 to 39</td>
</tr>
<tr>
<td></td>
<td>• Every year for members age 40 and over</td>
</tr>
<tr>
<td>Pap Smear and Pelvic Exam</td>
<td>• Every year for women age 21 and over.</td>
</tr>
<tr>
<td></td>
<td>• Cervical cancer screening is considered medically necessary for women under 21 years of age who are chronically immunosuppressed</td>
</tr>
</tbody>
</table>
Covered Services

Inclusions, Limitations or Exclusions

(for example, organ transplant recipients or seropositive for human immunodeficiency virus). Cervical cancer screening for women less than 21 years of age is considered not medically necessary for all other indications not listed above.

Clinical Breast Exam
- Every three years for women age 20 to 39
- Every year for women age 40 and over

Mammograms (Breast X-ray)
- Every year for women age 40 and over
- Mammography is also available for women between the ages of 35 to 39 who are considered to be at high risk for breast cancer

Fecal Blood Occult Test
- Every year for members age 50 and over

Sigmoidoscopy and DRE/PSA or Colonoscopy and DRE/PSA
- Every 48 months for members age 50 and over

For children’s preventive services, see information for EPSDT and well-baby and well-child care.

Private Duty Nursing Services
These services are covered under certain circumstances as outlined in the Medicaid service manuals. Private duty nursing services may be approved for chronically ill members who require extensive skilled nursing care to remain at home. Prior authorization is required.

Rehabilitative Services — Short Term (PT, OT, ST)
This is covered. See Habilitative Services for information.

Respiratory Therapy (RT)
This is covered. All-inclusive Respiratory/Pulmonary Rehabilitation Program is not a Medicaid-covered benefit.

Routine Physicals
These services are covered.

School-Based Child Health Services (SBCHS)
SBCHS members have a limit of no more than two individualized education plans in a calendar year.

The following services are not covered:
- Services provided to students over the age of 21 or under the age of 3
- Services classified as educational or recreational
- Services to non-Medicaid eligible individuals
- Information furnished by a provider to member over the telephone
- Dental or related services
- Treatment of obesity
- Any immunizations or biological products and other products available free of charge from the state health division
- Transportation of school-aged children to and from school, including specialized transportation for Medicaid-eligible children on days when they receive Medicaid covered services at school

Second Opinions
These services are covered.

Sexual Abuse Exam
These services are covered.

Skilled Nursing Facility (SNF) Services
Covered services include all nursing facilities, swing-bed admissions, and all other medically necessary services through the first 45 days of admission. On the 46th day, these services are covered by FFS.

Smoking Cessation Programs/Supplies
Our holistic program administered through National Jewish Health includes coaching, written and online education, and nicotine replacement therapy.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Inclusions, Limitations or Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>(NRT) delivered to the member’s home. Members can self-refer to the program by contacting member services or be referred through a clinical program such as Case Management or Disease Management. All FDA-approved tobacco cessation medications, both prescription and over-the-counter, are covered for a minimum of 90 days. Prior authorization is not required.</td>
<td></td>
</tr>
<tr>
<td>Combination therapy: The use of a combination of medications, including but not limited to the following combinations, is allowed:</td>
<td></td>
</tr>
<tr>
<td>• Long-term (over 14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray)</td>
<td></td>
</tr>
<tr>
<td>• Nicotine patch and inhaler</td>
<td></td>
</tr>
<tr>
<td>• Nicotine patch and bupropion SR</td>
<td></td>
</tr>
<tr>
<td>There are no step-therapy requirements.</td>
<td></td>
</tr>
<tr>
<td>Members are also referred to local health education classes that include topics to cover smoking cessation.</td>
<td></td>
</tr>
<tr>
<td>Our Disease Management (DM), Care Management (CM) or OB case management clinicians perform assessments for each member that include health risk due to smoking or exposure to smoke.</td>
<td></td>
</tr>
<tr>
<td>One of our case managers educates the member at risk on the effects of smoking and engages in a discussion around smoking cessation strategies and programs. Health Tips, educational tools that address tobacco use, are sent to members who are enrolled in the disease management, CM or OB case management programs and who have been identified as using tobacco products.</td>
<td></td>
</tr>
<tr>
<td>Members may also be referred to a behavioral health provider for evaluation and treatment of substance abuse, including tobacco use.</td>
<td></td>
</tr>
<tr>
<td>Transplants</td>
<td>Medicaid members over 21</td>
</tr>
<tr>
<td>These services are covered up to the service limit guidance in the appropriate Nevada Medicaid services manual. We cover the following transplant services for members who meet the eligibility and medical necessity requirements:</td>
<td></td>
</tr>
<tr>
<td>• Bone marrow/stem cell</td>
<td></td>
</tr>
<tr>
<td>• Cornea</td>
<td></td>
</tr>
<tr>
<td>• Kidney</td>
<td></td>
</tr>
<tr>
<td>• Liver for adults with end stage liver disease</td>
<td></td>
</tr>
<tr>
<td>Heart, lung, pancreas and intestinal transplants (and their associated costs) are NOT covered for adults.</td>
<td></td>
</tr>
<tr>
<td>Medicaid members under 21</td>
<td></td>
</tr>
<tr>
<td>We cover any medically necessary transplant that is not experimental.</td>
<td></td>
</tr>
<tr>
<td>Covered Services</td>
<td>Inclusions, Limitations or Exclusions</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Vision Ophthalmology/Optometry** | Exams  
Routine comprehensive exams and/or refractive exams of the eyes and glasses with a prescription for and provision of corrective eyeglasses are covered for Medicaid members of all ages once every 12 months. Eye exams for the following medical conditions/situations are covered based on medical necessity, do not require prior authorization, and are not limited to the 12-month restriction for examination and lenses:  
- Glaucoma  
- Diabetes  
- Healthy Kids/EPSDT referral services  
- Following cataract surgery  

Lenses  
Covered for members of all ages. No prior authorization is needed for members under age 21. Prior authorization is required for members age 21 and over if the 12-month limitation is exceeded.  

Frames  
Existing frames must be used whenever possible. If new frames are needed, they may be metal or plastic.  

Contacts  
Not covered unless:  
- Medically needed to meet minimum criteria required to avoid legal blindness.  
- Medically needed following cataract surgery.  
- Used as a means to avoid heavy glasses, which would hurt the bridge of the nose.  
- Required when the member has a diagnosis of keratoconus.  

EPSDT (Healthy Kids)  
Vision exams are covered as referred by the child’s PCP or developmental or educational professional. Exams under this condition do not require a prior authorization.  

Glasses may be provided at any interval without prior authorization of EPSDT members long as there is a change in refractive status from the most recent exam.  

The following are not covered:  
- Sunglasses and cosmetic lenses  
- Replacement lenses unless there is a significant change in refractive status  
- Transitional lenses  
- Faceted lenses  
- Additional cost of extended repair or replacement warranty  
- Frames with ornamentation  
- OkFrames, which attach to or act as a holder for hearing aid(s)  

**Well-Baby and Well-Child Care**  
Routine well-baby and well-child care services are covered for member ages 0 to 18 and include routine office visits with health assessments and physical exams, routine lab work, and age-appropriate immunizations.
5.2 Value-Added Benefits

The following table shows the value-added benefits Anthem covers for Medicaid and Nevada Check Up members.

<table>
<thead>
<tr>
<th>Membership to Boys &amp; Girls Clubs</th>
<th>Sports/School Physicals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition and Description</td>
<td></td>
</tr>
<tr>
<td>Free membership for children</td>
<td>One sports/school physical every 12 months</td>
</tr>
<tr>
<td>Member Eligibility</td>
<td></td>
</tr>
<tr>
<td>Children ages 5 to 14</td>
<td>Child ages 6 to 18</td>
</tr>
<tr>
<td>Limits or Restrictions</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>Physicals must be conducted by an Anthem PCP/PCS.</td>
</tr>
<tr>
<td>Providers</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Any Anthem PCP/PCS</td>
</tr>
<tr>
<td>Member Access</td>
<td></td>
</tr>
<tr>
<td>Members may access a Boys &amp; Girls club directly. A list of participating clubs is available from Member Services.</td>
<td>Members can self-refer to any Anthem PCP/PCS.</td>
</tr>
</tbody>
</table>

Additional member benefits include:

- Free cellphone with free monthly minutes, data and text messages.
- Additional transportation assistance to provider appointments and health-related services.
- My wellness guide so member can take control of their health and well-being — set goals, track progress and get tips for healthier living.
- Bedside delivery of medications to member’s bedside when discharged from a hospital setting.
- Free holistic smoking program — smoking cessation to support members age 18 or older and includes telephonic outreach, education, nicotine replacement therapy and coaching.
- Transitional care assistance for extra help from hospital to home — a collaboration between Anthem case managers and community partners in assisting members with extra services as needed when transitioning home (for example, transportation, bedside medication delivery, establishing follow up appointment with PCP, etc.).
- We also provide, at no charge to PCPs and various provider offices, our health and wellness or health tip information (for example, Health Tips).
- Visiting a doctor through video chat is a telehealth service to members and essentially offers online video chat if there is a need in support for minor illnesses.
- General Education Diploma (GED) or HiSet assistance — for members in need of completing their GED and obtaining a high school degree.
- Shelter bed reservations program assists members enrolled with Well Care for BH services with the need for overnight shelter. Transportation and case management are in addition to the services provided.
- 24/7 NurseLine to answer members’ medical questions and concerns anytime, day or night.
- New Baby, New Life is part of a corporate-supported, standardized Member Incentive Program (MIP) that enables the health plan to reward members for completing specific health activities for non-cash rewards that may assist in the prevention, wellness or management of chronic illnesses.
conditions. The program is highly versatile and intended to boost clinical performance metrics and health outcomes for pregnant women and new moms.

- Aunt Bertha — a free-to-use, online platform that allows members and providers to find social service programs (https://www.aunthertha.com).
- Free pregnancy test kits from in-network CVS and Walmart (select CVS brand or Walmart Equate brand only); limit of three kits per year for female patients.

**Patient360**

Patient360 is an interactive dashboard that gives you a robust picture of a member’s health and treatment history and helps you facilitate care coordination. Patient360 is available through our secure self-service website, which gives you instant access to detailed information about your Anthem patients. By selecting each tab in the dashboard, you can drill down to specific items in a member’s medical record. Information is available regarding a member’s demographics, care summaries, claims details, authorization details, and pharmacy and care management-related activities.

Patient360 is a multifaceted perspective on member utilization and pharmacy patterns. With this level of detail at your fingertips, you’ll avoid duplicating services, identify care gaps and trends and coordinate care more effectively. In addition, accessing this data electronically will reduce the number of communications needed between PCPs and case managers, as well as significantly increase patient confidentiality.

To access Patient360:
2. Select Payer Spaces.
3. Select the Anthem Blue Cross Blue Shield Medicaid tile
4. Select the Applications tab
5. Select Patient360.
6. Enter the required fields including the Anthem member ID.
   Note: Your organization’s administrator must assign you the Patient360 role before you are able to access the tool.

**Healthy Rewards Programs for Members**

The Healthy Rewards Program is a corporate-supported, standardized Member Incentive Program (MIP) that enables the health plan to reward members for completing specific healthy activities for non-cash rewards that may assist in the prevention, wellness or management of chronic conditions. The program is highly versatile and intended to boost clinical performance metrics and health outcomes. A few of the incentives are as follows:

- Incentives for adolescent well-care visits 12 to 21
- Incentives for well-child visit 3 to 6
- Incentives for breast cancer screening
- Incentives for diabetes screening — HbA1c
- Incentives for cervical cancer screening
- Incentives for asthma medication fills
- Incentives for antidepressant medication management fill
- Incentives for ADHD medication fill and doctor visits
- Incentives for prenatal and postpartum care visit
- Incentives for well-baby visits
5.3 New Baby, New Life Program

New Baby, New Life® is a proactive case management program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files, claims data, lab reports, hospital census reports, and provider notification of pregnancy and delivery notification forms and self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services including transportation, WIC, home-visitor programs, breastfeeding support and counseling.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That’s why we encourage all of our moms-to-be to take part in our New Baby, New Life program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Rewards to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.

Members are eligible to receive:

- Prenatal visit in the first trimester or within 42 days of enrollment with Anthem = $15 in rewards
- Attending at least six prenatal care visits = $40 in rewards
- Attending the postpartum visit within 7 to 84 days after delivery = $20 in rewards

As part of the New Baby, New Life program, members are offered the My Advocate® program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR), web or smart phone application. This program does not replace the high-touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers, and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate, visit www.myadvocatehelps.com.

Notification of pregnancy and delivery to Anthem at 1-800-964-3627 is required at the first prenatal visit and following birth.

You should also complete the Maternity HEDIS® Form using the Availity Portal.

- Perform an Eligibility and Benefits request on an Anthem member and choose one of the following benefit service types: Maternity, Obstetrical, Gynecological, Obstetrical/Gynecological.
HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

- Before you see the benefit results screen you will be asked if the member is pregnant and given a Yes or No option. If you indicate “Yes” you will be asked what the estimated due date is and can fill that date out if you have an estimate or leave it blank if you do not.
- After you submit your answer, you will be taken to the benefits page like normal. In the background a HEDIS Maternity Form will have been generated for this patient in the HEDIS Maternity application in the Payer Spaces for the Anthem plan.

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the You and Your Baby in the NICU program and a NICU Post Traumatic Stress Disorder (NICU PTSD) program. Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. Parents are provided with an educational resource outlining successful strategies they may deploy to collaborate with the care team.

Please help us identify members who would benefit from OB case management and make referrals to the case management program by calling 1-844-396-2330 and asking for an OB case manager.

### 5.4 Early and Periodic Screening, Diagnosis and Treatment/Well-Child Visits/Healthy Kids

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) are preventive and diagnostic services available to Medicaid members under age 21. In Nevada, the EPSDT program is known as Healthy Kids. The program is designed to identify medical conditions and to provide medically necessary treatment to correct such conditions. Healthy Kids offers the opportunity for optimum health status for children through regular, preventive health services and the early detection and treatment of disease. EPSDT services include but are not limited to the following:

- Screening services, which include a comprehensive health and developmental history (including assessment of both physical and mental health development)
- A comprehensive, unclothed physical exam
- Age-appropriate immunizations (according to current American Committee on Immunization Practices [ACIP] schedule)
- Laboratory tests (including blood lead level assessment appropriate to age and risk as directed by current federal requirements)
- Health education/anticipatory guidance
- Vision screen
- Dental screen
- Hearing screen
- Age-appropriate TB screening per CMS requirements
- Other necessary health care, diagnostic services, treatment and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state Medicaid plan

HEDIS quality measurements require that all well-child/adolescent visits for Medicaid and Check Up measures must also include:
• BMI percentile documentation.
• Counseling for nutrition.
• Counseling for physical activity.

The state Medicaid plan requires that EPSDT screenings are billed using appropriate codes found in the Hewlett Packard Enterprise Services (HPES) Billing Guide, Physician Billing Guide, 99381-99385 or 99391-99395, with modifier EP or TS:
  • Use modifier EP for service that is part of the Medicaid EPSDT program.
  • Use modifier TS if referral or follow-up is indicated. Also complete field 21 on the CMS-1500 claim form with the ICD-10 code for the condition requiring follow up.

Anthem allows reimbursement for preventive medicine (that is, well-child) and limited sick visits on the same day unless provider, state, federal or CMS contracts or requirements indicate otherwise. Reimbursement is based on the fee schedule or contracted/negotiated rate for the preventive medicine and the allowed sick visit under the following conditions:
  • Modifier 25 must be billed with the applicable evaluation and management (E&M) code for the allowed sick visit. If modifier 25 is not billed appropriately, the sick visit will be denied.
  • Appropriate diagnosis codes must be billed for respective visits.

Note: Nevada Check Up members are not eligible for EPSDT, but they are eligible for well-child care services.

Well-child care services are available for Nevada Check Up members ages 0 to 18. These services include regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children and adolescents as defined by the state.

Well-child care services should be performed for newborns in the hospital and then as follows:

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Under 1</th>
<th>1 to 2</th>
<th>3 to 5</th>
<th>6 to 9</th>
<th>10 to 14</th>
<th>15 to 18</th>
<th>19 to 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 days old</td>
<td>12 months</td>
<td>3 years</td>
<td>6 years</td>
<td>10 years</td>
<td>15 years</td>
<td>19 years</td>
<td>20 years</td>
</tr>
<tr>
<td>1 month</td>
<td>15 months</td>
<td>4 years</td>
<td>7 years</td>
<td>11 years</td>
<td>16 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 months</td>
<td>18 months</td>
<td>5 years</td>
<td>8 years</td>
<td>12 years</td>
<td>17 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 months</td>
<td>24 months</td>
<td></td>
<td>9 years</td>
<td>13 years</td>
<td>18 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>30 months</td>
<td></td>
<td></td>
<td>14 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 months</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

5.5 Immunizations

You must enroll in the Vaccines for Children (VFC) program administered by the Nevada State Health Division. If you’re licensed by the state to prescribe vaccines, contact the Nevada State Health Division to enroll. The immunization program will review and approve your enrollment request. As a VFC-enrolled provider, you must cooperate with the Nevada State Health Division for purposes of performing orientation and monitoring activities regarding VFC program requirements.

Upon successful enrollment in the VFC program, you may request state-supplied vaccines to be administered to members through 18 years of age in accordance with the most current ACIP schedule and/or recommendation and following VFC program requirements.
Participate in the Nevada State Health Division’s Immunization Registry by reporting to the state all immunizations of children up to 2 years of age. We’ll assist you if you don’t have the capability to meet these requirements upon request.

Coverage excludes any immunizations, biological products and other products available free of charge from the State Health Division.

Vaccine administrations are separately reimbursable expenses from well-child exams or office visits. When the vaccine administration is the only service performed, Anthem does not allow reimbursement for a minimal office visit (that is, an office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician where the presenting problem[s] are usually minimal and typically five minutes are spent performing or supervising these services).

Members can self-refer to a qualified provider (in- or out-of-network).

We’ll reimburse local health departments (LHDs) for the administration of vaccines regardless of whether or not the LHD is under contract with us.

Note: We cover the administration fee only for members less than 21 years of age.

5.6 Well-Child Visits Reminder Program

A list of our members who, based on our claims data, may not have received well-child services according to the above schedule is sent to their PCPs/PCSs each quarter. Additionally, we mail information to these members encouraging them to contact the offices of their PCPs/PCSs to set up appointments for needed services.

Please note:
- The specific service(s) needed for each member is listed in the report. Reports are based only on services received during the time the member is enrolled with us.
- Services must be rendered on or after the due date in accordance with federal EPSDT and state Department of Health guidelines. In accordance with these guidelines, services received prior to the specified schedule date do not fulfill EPSDT requirements.
- This list is generated based on our claims data received prior to the date printed on the list. In some instances, the appropriate services may have been provided after the report run date.
- To ensure accuracy in tracking preventive services, please submit a completed claim form for those dates of service to our Claims department at:
  Anthem Blue Cross and Blue Shield Healthcare Solutions
  P.O. Box 61010
  Virginia Beach, VA 23466-1010
5.7 Blood Lead Screening

You’re required to furnish a screening program consisting of a screening and a blood test for the presence of lead toxicity in children. During well-child visits for children between the ages of 6 months and 6 years old, the PCP/PCS will screen each child for lead poisoning. Blood tests should be performed at 12 months and 24 months of age to determine lead exposure and toxicity. In addition, children over the age of 24 months up to 72 months should receive blood screening lead tests if there is no past record of a lead screening.

We contract with MEDTOX Laboratories* to provide our PCPs with a filter paper lead screening method. The MEDTOX method of blood lead testing is a fast, noninvasive and easy way to conduct lead testing. Supplies are provided at no charge to your office; once the sample cards are mailed back to MEDTOX, you can expect results delivered within 24 to 48 hours of receipt.

The Nevada Division of Heath Care Financing and Policy (DHCFP) has approved the MEDTOX test as an acceptable technique for lead screening. Bill with CPT code 36416 along with the applicable office visit code when submitting a claim for the procedure.

5.8 Pharmacy Services

Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers enrolled in Nevada Medicaid Program for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies enrolled in Nevada Medicaid Program including CVS, Smith’s (Kroger) and Wal-Mart. Walgreens and Rite Aid are not part of the pharmacy network.

We contract with IngenioRx* to process prescription drug claims using a computerized point-of-sale (POS) system. This system gives participating pharmacies online real-time access to beneficiary eligibility, drug coverage (to include prior authorization requirements), prescription limitations, pricing/payment information and prospective drug utilization review. Pharmacy providers in the Anthem pharmacy network (CVS, Smith’s (Kroger) and WalMart) should submit pharmacy benefit claims to IngenioRx for our members. Pharmacies may dispense up to a 30-day supply of medication. If desirable, members may receive a 60-day supply of maintenance medication through our mail order pharmacy. Pharmacies may dispense up to a 12 month supply for FDA approved contraceptives.

If a member is transitioning to us from FFS or another managed care organization (MCO), we offer a transition benefit for continuity of care. The member will receive a transition benefit for a one-time fill during the first 30 days for any covered drug. Members may receive 2 fills during first 60 days for any maintenance drug and 3 fills during first 90 days for any behavioral health drug. After the member has used the transition benefit, providers will need to submit a prior authorization request for possible approval of the member continuing on this drug.

Members do not have a prescription copay.
**Covered Drugs**

Our pharmacy program uses a *Preferred Drug List (PDL)*. This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The *PDL* is comprised of drug products reviewed and approved by our Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is comprised of actively practicing network physicians, pharmacists and other health care professionals who evaluate safety, efficacy, adverse effects, outcomes and total pharmacoeconomic value for each drug product reviewed. The *PDL* also includes several over-the-counter (OTC) products that are recommended as first-line treatment where medically appropriate. To prescribe medications that do not appear on the *PDL*, please contact Pharmacy Services at **1-844-396-2330**. Please refer to our *PDL* or complete formulary on our website.

Pharmacy coverage includes:

- Prescription drugs approved by the United States Food and Drug Administration (FDA)
- Over-The-Counter (OTC) items approved by the FDA and covered by the Fee-For-Service (FFS) Program
  - Note: OTC items still require a prescription in order to be covered under the Medicaid plan and for the pharmacy to be able to dispense the medication.
- Self-injectable drugs (including insulin)
  - Note: Claims for physician-administered injectable medications should be submitted to the medical benefit with a CMS 1500 form and include a procedure code and an NDC.
- Contraceptives (Contraceptive devices are covered under the medial benefit and should be billed to Anthem).
- Smoking cessation drugs
- Various supplies (diabetic testing supplies, spacers)
  - Note: Claims for Durable Medical Equipment (DME) supplies (i.e. nebulizers, insulin pumps, enteral nutrition) submitted to the medical benefit with a CMS 1500 form and include a procedure code and an NDC
- Vaccines: limited to adults only for flu and pneumococcal.
- Free pregnancy test kits from in-network CVS and Walmart (select CVS brand or Walmart Equate brand only); limit of three kits per year for female patients

Services **not** covered by the pharmacy benefit include:

- Drugs not approved by the FDA
- Drugs from manufacturers that do not participate in a rebate agreement with the Centers for Medicare and Medicaid Services (CMS)
- Drugs not on the FFS OTC Drug Formulary
- Drugs to help members get pregnant
- Drugs used for cosmetic reasons
- Drugs for hair growth
- Drugs used to treat erectile problems
- Drugs used for weight loss
- Experimental or investigational drugs

**Mandatory Generic Drug Policy**

Generic substitution for brand-name equivalent drugs is required. Generic drugs must be provided when available. When a generic drug is available, brand-name products will only be approved through written
prior authorization, with the exception of the Narrow Therapeutic Index (NTI) medications. To prescribe a brand name drug when a generic equivalent is available, the prescriber will need to certify the need by:

- Documenting in the member’s medical record the need for the brand-name product in place of the generic form
- Submitting written prior authorization
- Certification must be in the prescriber’s own handwriting
- Certification must be written directly on the prescription blank with a phrase indicating the need for a specific brand is required (An example would be “Brand Medically necessary.”).

**Prior Authorization Drugs**

We strongly encourage you to write prescriptions for products as listed on our complete formulary or our PDL. Medications not listed in the formulary or PDL are considered to be nonformulary and are subject to prior authorization. Some medications listed on our formulary or PDL may have additional requirements or limitations of coverage. These requirements and limits may include prior authorization, quantity limits, age limits or step therapy. Additionally, if a medication is available as a generic formulation, this will be Anthem’s preferred agent unless otherwise noted. If a brand-name medication is requested when a generic exists, a prior authorization request will need to be submitted. If you have any questions about coverage of a certain medication, please contact the Anthem Pharmacy Department at 1-844-396-2330 (Monday to Friday, 5 a.m. to 6 p.m. PST; Saturday from 7 a.m. to 11 a.m. PST).

To request prior authorization (PA), the provider must contact the Anthem Pharmacy Department at 1-844-396-2330. Providers may also submit PA via fax or electronically. Providers should be prepared to provide relevant clinical information regarding the member’s need for a non-preferred product or a medication requiring prior authorization. Decisions are based on medical necessity and are determined according to certain established medical criteria.

For drugs requiring PA, pharmacies may dispense a 72 hour emergency supply for a Medicaid covered drug to allow time for the PA review. Decisions on pharmacy PAs are made within 24 hours.

### 5.9 Specialty Drug Program

We contract with IngenioRx as our exclusive pharmacy supplier for high-cost, specialty/self-injectable drugs available under our pharmacy benefit that treat a number of chronic or rare conditions. (Note: IngenioRx should not be used for physician-administered injectable medications. Claims for physician-administered injectable medications covered should be submitted to the medical benefit with a CMS 1500 form and include a procedure code and an NDC.)

Please call IngenioRx at 1-833-255-0646 to request a specific medication.

A full listing of the medications supplied by IngenioRx can be found on our website at [https://mediproviders.anthem.com/nv](https://mediproviders.anthem.com/nv) and is current at the time of printing. Because new specialty drugs continually become available, you should check with us before providing any specialty/injectable drugs.

Certain specialty drugs/ medical injectables require PA/precertification. To determine whether the medication you are prescribing requires PA/precertification, please refer to the Searchable Formulary or
the Precertification Lookup Tool at https://mediproviders.anthem.com_nv. If it’s determined the medication you are seeking to prescribe requires PA/precertification, contact the Pharmacy Department at 1-844-396-2330.

When prescribing a specialty drug, please fax your request to IngenioRX at 1-833-263-2871 or call IngenioRx at 1-833-255-0646, and they will coordinate shipment to your office or to the member’s home. You should not provide these drugs from your office stock without first obtaining precertification from us.

5.10 Behavioral Health Services

Members may self-refer, or you may direct members to our network of behavioral health care providers for behavioral health services. We’re responsible for the provision of mental health, alcohol and other drug abuse assessments and treatment services as follows:

- Inpatient mental health and substance abuse services
- Outpatient mental health and substance abuse services
- Mental health rehabilitative treatment services
- Case management
- Residential treatment center (RTC)

Medicaid

We’re responsible for all services covered until the member is properly disenrolled from managed care, as per the Nevada Medicaid Services Manual.

Anthem must notify DHCFP of a member’s admission to an RTC within five days of admission. The member will be disenrolled from Anthem effective the first day of the next administratively possible month following the RTC admission, and services will be reimbursed by FFS thereafter.

Nevada Check Up

Anthem must notify DHCFP of a member’s admission to an RTC within five days of admission. Members who are covered under Nevada Check Up will remain enrolled with Anthem throughout their RTC admission. While Anthem remains responsible for reimbursement of all ancillary services during the RTC admission (for example, physician services, optometry, laboratory, dental and X-ray services, etc.) the admission and bed day rate will be covered by FFS for this population commencing on the first day of admission.

Services to Seriously Emotionally Disturbed and Serious Mental Illness Members

Our network providers must ensure members who are referred for evaluation for the seriously emotionally disturbed (SED) or serious mental illness (SMI), or who have been determined SED or SMI, are receiving covered medically necessary medical, outpatient or rehabilitative mental health services using an integrated wraparound model.

This model ensures the provision of biopsychosocial services based on an individual’s needs and strengths is family-driven, client-centered and culturally competent. Services are provided according to a written individualized treatment plan, which contains measurable goals and objectives and includes
access to an array of medically necessary outpatient mental health and rehabilitative mental health services across the continuum of care. Our network providers must ensure services are community-based, provided in the least restrictive and most normative setting possible, and include effective care coordination.

Our network providers must ensure the parent or guardian of a minor member who is referred for SED assessment or an adult who is referred for SMI assessment is fully informed of the reason why the assessment is necessary. You must obtain authorization from the minor member’s parent or guardian or from the enrolled adult or his or her personal representative to conduct the assessment and to release the determination to us, the DHCFP and/or its designee. (Note: Policy regarding who the DHCFP recognizes as a personal representative is set forth in Chapter 3 of the *DHCFP HIPAA Privacy Manual*.)

Anthem and our designated subcontractors/network providers are the only entities with the authority to make the SED or SMI determination for our enrolled member. No other entity can make a determination on behalf of a Medicaid member enrolled with Anthem. If a nondesignated entity makes a determination, Anthem will reject the determination and ask that the enrolled member be referred to Anthem for a determination and services. SED and SMI determinations made by authorized entities referenced in Chapters 400 and 2500 of the Nevada Medicaid Services Manual under Fee-For-Service (FFS) Medicaid will be considered valid for member who transition from FFS Medicaid to managed care. Likewise, determinations made by Anthem or our designated subcontractors/network providers will be considered valid for member who transition from managed care to FFS Medicaid. We will participate and have oversight of the transition of member from managed care to FFS Medicaid and have final review and determination. SED and SMI determinations made by appropriately licensed mental health practitioners within the 12-month period preceding initial Medicaid eligibility will be considered valid for either FFS Medicaid or managed care member and reviewed by Anthem for final determination.

Pursuant to the state of Nevada Title XIX State Plan, Medicaid member have the option of disenrolling from managed care on the 46th day, if determined to be SED or SMI, except in the case of admission to an RTC when disenrollment on the admission is mandatory. Pursuant to the Nevada Title XXI State Plan, in urban areas only, Nevada Check Up member must remain enrolled with the MCO responsible for ongoing patient care. When one of our members is determined to be SED or SMI and wishes to disenroll from managed care, the Anthem provider who made the determination should complete the Request for Managed Care Disenrollment Based on SED/SMI Determination form.

Member who receive either an SED or SMI determination must be redetermined at least annually. For members who have voluntarily elected to remain enrolled in managed care, the process for these redeterminations is the same as for the initial SED or SMI determination as stated above.

Forms to obtain member consent for an SED/SMI evaluation, to document and notify DHCFP of an SED/SMI determination, and to enable the SED or SMI member to disenroll from Medicaid managed care are located on the DHCFP website.

*Within five business days, you’re required to submit these forms to DHCFP per the instructions on the forms.*
Patient360
Patient360 is a read-only dashboard that gives you a robust picture of a member’s health and treatment history and helps you facilitate care coordination. Patient360 is available through our secure self-service website, which gives you instant access to detailed information about your Anthem patients. By clicking each tab in the dashboard, you can drill down to specific items in a member’s medical record. Information is available regarding a member’s demographics, care summaries, claims details, authorization details, and pharmacy and care management-related activities.

Patient360 is a multifaceted perspective on member utilization and pharmacy patterns. With this level of detail at your fingertips, you’ll avoid duplicating services, identify care gaps and trends and coordinate care more effectively. In addition, accessing this data electronically will reduce the number of communications needed between PCPs and case managers, as well as significantly increase patient confidentiality.

To access Patient360:
2. Select Applications from the navigation.
4. Enter the Anthem member’s information.

5.11 Member Rights and Responsibilities
Members have rights and responsibilities when participating with an MCO. Our Member Services representatives serve as advocates for our members. Members can find a list of these rights in the member handbook and on the member website at www.anthem.com/nvmedicaid. They can request a hard copy by calling Member Services at 1-844-396-2329 (TTY 711). Below are our members’ rights and responsibilities:

Member Rights
An Anthem member has the right to:
- Be treated with respect, dignity and have their right to privacy respected. This includes:
  - Knowing their medical records and discussions with their PCPs will be kept private and confidential.
  - Being treated fairly.
- Receive information about Anthem, its services, practitioners and providers, and member rights and responsibilities.
- Choose a practitioner who is part of the Anthem network and refuse care from specific PCPs and providers. This includes:
  - Knowing how to choose and change their health plan and PCP.
  - Choosing any health plan they want that is available in their area and choosing their PCP from that plan.
  - Changing their PCP.
  - Selecting a specialist to serve as their PCP if they have a chronic condition.
  - Changing their health plan without penalty.
- Participate in the decision-making process for their health care. This includes:
  - Working as part of a team with their practitioner to decide what health care is best for them.
Taking part in an honest discussion on the proper or medically needed treatment options for their condition, without concern about the cost or benefit coverage.

- Deciding on care recommended by their PCP and their other providers.
- Being told and understanding the results of the decision.
- Refusing treatment.

- Express and expect resolution of grievances and appeals about:
  - Anthem.
  - Our network PCPs and providers.
  - The care we provide.

- Create an advanced directive to tell their doctor the kind of care they want if they are not able to communicate their decisions.

- Have access to their medical records in agreement with all federal and state laws and be able to request the records be changed or corrected in agreement with federal and state laws.

- Make suggestions about the Anthem member rights and responsibilities policy.

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

- Receive information on available treatment options and alternatives that is presented in a way that they are able to understand.

**Member Responsibilities**

An Anthem member has the responsibility to:

- Provide information, the best they can, to help Anthem and our providers give them the best care, including:
  - Telling their practitioners about their health.
  - Talking to their practitioners about their health care needs and asking questions about the different ways health care problems can be treated.
  - Helping their practitioners get their medical records.
  - Providing their practitioners with the right information.

- Follow instructions and guidelines which they have agreed to given by Anthem, practitioners and PCPs.

- Understand their health problems and work with their PCPs and providers to find an agreed upon plan to help treat their illness or condition, including:
  - Working as a team with their practitioners to decide what health care is best for them.
  - Understanding how what they do can affect their health.
  - Doing the best they can to stay healthy.
  - Treating PCPs and staff with respect.

- Notify Anthem if they have other health insurance.

- Carry their ID card at all times.

- Update demographic information with the Division of Welfare and Social Services.

### 5.12 Member Grievance

We have a grievance resolution process in place for our members. All members or persons acting on behalf of members have a right to voice dissatisfaction of any aspect of ours or a provider’s operations. You can file a grievance on behalf of a member only after the member has granted you written
permission to act as his or her personal representative. You must adhere to the same regulated time frames as we give the members.

**Members are provided with the following information:**
If you have a problem with our services or network providers, we would like you to tell us about it. Please call Member Services. We will try to solve your problem on the phone.

If we can’t take care of the problem when you call us, you can file a grievance. You can:

- Write a letter to us and include information, such as:
  - The date the problem happened.
  - The names of people involved.
  - Details about the problem.
- File a grievance on the phone.
- Ask Member Services for help with writing a letter; include information such as the date the problem happened and the people involved.
- Send your letter to:
  
  Anthem Blue Cross and Blue Shield Healthcare Solutions  
  Quality Management Department  
  Desert Canyon Building 9  
  9133 W. Russell Road  
  Las Vegas, NV 89148

When we get your call or letter, we will:
1. Send you a letter within five calendar days to let you know we received your grievance.
2. Look into your grievance in a timely manner.
3. Send you a letter within 90 calendar days of when you first told us about your grievance; the letter will advise you of our decision.

**Second Level Grievance Review**
You may file a second level grievance review if you are not happy with our decision, and your grievance is about:

- Your ability to receive benefit coverage
- Access to care
- Access to services
- Payment for services

Ask us for a second level grievance review in writing within 90 calendar days of the date on the original grievance resolution letter we sent you. Mail your second level grievance review request to the same address that you sent your initial grievance request. We will send you a letter within five calendar days to let you know we got your request. Someone at a higher level than the reviewer who looked at your initial grievance request will look at your second level request. We will send you a letter with our decision within 30 calendar days.

The second level grievance review is the final level of review for grievances.
5.13 Authorization and Notice Timeliness Requirements

We will provide standard authorization decisions as expeditiously as the member’s health requires and within the state’s established timelines that will not exceed 14 calendar days following receipt of the prior authorization request for service, with a possible extension of up to 14 additional calendar days if you or the member request the extension or Anthem justifies to the DHCFP a need for additional information and how the extension is in the member’s interests. For cases in which a provider indicates or we determine that following the standard time frame could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function, we will make an expedited authorization decision and provide a notice of action as expeditiously as the member’s health condition warrants and no later than three calendar days after receipt of the request for service.

We may extend the three-calendar day time period by up to 14 calendar days if the member requests an extension or if we justify to the DHCFP a need for additional information and how the extension is in the member’s interests.

5.14 Notice of Action

We will provide a written notice of action to the member and provider when we make an adverse determination affecting the member.

To ensure ease of understanding by non-English speaking or visually impaired members or members with limited reading proficiency, the written notice to the member must meet the language and format requirements of 42 CFR 438.10(c) and (d).

A written notice of action to the member contains the following:

- The action we or our subcontractor has taken or intends to take
- The reasons for the action
- Your or the member’s right to file an appeal
- The member’s right to request a state fair hearing after the member has exhausted our internal appeal procedures
- The procedures for exercising the member’s rights to appeal
- The circumstances under which expedited resolution is available and how to request it
- The member’s rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued and the circumstances under which the member may be required to pay the costs of these services
- The member’s right to represent himself or use legal counsel, a relative, a friend or other spokesman
- The specific regulations that support the action or the change in federal or state law that requires the action

We must give notice at least 10 days before the date of action when the action is a termination, suspension or reduction of previously authorized covered services. This time frame may be shortened to five days if probable member fraud has been verified.
We must give notice by the date of the action for the following circumstances:

- The death of the member
- A signed written member statement requesting termination or giving information requiring termination or reduction of services (where the member understands that this must be the result of supplying that information)
- The member’s admission to an institution where he or she is ineligible for further services
- The member’s address is unknown and mail directed to him or her has no forwarding address
- The member has been accepted for Medicaid services by another local jurisdiction
- The member’s physician prescribes the change in level of medical care
- An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions
- The safety or health of individuals in the facility would be endangered, the health of the resident improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident’s urgent medical needs or the resident has not resided in the nursing facility for 30 days (applies only to adverse action for nursing facility transfers)

It is necessary that we give a notice of action on the date of action when the action is a denial of payment.

We must give notice on the date that the time frames expire when service authorization decisions are not reached within the time frames for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

These notices must include:

- The member’s right to file an appeal if he or she disagrees with that decision.
- The member’s right to receive written resolution notice. In addition, reasonable efforts will be made to provide oral resolution notice.

5.15 Medical Necessity Appeals

If you or the member do not agree with the adverse determination of medically necessary services made by Anthem, an appeal can be filed. You may appeal on behalf of the member as long as you have received written authorization from the member. However, you do not need prior written authorization from the member if you or the member are making an expedited appeal on behalf of the member.

The Provider Appeal Request Form is available in Appendix A. Complete the appeal request form and send it to:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

We will process and resolve each medical necessity appeal and provide notice as expeditiously as the member’s health condition requires within the time frames specified as follows:

- **Standard resolution of appeals**: 30 calendar days from the date of receipt of the appeal. An oral appeal can be filed by contacting Member Services at 1-844-396-2329. The date the oral appeal
is filed with Member Services will be used in calculating the resolution time period. When an oral appeal is filed, it **must** be followed up in writing within 10 calendar days. If the written appeal is not submitted within the specified time period, the appeal will be closed. Upon receipt of the written appeal, Anthem will reopen the appeal with the date the written appeal was received as the new date to calculate the resolution time period.

- **Expedited resolution of appeals:** three calendar days from the date of receipt of the appeal. For cases in which a provider indicates that following the standard time frame could seriously jeopardize the member’s life or health, or ability to attain, maintain or regain maximum function, we request that you contact Provider Services at **1-844-396-2330** for assistance in submitting your appeal.

- If we deny a request for **expedited** resolution of an appeal, we will transfer the appeal to the standard resolution time of appeals. We make reasonable efforts to give the member oral notice of resolution of an expedited appeal and follow up within two calendar days with a written notice. We ensure that punitive action is not taken against a provider who supports an expedited appeal.

We are required to inform the member of the limited time available to present evidence and allegations of fact or law, in person or in writing, in the case of the expedited resolution.

These time frames may be extended up to 14 calendar days if the member requests such an extension or we demonstrate to the satisfaction of the DHCFP the need for additional information and how the extension is in the member’s interests. If DHCFP grants us a request for an extension, we must give the member written notice of the reason for the delay.

We will notify the member and physician of the disposition of appeals in writing. The written notice must include the results of the resolution process and the date it was completed. For appeals that are not wholly resolved in favor of the member, the notice must also state:

- The right of the member to request a state fair hearing from the DHCFP and how to do so.
- The right to request to receive benefits while the hearing is pending and how to make this request.
- The possibility the member may be held liable for the cost of those benefits if the state fair hearing officer upholds our action.

### 5.16 Continuation of Benefits during Appeals or State Fair Hearings

While our appeal process and the state fair hearing are pending, we must continue the member’s benefits if all of the following conditions exist:

- The appeal is submitted to us on or before the later of the following: within 10 days of our mailing the notice of action or the intended effective date of our proposed action.
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The original periods covered by the original authorization have not expired.
- The member requests a continuation of benefits.
If at the member’s request we continue the member’s benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal.
- Ten days pass after we mail the notice of action, providing the resolution of the appeal against the member, unless the member within the 10-day time frame has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached.
- A state fair hearing officer issues a hearing decision adverse to the member.
- The time period of service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the member, we may recover the cost of the services furnished to the member while the appeal was pending, to the extent they were furnished solely because of the requirements of this section and in accordance with policy set forth in 42 CFR 431.230(b).

5.17 Member State Fair Hearing Process

We will inform the member of his or her right to a state fair hearing and how to obtain such a hearing. In addition, we must explain representation rules to the member and provided by Anthem pursuant to 42 CFR 431.200(b); 42 CFR 431.220(5); 42 CFR 438.414; and 42 CFR 438.10(g) (1).

Members are informed of the following:
You have the right to ask for a fair hearing from the state after the Anthem appeal process has been exhausted. You may ask for a fair hearing within 120 calendar days from the date of the appeal letter saying we denied coverage of services.

Nevada Medicaid and Check Up members can ask for a fair hearing by sending the Member State Fair Hearing form Anthem sent you with the notice of decision or a letter asking for a state fair hearing along with the Anthem notice of decision to:
Nevada Division of Health Care Financing and Policy Hearings
1100 E. William St., Suite 102
Carson City, NV 89701

If you have any questions about your rights to request a fair hearing, call Anthem Member Services. Or if you have questions regarding the fair hearing, you may call the hearings supervisor at 1-702-486-3000, ext. 43604, in the Las Vegas area or 1-775-684-3604 if you live in the Carson City area. Or, call the toll-free number: 1-800-992-0900, ext. 43604.

If you ask for a fair hearing, you will get a letter from the state telling you the date and time of a hearing preparation meeting. The hearing preparation meeting will be held by phone, and you can explain why you disagree with the decision made by Anthem. If you proceed to a fair hearing, you must attend the fair hearing in person unless you get the hearing officer’s consent to attend by phone. You do not have to pay any costs to take part in the hearing.

Expedited State Fair Hearing: If a recipient sends in a fair hearing request to the DHCFP with clinical documentation that supports the urgency of the request and requests the hearing to be expedited, the Hearings Unit will send the clinical documentation for medical review by an impartial, third party physician. If the physician determines the time otherwise permitted for a standard fair hearing
decision — 120 days — could jeopardize the individual’s life, health, or ability to attain, maintain or regain maximum function, a hearing decision will be issued within three working days. The MCO clinician (physician) and MCO attorney will need to represent themselves at the expedited fair hearing as is the current process for **standard fair hearings**. The expedited fair hearings are all held telephonically due to time constraints. If the recipient does not receive an expedited fair hearing, the hearing request will be treated as a standard fair hearing request. The member request for state fair hearing form can be found in **Appendix A** of this manual.

5.18 First Line of Defense Against Fraud and Abuse

**General Obligation to Prevent, Detect and Deter Fraud, Waste and Abuse**

Anthem recognizes the importance of preventing, detecting and investigating fraud, waste and abuse and is committed to protecting and preserving the integrity and availability of health care resources for covered individuals, clients and business partners. Prevention of fraud is an enterprise-wide effort; the company’s fraud program is applied equally to commercial plans as well as publicly funded programs, such as Medicare and Medicaid. All claims submissions are reviewed multiple times using automation and manual processes to detect possible fraud, waste and abuse. Prevention and detection of fraud, waste and abuse is in accordance with applicable state and federal law.

**Understanding Fraud, Waste and Abuse**

Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. The attempt itself is fraud, regardless of whether or not it is successful.

- **Waste:** Generally defined as activities involving careless, poor or inefficient billing, or treatment methods causing unnecessary expenses and/or mismanagement of resources.

- **Abuse:** Any practice inconsistent with sound fiscal, business or medical practices that results in an unnecessary cost to the Medicaid program including administrative costs from acts that adversely affect providers or members.

The Special Investigations Unit (SIU) is responsible for investigating allegations of provider and member fraud, waste and abuse.

**Prepayment Review Program**

Through a variety of means, certain providers or facilities, or certain claims submitted by providers or facilities, may come to Anthem’s attention for behavior that might be identified as unusual or for coding, billing or claims activity that indicates the provider or facility is an outlier with respect to his/her/its peers. For example, Anthem uses computer algorithm software tools designed to identify providers or facilities whose billing practices, including billing or coding practices, indicate conduct that is unusual or outside the norm of the provider’s or facility’s peers.

Once a claim, provider or facility is identified as an outlier, further investigation is conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual claim, coding or billing practice.

If, despite the provider’s or facility’s response, Anthem continues to believe the provider’s or facility’s actions involve fraud, waste or abuse or some other inappropriate activity, the provider or facility will
then be notified the provider or facility is being placed on prepayment review. This means the provider or facility will be required to submit medical records with each claim so Anthem can review the services being billed. Failure to submit medical records to Anthem in accordance with this requirement will result in a rejection of the claim under review. The providers or facilities will be given the opportunity to request a discussion of his/her/its prepayment review status.

The provider or facility will remain subject to the prepayment review process until Anthem is satisfied that any inappropriate activity has been corrected. If the inappropriate activity is not corrected, the provider or facility could face corrective measures, up to and including termination from our network.

Finally, subject to the terms of your provider contract, providers and facilities are prohibited from billing covered individuals for services we have determined are not payable as a result of the prepayment review process, whether due to fraud, waste or abuse; any other coding or billing issue; or for failure to submit medical records as set forth above. Providers or facilities whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of the applicable provider or facility agreement and state law. Providers or facilities also may appeal such determination in accordance with applicable grievance and appeal procedures.

Examples of Provider Fraud, Waste and Abuse
The following are examples of provider fraud, waste and abuse:
- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

Examples of Member Fraud, Waste and Abuse
The following are examples of member fraud, waste and abuse:
- Forging, altering or selling prescriptions
- Letting someone else use the member’s Medicaid identification card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service plan area
- Using someone else’s Medicaid identification card
- Violating the Pain Management Contract

Reporting Provider or Member Fraud, Waste and Abuse
Stopping health care fraud starts with you. If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or an Anthem member has committed fraud, waste or abuse, contact us:
- **Anthem Fraud, Waste and Abuse Hotline:** 1-877-660-7890
- **Fraud Referral Form:** [https://mediproviders.anthem.com/pages/wfa.aspx](https://mediproviders.anthem.com/pages/wfa.aspx)
When reporting possible fraud, waste or abuse involving a **provider** (a doctor, dentist, counselor, medical supply company, etc.), include the following:
- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

When reporting possible fraud, waste or abuse involving a **member**, include the following:
- The member’s name
- The member’s date of birth, Social Security number or case number, if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

**Anonymous Reporting of Suspected Fraud, Waste and Abuse**
Any incident of fraud, waste or abuse may be reported to us anonymously by using our hotline; however, our ability to fully investigate an anonymously reported matter may be handicapped. As a result, we encourage you to provide as much detailed information as possible.

**5.19 HIPAA**
The Health Insurance Portability and Accountability Act (HIPPA) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud, and simplifies the administration of health insurance.

We strive to ensure both Anthem and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers are mandated to have appropriate procedures implemented to demonstrate compliance with the HIPAA privacy regulations.

We recognize our responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, you should only request the minimum necessary member information required to accomplish the intended purpose when contacting us. However, please note that the privacy regulations allow the transfer or sharing of member information, which may be requested by Anthem to conduct business and make decisions about care, such as a member’s medical record, to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.
Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with access restricted to individuals who need member information to perform their jobs. When faxing information to us, verify that the receiving fax number is correct, notify the appropriate staff at Anthem and verify that the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing member information to us (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box or department at Anthem.

Our voicemail system is secure and password protected. When leaving messages for our associates, you should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting us, please be prepared to verify the provider’s name, address, NPI number, and tax identification number (TIN) or Anthem provider number.

6 MEMBER MANAGEMENT SUPPORT

6.1 Welcome Call

As part of our member management strategy, we offer a welcome call to new members. During the welcome call, new members are educated regarding the health plan and available services. Additionally, Member Services representatives perform a Health Needs Assessment to identify issues that need special attention such as pregnancy care. They also offer to assist the member with any current needs such as scheduling an initial checkup or clarifying benefits under their plan.

6.2 Appointment Scheduling

Through our participating providers, we ensure members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. You are expected to respond to our member’s needs and requests in a timely manner. The PCP/PCS should make every effort to schedule our members for appointments using the guidelines in the PCP/PCS Access and Availability section.

6.3 24/7 NurseLine

Our 24/7 NurseLine is a service designed to support the provider by offering information and education about medical conditions, health care and prevention to members after normal physician practice hours. The 24/7 NurseLine provides triage services and helps direct members to appropriate levels of care. The 24/7 NurseLine phone number is 1-844-396-2329 (TTY 711) and is listed on the member’s ID card.
This ensures members have an additional avenue of access to health care information when needed. Features of the 24/7 NurseLine include the following:

- Constant availability — 24 hours a day, 7 days a week
- Information based on nationally recognized and accepted guidelines
- Free translation services for 170 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions

The nurse will fax the member’s assessment report to the provider’s office within 24 hours of receipt of the call.

6.4 Interpreter Services

Interpreter services are available if needed. Anthem partners with CulturaLink®, which provides interpretative services for language and hard of hearing (deaf). Our relationship with this company assists in improving patient-centered care and creating an effective, diverse workforce through services focused on diversity, inclusion and cultural competence. They provide hundreds of health care providers with best-in-class consulting along with comprehensive translation and interpretation in more than 200 languages with 24/7 service. Providers can reach CulturaLink for services at 1-888-844-1414.

Members who are deaf or hard of hearing should call the toll free AT&T Relay Service at TTY 711 (1-844-396-2329) at least five days before the scheduled appointment.

6.5 Health Promotion

We strive to improve healthy behaviors, reduce illness and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members and network providers who are contracted with Anthem.

We manage projects that offer our members education and information regarding their health. Ongoing projects include:

- A semiannual member newsletter
- Creation and distribution of Health Tips, the Anthem health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Relationship development with community-based organizations to enhance opportunities for members

6.6 Case Management

Case management is designed to respond proactively to a member’s needs when conditions or diagnoses require care and treatment for extended periods of time. When a member is identified (usually through predictive modeling, precertification, admission review and/or provider or member request), the member is assigned to a case manager — an Anthem clinician — who helps identify medically appropriate alternative methods or settings in which care may be delivered.
You, on behalf of the member, may request participation in the program. The case manager will work with the member, you and/or hospital to identify the:

- Intensity level of case management services needed.
- Appropriate alternate settings where care may be delivered.
- Health care services required.
- Equipment and/or supplies required.
- Community-based services available.
- Communication required (for example, between member and PCP/PCS).

The case manager will assist the member, utilization review team and PCP/PCS/hospital in developing the plan of care, ensuring the member’s medical needs are met and linking the member with community resources and Anthem programs for outpatient case management and/or the Disease Management.

**Comprehensive Member Assessment**

A case manager will conduct a comprehensive assessment to further determine members’ needs. The assessment will include a range of questions that identify and evaluate the member’s medical and behavioral health condition, functional status, goals, life environment, support systems, emotional status, capability for self-care and the current treatment plan.

Using the structured online assessment tool, case managers will conduct telephone interviews to collect and assess information from the members or their representatives. To complete the assessment, case managers may obtain information from the PCPs/PCSs and specialists, our continuous case finding information and other sources to coordinate and determine current medical needs and needed nonmedical services.

**Individualized Plan of Care**

Case managers will use information from the assessment to determine appropriateness of care management services and guide, develop and implement a care plan in collaboration with the member, his or her family, and the member’s provider. Our experience has shown that members are more likely to comply with treatment planning if they are empowered to make their own health care decisions.

Case managers will consider members’ needs for social, educational, therapeutic and other nonmedical support services such as personal care, WIC and transportation vendors, as well as the strengths and needs of the family. When the nonmedical needs are extensive or complex, case manager clinicians will collaborate with case manager social workers. Case managers will also coordinate with member advocates or outreach associates to contact difficult-to-reach members and coordinate with community resources. If a member is already receiving care management services from another entity, such as a community services organization, the plan will define processes for coordinating medical, mental health and substance abuse, and social service components of care management and the roles of each team. Case managers will collaborate with PCPs/PCSs and specialists to ensure the plans of care support providers’ medical plans. Case managers will forward written care plans to practitioners via fax or mail. The plan of care should be reviewed/revised, signed and returned to the case manager.

**Children with Special Health Care Needs (CSHCN)**

Children who have, or at risk for, chronic physical, developmental, behavioral, or emotional conditions; and also require health and related services of a type and amount beyond that required by children in general; and are receiving services through family-centered, community-based, coordinated care systems
receiving grant funds, under Section 501 (a)(1)(D) of Title V of the Social Security Act (known as Nevada Early Intervention Program); or children self-identified by parents/guardians as potentially having special health care needs. Case management will outreach to these families as they are referred to Anthem or are identified via screenings.

6.7 Integrated Medical Management Model (IM³)

We will provide a member-centric case management approach customized to the individual’s needs, the diagnosis and prognosis, the care environment, and available treatment alternatives. The components of our approach, which is defined through an integrated medical management model (IM³), include continuous monitoring and evaluation.

Our continuous case finding (CCF) methodology guides performance of a number of ongoing analyses that identify and prioritize existing members for care management referral as needed. We typically identify catastrophic cases during daily rounding on the inpatient census, monitoring each case on admission and when a member’s situation changes. A prioritized list of high-risk members with their Chronic Illness Intensity Index, our proprietary predictive model that factors in manageable physical and behavioral health conditions that drive cost and utilization specific to each of these populations (Medicaid and Nevada Check Up), is generated monthly using multiple data sources. This list assigns each member to a management group based on his or her score so members who are at highest risk are flagged for immediate case management by an interdisciplinary team. This algorithm also allows identification of members for Disease Management programs. Medical management nurses use their clinical expertise to identify members with health factors, such as chronic illness or behavioral health issues, who would benefit from care coordination services.

Our case management staff will routinely conduct systematic review of paid claims, encounter, utilization and pharmacy data, as well as daily census reports, to gain a full picture of members identified for case management. We will interface with the pharmacy benefits manager to identify candidates for case management based on drug utilization and defined thresholds. Additionally, release from the inpatient setting can be an automatic trigger for case management.

6.8 Disease Management/Population Health

Disease Management (DM) programs are based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with chronic conditions. The programs include a holistic, member-centric care management approach that allows case managers to focus on multiple needs of members.

Earning National Committee for Quality Assurance (NCQA) disease management accreditation is an indication that a disease management program is dedicated to giving patients and practitioners the systems support, education and other help necessary to ensure good outcomes and good care.

Our disease management programs include:
- Behavioral health (Severe Mental Illness)
  - Bipolar disorder
- Schizophrenia
- Substance use disorder
In addition to our 12 condition-specific disease management programs, our member-centric, holistic approach also allows us to assist members with smoking and weight management education.

**Program Features:**
- Uses proactive population identification processes
- Identifies chronic disease care gaps
- Based on evidence-based national practice guidelines
- Based on collaborative practice models to include physician and support-service providers in treatment planning for members
- Continuous patient self-management education including primary prevention, coaching on healthy behaviors and compliance/monitoring, and case management for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Disease Management programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Additionally, all our programs are based on nationally approved clinical practice guidelines located at [https://mediproviders.anthem.com/nv](https://mediproviders.anthem.com/nv). A copy of the guidelines can be printed from the website.

**Objectives**
Disease Management programs are designed to:
- Address gaps in care.
- Improve the understanding of disease processes.
- Improve the quality of life for our members.
- Collaborate to develop member-centered goals and interventions.
- Support relationships between member and network providers.
- Increase network provider awareness of Disease Management programs.
- Reduce acute episodes requiring emergent or inpatient care.

**Who Is Eligible?**
All Anthem members with the above conditions/diagnoses are eligible for DM services. Members are identified through continuous case finding efforts including not be limited to: continuous case findings, claims mining and referrals.

**How Can You Use DM Services?**
As a valued provider, we welcome your referrals of patients who can benefit from additional education and case management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their disease. Program evaluation, outcome
measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

**DM Provider Rights and Responsibilities**

You have the right to:
- Have information about us, including provided programs and services, our staff and our staff’s qualifications and any contractual relationships.
- Decline to participate in or work with our programs and services for your patients, depending on contractual requirements.
- Be informed of how we coordinate our interventions with treatment plans for individual patients.
- Know how to contact the person responsible for managing and communicating with your patients.
- Be supported by us to make decisions interactively with patients regarding their health care.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints regarding DM as outlined in our provider complaint and grievance procedure.

**Hours of Operation**

Our case managers are registered nurses and are available Monday through Friday, from 8:30 a.m. to 5:30 p.m. Pacific time; however, confidential voicemail is available 24 hours a day.

**Contact Information**

To contact a DM team member, call **1-888-830-4300**. Additional information about DM can be obtained by visiting [https://mediproviders.anthem.com/nv](https://mediproviders.anthem.com/nv). Members can obtain information about our DM program by visiting [www.anthem.com/nvmedicaid](http://www.anthem.com/nvmedicaid).

### 6.9 Consumer Advocacy Council

The Consumer Advocacy Council provides advice to us regarding health education and outreach program development. The committee strives to ensure materials and programs meet cultural competency requirements, are easily understood by members and address the health education needs of the member. Members are offered the opportunity to be included on this council.

The responsibilities of the Consumer Advocacy Council are:
- Identifying health education needs of the membership based on review of demographic and epidemiologic data.
- Identifying cultural values and beliefs that must be considered in developing a culturally competent health education program.
- Assisting in the review, development, implementation and evaluation of the member health education tools for the outreach program.
- Reviewing the health education plan and making recommendations on health education strategies.
- Assisting the plan in decision making in the areas of member grievances, marketing, member services, case management, outreach, health needs and cultural competency.
• Providing input into the annual review of policies and procedures, QM program results and outcomes, and future program goals and interventions.
7 PROVIDER RESPONSIBILITIES

7.1 Medical Home

The PCP/PCS is the foundation of the collaborative concept known as a medical home. He or she is responsible for providing, managing and coordinating all aspects of the member’s medical care and providing all care that is within the scope of his or her practice. The PCP/PCS is also responsible for coordinating member care with specialists and conferring and collaborating with specialists.

We promote the medical home concept to all of our members. The PCP/PCS is the member and family’s initial contact point when accessing health care. The PCP’s/PCS’s relationship with the member and family, together with the health care providers within the medical home and the extended network of consultants and specialists with whom the medical home works, have an ongoing and collaborative contractual relationship. Providers in the medical home are knowledgeable about the member’s and family’s special, health-related social and educational needs and are connected to necessary resources in the community that will assist the family in meeting those needs. When a member is referred for a consultation or specialty/hospital services or health and health-related services by the PCP/PCS through the medical home, the medical home provider maintains the primary relationship with the member and family. He or she keeps abreast of the current status of the member and family through a planned feedback mechanism with the PCP/PCS who receives them into the medical home for continuing primary medical care and preventive health services.

7.2 Responsibilities of the PCP/PCS

The PCP is a network physician who has responsibility for the complete care of his or her members, whether providing it himself or herself or by referral to the appropriate provider of care within the network. FQHCs and RHCs may be included as PCPs. Below are highlights of the PCP’s/PCS’s responsibilities.

The PCP/PCS shall:

- Manage the medical and health care needs of members, including: monitoring and following up on care provided by other providers (including FFS); providing coordination necessary for referrals to specialists and FFS providers (both in- and out-of-network); and maintaining a medical record of all services rendered by the PCP/PCS and other providers.
- Ensure to include a signed Acknowledgment of Patient Information on Advance Directives (http://dhefp.nv.gov/Resources/PI/AdvanceDirectives) and/or maintain the member’s up-to-date executed living will or advance directive in the member’s medical chart.
- Provide 24-hour coverage 7 days a week; regular hours of operation should be clearly defined and communicated to members.
- Provide services ethically and legally and in a culturally competent manner, meeting the unique needs of members with special health care needs.
- Participate in any system we establish to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Make provisions to communicate in the language or fashion primarily used by his or her membership.
Participate and cooperate with us in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs we establish.

Participate and cooperate in HEDIS and Risk Adjustment audits conducted by Anthem.

Participate in and cooperate with our complaint and grievance procedures when notified by us of a member grievance.

Not balance-bill members.

Continue care in progress during and after termination of his or her contract for up to 60 calendar days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.

Fill out the maternity risk screen included in Appendix A of this manual during the first office visit and return it to us via fax at 1-800-964-3627 in order to identify members who would benefit from OB case management and participate in our New Baby, New Life program.

Comply with all applicable federal and state laws regarding the confidentiality of patient records.

Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood borne pathogens.

Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act.

Support, cooperate and comply with our Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.

Inform us if a member objects to provision of any counseling, treatments or referral services for religious reasons.

Treat all members with respect and dignity, provide members with appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.

Provide to members complete information concerning their diagnoses, evaluations, treatments and prognoses and give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons.

Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program, and advise members on treatments that may be self-administered.

Contact members as quickly as possible when clinically indicated for follow-up regarding significant problems and/or an abnormal laboratory or radiological finding.

Freely communicate with the members about their treatment, regardless of benefit coverage limitations; the practitioner will in no way be discouraged or inhibited from doing this.

Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.

Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide high-quality patient care.

Agree that any notation in a member’s clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of care not related to research.

Complete Certification Statement for Abortion to Save the Life of the Mother and/or a Certification Statement for Abortion due to Sexual Assault (Rape) or Incest when applicable; the forms can be found here: https://www.medicaid.nv.gov/providers/forms/forms.aspx.
• Communicate a member’s coordination of care between specialists and PCPs/PCSs.
• Limit a member’s waiting time to no more than one hour from the scheduled appointment time, except when you are unavailable due to an emergency; you are allowed to be delayed in meeting scheduled appointment times when you work in urgent cases or if a serious problem is found, or the patient has an unknown need that requires more services or education than was described at the time the appointment was scheduled.

PCP/PCS responsibilities for the initial newborn examination and subsequent care until discharge include the following:
• The initial physical examination done in the delivery room must be a rapid screening for life-threatening anomalies that may require immediate billable attention.
• Complete physical examination must be done within 24 hours of delivery but after the six-hour transition period when the infant has stabilized; this examination is billable.
• Brief examinations should be performed daily until discharge; on day of discharge, physician may bill either the brief examination or discharge day code, not both.
• In accordance with NRS 442.540, all newborns must receive hearing screenings; this testing and interpretation are included in the facility’s per diem rate.

No prior authorization is required when circumcision is performed up to 1 year of age. If a newborn is discharged less than 24 hours after delivery, we will reimburse newborn follow-up visits in the physician’s office up to four days post-circumcision.

Continuity of Care
It may be necessary to transfer a member from Anthem to another MCO or to FFS for a variety of reasons. When notified that a member has been transferred to another MCO or to FFS, you must have written policies and procedures for transferring relevant patient information, medical records and other pertinent materials to the other plan or FFS provider.

Prior to transferring a member, you must send the receiving plan or provider information regarding the member’s condition. This information will include the name of the assigned PCP/PCS and the following information without limitation as to whether the member is:
• Hospitalized.
• Pregnant.
• Receiving dialysis.
• Chronically ill (for example, diabetic, hemophilic, etc.).
• Receiving significant outpatient treatment and/or medications, and/or pending payment authorization request for evaluation or treatment.
• On an apnea monitor.
• Receiving behavioral or mental health services.
• Involved in or pending authorization for major organ or tissue transplantation.
• Scheduled for surgery or postsurgical follow-up on a date subsequent to transition.
• Scheduled for precertified procedures and/or therapies on a date subsequent to transition.
• Referred to a specialist(s).
• Receiving substance abuse treatment if the member is 21 or older.
• Receiving prescription medications.
• Receiving durable medical equipment or currently using rental equipment.
• Currently experiencing health problems.
• Receiving case management (including the case manager’s name and phone number).

Nevada Early Intervention Services, in accordance with an individualized family service plan (IFSP), provides a case manager who assists in developing a plan to transition the child to the next service delivery system. For most children this would be the school district, and services are provided for the child through an individual education program (IEP).

When a member is transferred to you from another MCO or FFS, you should request medical records and other pertinent materials from the former provider.

When a member changes MCOs or reverts to FFS while hospitalized, we will notify the receiving MCO, the receiving provider or the DHCFP Quality Improvement Organization (QIO), as appropriate, of the change within five calendar days.

New Members Who are Pregnant
A pregnant woman who enrolled with us while pregnant must be allowed to remain in the care of a non-network provider if at all possible.

7.3 PCP/PCS Access and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Health care services provided through us must be accessible to all members. At least once a year, an Anthem vendor will conduct a survey to ensure providers are adhering to Anthem access standards.

We’re dedicated to arranging access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. You are required to adhere to the following access/appointment standards:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>After-hours access</td>
<td>Members must have access to communicate with provider after hours. See below for details.</td>
</tr>
<tr>
<td>Medically necessary care</td>
<td>Same day</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Two calendar days</td>
</tr>
<tr>
<td>Routine care</td>
<td>Two weeks (doesn’t apply to regular visits to monitor chronic condition if condition requires more frequent visits)</td>
</tr>
</tbody>
</table>

You may not use discriminatory practices such as preference to other insured or private-pay patients, separate waiting rooms or appointment days.

We will routinely monitor providers’ adherence to the access-to-care standards. To ensure after-hours coverage, PCPs/PCSs must maintain one of the following arrangements for members to contact them after normal business hours:

• Have the office telephone line answered after hours by an answering service, which can contact the PCP/PCS or another designated network medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
• Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP/PCS, directing the member to call
another number to reach the PCP/PCS or another provider designated by the PCP/PCS. Someone must be available to answer the designated provider’s telephone. Another recording is not acceptable.

- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP/PCS or a designated Anthem network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are not acceptable:

- Office telephone is only answered during office hours.
- Office telephone is answered after-hours by a recording that tells members to leave a message.
- Office telephone is answered after-hours by a recording that directs members to go to an emergency room for any services needed.
- Members’ after-hours calls are returned outside of 30 minutes.

For urgent care and additional after-hours care information, see the Urgent Care/After-hours Care section.

### 7.4 Member Missed Appointments

Our members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointments. This practice can be detrimental to their health. We require you to attempt to contact any member who has not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment. If the member has missed too many appointments, you may ask the member to be assigned to another PCP. You may not charge the member a fee for any missed appointments. Please ask the member to call Anthem Member Services at 1-844-396-2329 (TTY 711) for help in locating a PCP.

Our members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at 1-844-396-2330 to address the situation. Our staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCPs/PCSs.

### 7.5 Noncompliant Anthem Members

We recognize you may need help in managing noncompliant members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion of treatment and/or making or appearing for appointments, please contact our National Customer Care department at 1-844-396-2330.

A Member Services representative will contact the member to provide the education.
7.6 PCP/PCS Transfers

To maintain continuity of care, we encourage members to remain with their PCPs/PCSs. However, members may request to change their PCP/PCS for any reason by contacting our Member Services department at 1-844-396-2329 (TTY 711). The member’s name will be provided to the PCP/PCS on the membership roster.

Members can call to request a PCP/PCS change any day of the month. PCP/PCS change requests will be processed generally on the same day or by the next business day. New member ID cards will be mailed within five business days.

7.7 Covering Physicians

During an absence or unavailability, you will need to arrange for coverage of your members. You will either: 1) make arrangements with one or more network providers to provide care for your members or 2) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. In addition, the covering provider will agree to the terms and conditions of the Network Provider Agreement, including without limitation any applicable limitations on compensation, billing and participation. You will be solely responsible for a non-network provider’s adherence to such provisions. You will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on your behalf.

7.8 Specialist as a PCP/PCS

We contract with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services.

Under certain circumstances, when a member requires the regular care of the specialist, we may approve a specialist to serve as a member’s PCP/PCS. The criteria for a specialist to serve as a member’s PCP/PCS include the member having a disability or a chronic or condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the nonspecialist PCP/PCS. This would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must meet the requirements for PCP/PCS participation (including contractual obligations and credentialing), provide access to care 24 hours a day, 7 days a week and coordinate the member’s health care, including preventive care. For further information, see the Specialist as PCP/PCS Request Form located in Appendix A of the manual.

7.9 Reporting Changes in Address and/or Practice Status

Demographic changes can be emailed to Provider Relations Team at nv-1providerservices@anthem.com
7.10 Second Opinions

A member, parent, legally appointed representative or the member’s PCP/PCS may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion must be provided at no cost to the member.

The second opinion must be obtained from a network provider (see the Provider Referral Directory). Or, if there is not a network provider with the expertise required for the condition, a non-network provider. Once approved, the PCP/PCS will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP/PCS will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by you or the member
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When we request a second opinion, we will make the necessary arrangements for the appointment, payment and reporting. We will inform the member and the PCP/PCS of the results of the second opinion and the consulting provider’s conclusion and recommendation(s) regarding further action.

7.11 Specialty Care Providers

We contract with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who has the responsibility for providing the specialized care for members, (See Role and Responsibility of the Specialty Care Provider). In addition to sharing many of the same responsibilities to members as the PCP/PCS (See Responsibilities of the PCP/PCS), the specialty care provider provides services that include medically necessary covered services as identified in Section 5.

7.12 Role and Responsibility of the Specialty Care Providers

Obligations of the specialists include but are not limited to the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to them
- Submitting to us required claims information including source of referral and referral number
- Arranging for coverage with network providers while off-duty or on vacation
- Verifying member eligibility and precertification of services (if required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member’s PCP/PCS on a timely basis, following a referral or routinely scheduled consultative visit
- Notifying the member’s PCP/PCS when scheduling a hospital admission or scheduling any procedure requiring the PCP’s/PCS’s approval
- Coordinating care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance abuse disorders

The specialist must:
- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, including those engaged on a fee-for-service (FFS) basis; provide coordination necessary for referrals to other specialists and FFS providers (both in- and out-of-network); and maintain a medical record of all services rendered by the specialist and other providers.
- Provide 24-hour coverage 7 days a week and maintain regular hours of operation that are clearly defined and communicated to members.
- Provide services ethically and legally in a culturally competent manner that meets the unique needs of members with special health care requirements.
- Participate in the systems we established that facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Participate and cooperate with us in any reasonable internal or external quality assurance, utilization review, continuing education or other similar programs we established.
- Participate and cooperate in HEDIS and risk adjustment audits conducted by Anthem.
- Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers, including behavioral health providers, involved in delivering care and services to consumers.
- Participate in and cooperate with our complaint and grievance processes and procedures. We will notify the specialist of any member grievance brought against the specialist.
- Not balance-bill members.
- Continue care in progress during and after termination of his or her contract for up to 60 days, until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Fill out the maternity risk screen during the first office visit and return it to us via fax at 1-800-964-3627 in order to identify members who would benefit from OB case management and participate in our New Baby, New Life program.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan regarding blood borne pathogens in compliance with Occupational Safety and Health Administration (OSHA) standards.
- Make best efforts to fulfill the obligations under the Americans with Disabilities Act applicable to his or her practice location.
- Support, cooperate and comply with our Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
Inform us if a member objects for religious reasons to the provision of any counseling, treatment or referral services.

Treat all members with respect and dignity; provide members with appropriate privacy; and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release as allowed under applicable laws and regulations.

Provide to members complete information concerning his or her diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving his or her health care, except when contraindicated for medical reasons.

Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program; advise members on treatments that may be self-administered.

When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.

Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.

Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality patient care.

Agree that any notation in a member’s clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch-related care.

Communicate a member’s coordination of care between specialists and PCPs/PCSs.

Adhere to the member’s established living will or advance directive on file with the PCP; if the member does not have an advance directive on file with the PCP, the specialist should require the member sign an Acknowledgement of Patient Information on Advance Directives form (http://dhcfp.nv.gov/Resources/PI/AdvanceDirectives) and keep it with the member’s medical record.

Ensure the member’s waiting time is no more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency. You are allowed to be delayed in meeting scheduled appointment times when you work in urgent cases, when a serious problem is found, or when the patient has an unknown need that requires more services or education than was described at the time the appointment was scheduled.

### 7.13 Specialty Care Providers Access and Availability

We will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if he/she has a provider agreement with us to provide specialty services to members. At least once a year, an Anthem vendor will conduct a survey to ensure providers are adhering to Anthem access standards.

Specialists must adhere to the following access guidelines:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care</td>
<td>Within three calendar days</td>
</tr>
<tr>
<td>Routine</td>
<td>Within 30 calendar days</td>
</tr>
</tbody>
</table>
| Prenatal care initial visit   | First trimester: within seven calendar days of the first request  
                                | Second trimester: within seven calendar days of the first request |
Third trimester: within three calendar days of the first request
High-risk: within three calendar days of identification of high risk by Anthem or OB provider or immediately if an emergency exists

Behavioral health providers must adhere to the following access guidelines:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care for non-life threatening emergency</td>
<td>Within six hours</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Initial visit for routine appointment</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Follow-up routine care</td>
<td>Within two weeks</td>
</tr>
</tbody>
</table>

### 7.14 Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures that come together in a system, agency or among professionals to enable effective work in cross-cultural situations. It is an awareness and appreciation of customs, values and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual. Cultural competency assists you to:

- Acknowledge the importance of culture and language.
- Embrace cultural strengths with people and communities.
- Assess cross-cultural relations.
- Understand cultural and linguistic differences.
- Strive to expand cultural knowledge.

The quality of the member-provider interaction has a profound impact on the ability of a patient to communicate symptoms to you as his/her provider and to adhere to recommended treatment. Some of the reasons that justify your need for cultural competency include but are not limited to:

- The perception that illness and disease, and their causes, vary by culture.
- The diversity of belief systems related to health, healing and wellness are very diverse.
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers.
- The fact that individual preferences affect traditional and nontraditional approaches to health care.
- The fact that health care providers from culturally and linguistically diverse groups are underrepresented in the current service delivery system.

Culture is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs and may be influenced by factors such as geographic location, lifestyle and age. Cultural barriers between you and the member can impact the member-provider relationship in many ways, including but not limited to:

- The member’s level of comfort with you and the member’s fear of what might be found upon examination.
- The differences in understanding on the part of diverse consumers in the U.S. health care system.
- A fear of rejection of personal health beliefs.
• The member’s expectation of you and of the treatment.

The Anthem Cultural Competency training program is available to all providers, regardless of participation status. This resource offers free tools designed to help promote health and health equity and develop a more culturally competent practice. The online training also provides a link directly to the Think Cultural Health website, provided through the U.S. Department of Health and Human Services.

To be culturally competent, we expect you and all providers serving members within this geographic location to demonstrate the following:

**Cultural Awareness**

- The ability to recognize the cultural factors (norms, values, communication patterns, economic disparities and world views) that shape personal and professional behavior.
- The ability to modify one’s own behavioral style to respond to the needs of others, while at the same time maintaining a professional level of respect and objectivity.

**Knowledge**

- Culture plays a crucial role in the formation of health or illness beliefs.
- Different cultures have different attitudes about seeking help.
- Feelings about disclosure are culturally unique.
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups.
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups.
- Economic disparities can shape a member’s response to medical advice and attitudes about seeking help.
- Resources, such as formally trained interpreters fluent in communicating in the member’s primary non-English language, should be offered to and utilized by members with various cultural and ethnic differences; members/providers should call Anthem Member Services at 1-844-396-2329 (TTY 711) at least 24 hours before their scheduled appointment and tell us they have a need for an interpreter.
- Interpreters who provide communication for deaf or hard-of-hearing members should be offered to and used by members who need these services; members should call the toll-free AT&T Relay Service at TTY 711 at least five days before the scheduled appointment, and we will set up and pay for the member to have a person who knows sign language help during the office visit.

**Skills**

- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of others’ needs, values and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
• The ability to recognize the importance of time and the use of group process to develop and enhance cross-cultural knowledge and understanding
• The ability to withhold judgment, action or speech in the absence of information about a person’s culture
• The ability to listen with respect
• The ability to formulate culturally competent treatment plans
• The ability to utilize culturally appropriate community resources
• The ability to know when and how to use interpreters and to understand the limitations of using interpreters
• The ability to treat each person uniquely
• The ability to recognize racial, ethnic and economic differences and know when to respond to culturally based cues
• The ability to seek out information
• The ability to use agency resources
• The capacity to respond flexibly to a range of possible solutions
• Acceptance of ethnic differences among people and an understanding of how these differences affect the treatment process
• A willingness to work with clients of various ethnic groups

7.15 Member Records

Using nationally recognized standards of care, we work with providers to develop clinical policies and guidelines of care for our membership. The Medical Advisory Committee (MAC) oversees and directs us in formalizing, adopting and monitoring guidelines. We require medical records to be maintained in a manner that is current, detailed and organized and permits effective and confidential member care and quality review.

You are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record will be maintained at the primary care site for every member and be available to the PCP/PCS and other providers. The member’s medical record is the property of the provider who generates the record.

Anthem or the member’s previous provider must forward a copy of all medical records in its possession to a new provider within 10 business days from receipt of request.

We will assist the member or the parent/guardian of the member in obtaining a copy of the member’s medical record. You must furnish medical records in a timely manner upon receipt of a request, but not more than 30 days from the date of the request. Providers must supply the first copy of medical records at no charge on request. The fee for additional copies must not exceed the actual cost of time and materials used to compile, copy and furnish such records.

Federal regulations (42 CFR 438.240) mandate that each managed care organization have an ongoing quality assessment and performance improvement program for the services it furnishes its members. To comply with this requirement, DHCFP has established 18 quality assurance standards as measurements to assess the effectiveness of the quality program established by each MCO providing medical coverage to Nevada Medicaid and Nevada Check Up. One of these standards includes a comprehensive audit of
provider record keeping with specific attention to the member medical record. This section will highlight those elements of the member medical record we will review during our on-site review.

These medical record standards will meet, at a minimum, the following medical record requirements:

1. **Member identification information.** Each page or electronic file in the record must contain the member’s name or member ID number.
2. **Personal/demographic data.** The record must include age, gender, address, employer, home and work telephone numbers, and marital status.
3. **Date and corroborating.** All entries must be dated and author identified.
4. **Legibility.** Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. **Allergies.** Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies — NKA) must be noted in an easily recognizable location.
6. **Past medical history.** Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, the history must include prenatal care of the mother and birth.
7. **Immunizations.** For pediatric members age 20 and under, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and their dates of administration when possible.
8. **Diagnostic information.**
9. **Medication information** (includes medication information/instruction to member).
10. **Identification of current problems.** Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record.
11. **Instructions.** Record must include evidence that the member was provided with basic teaching/instructions regarding physical and/or behavioral health condition.
12. **Smoking/alcohol/substance abuse.** A notation concerning cigarettes and alcohol use and substance abuse must be stated if present for members age 11 and older and seen three or more times. Abbreviations and symbols may be appropriate.
13. **Consultations, referrals and specialist reports.** Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician’s initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
14. **Emergencies.** All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the member is part of the PCP/PCS’s panel must be noted.
15. **Hospital discharge summaries.** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the member is enrolled and for prior admissions, as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the member being enrolled may be pertinent to the member’s current medical condition.
16. **Advance directive.** For medical records of members age 18 and older, the medical record must document whether or not the individual has executed an advance directive. A signed Acknowledgment of Member Information on Advance Directives should be maintained in the member record. An advance directive is a written instruction such as a living will or durable power of attorney that directs health care decision-making for individuals who are incapacitated.
As part of the medical record review, the nurse reviewer will routinely audit member records for documentation of compliance with Anthem clinical practice guidelines and state-mandated EPSDT screening for Medicaid members under age 21. The nurse reviewer will relay his or her findings to the office at the time of review and identify any deficiencies. If deficiencies are found, a corrective action plan is created and sent to the office, and a reaudit scheduled.

Each year, HEDIS information is collected through claims and encounter data. If claims or encounter data is not available, Quality staff will schedule additional onsite visits in February or March to obtain clinical records for additional data collection.

### 7.16 Member Visit Data

Documentation of individual encounters must provide adequate evidence of, at a minimum:

1. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints.
2. For members receiving behavioral health treatment, documentation that includes at-risk factors (danger to self or others, ability to care for self, affect, perceptual disorders, cognitive functioning and significant social health).
3. An admission or initial assessment that must include current support systems or lack of support systems.
4. For members receiving behavioral health treatment, a documented assessment that is done with each visit relating to client status/symptoms to the treatment process and that may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period.
5. A plan of treatment that includes activities/therapies and goals to be carried out.
6. Diagnostic tests.
7. Documented therapies and other prescribed regimens for members who receive behavioral health treatment and that include evidence of family involvement as applicable and include evidence that the family was included in therapy sessions, when appropriate.
8. Regarding follow-up care encounter forms or notes with a notation indicating follow-up care, a call or a visit that must note in weeks, months or PRN the specific time to return with unresolved problems from any previous visits being addressed in subsequent visits.
9. Referrals and results including all other aspects of member care, such as ancillary services.

We will systematically review medical records to ensure compliance with the standards. We will institute actions for improvement when standards are not met.

Providers must maintain an appropriate record keeping system for services to our members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records must be retained in accordance with the record retention requirements of 45 CFR 164.316(b) (2), that is, records must be retained for six years from the date of service.
7.17 Clinical Practice Guidelines

Using nationally recognized standards of care, we work with providers to develop clinical policies and guidelines for the care of our membership. We expect you to adhere to the relevant clinical practice guidelines when delivering care to our members. The Medical Advisory Committee (MAC) oversees and directs us in formulating, adopting and monitoring guidelines.

We select at least four evidence-based clinical practice guidelines that are relevant to the member population. We will measure performance against at least two important aspects of each of the four clinical practice guidelines annually. The guidelines must be reviewed and revised at least every two years or whenever the guidelines change.

A complete list of clinical practice guideline is located on our website. You may request hard copies of them as necessary by contacting Provider Services. See also the Quality Management section of this provider manual.

7.18 Advance Directives

We respect the right of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

We adhere to The Member Self-Determination Act and maintain written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances. There are two types of advance directives. A durable power of attorney for health care allows the member to name a member advocate to act on behalf of the member. A living will allows the member to state his or her wishes about life-sustaining treatment in writing but does not name a member advocate.

Member Services and outreach associates encourage members to request an advance directive form and education from their PCP/PCS at their first appointment.

Members over age 18 and emancipated minors are able to make an advance directive. You should inform members of their right to make an advance directive. The member’s response is to be documented in the medical record using a signed Acknowledgment of Member Information on Advance Directives. We will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive. If you object to the request for care that is made by an Anthem member in his or her advance directive, the member may select another PCP or provider who will honor the request. We will assist you and the member in finding another provider.
Member Services and outreach associates will assist members regarding questions about advance directives; however, no associate of ours may serve as witness to an advance directive or as a member’s designated agent or representative.

We note the presence of advance directives in the medical records when conducting medical chart audits. Advance directive forms can be found online at http://dhcfp.nv.gov/Resources/PI/AdvanceDirectives.
8 MEDICAL MANAGEMENT

8.1 Medical Review Criteria

Anthem has its own nationally recognized medical policy process for all of its subsidiary entities. Anthem medical policies, which are publicly accessible on the Anthem Medical Policy and Clinical Utilization Management (UM) Guideline subsidiary website, are the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive.

A list of the specific Anthem Clinical UM Guidelines used is posted and maintained on the provider self-service website and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical-appropriateness claims edits and retrospective review.

Written requests can be submitted to:

Provider Services
Desert Canyon Building 9
9133 W. Russell Road
Las Vegas, NV 89148

Federal and state law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or Centers for Medicare & Medicaid Services (CMS) requirements will supersede Anthem medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria. Except in cases where superseded by Nevada DHCFP or CMS requirements, all nonbehavioral/behavioral health inpatient and outpatient precertification requests and behavioral health concurrent reviews will be determined using Anthem’s medical policies and clinical UM guidelines. The MCG Care Guidelines are used for nonbehavioral health concurrent review determinations and/or when the Nevada Medicaid Services Manual and Anthem medical policies are silent.

We work with network providers to develop clinical guidelines of care for our membership. The medical advisory committee assists us in formalizing and monitoring guidelines.

If we utilize noncommercial criteria, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Criteria are based on review of market practice and national standards/best practices.
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated, as necessary. The criteria must reflect the names and qualifications of those involved in the development, the process used in the development, and when and how often the criteria will be evaluated and updated.
Clinical Criteria
We utilize nationally recognized standards of care for clinical decision support for medical management coverage decisions. The criteria provides a system for screening proposed medical care based on member-specific, best medical care practices and rule-based systems to match appropriate services to member needs based upon clinical appropriateness. Criteria include the following:

- Acute care
- Home care
- Radiation therapy
- Rehabilitation
- Subacute care
- Surgery and procedures
- Pharmaceuticals
- Imaging studies and X-rays
  - Note: AIM Specialty Health manages preauthorization for computerized tomography, computerized axial tomography, nuclear cardiology, magnetic resonance imaging, magnetic resonance angiogram and positron emission tomography scan. They can be contacted at 1-800-714-0040.

Our utilization reviewers use these criteria as part of the precertification of scheduled admission, concurrent review and discharge planning process to determine clinical appropriateness and medical necessity for coverage of continued hospitalization.

Copies of the criteria used in a case to make a clinical determination may be obtained by contacting the local health plan at 1-702-228-1308. You may also submit your request in writing to:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Medical Management
Desert Canyon Building 9
9133 W. Russell Road
Las Vegas, NV 89148

8.2 Utilization Management Decision Making
Anthem, as a corporation and as individuals involved in utilization management (UM) decisions, is governed by the following principles:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Anthem does not reward practitioners or other individuals for issuing denial of coverage or care. Decisions about contracting with or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.
8.3 **Precertification/Notification Process**

Some procedures require precertification for payment of services. Please check with Provider Services or the website for details.

- Precertification is defined as the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member’s severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request.
- Prospective means the coverage request occurred prior to the service being provided.
- Notification is defined as prior to rendering covered medical services to a member, you must notify us by telephone, provider website or fax of the intent to do so. There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified.

8.4 **Peer-to-Peer Discussion**

If the medical director denies coverage of the request, the appropriate notice of action (including the member’s appeal rights) will be mailed to the requesting provider/member’s PCP and/or attending physician and member. You have the right to discuss this decision with our medical director within a reasonable time from the receipt of the denial by calling the local health plan at **1-702-228-1308**, Monday through Friday from 8 a.m. to 5 p.m. Pacific time.
9 HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

9.1 Precertification of All Inpatient Elective Admissions

We require precertification of all inpatient elective admissions. The referring primary care physician, specialist or hospital facility is responsible for precertification.

The referring physician identifies the need to schedule a hospital admission and must submit the request to our National Contact Center department fax number 1-800-964-3627.

Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 14 days prior to the scheduled admission. This will allow us to verify benefits and process the precertification request. If a procedure needs to be scheduled prior to the standard 14 days, please contact Anthem directly to notify us. For services that require precertification, we make case-by-case determinations that consider the individual’s health care needs and medical history in conjunction with nationally recognized standards of care.

The hospital can confirm that an authorization is on file by calling our automated Provider Inquiry Line at 1-844-396-2330 (see Claim Submission and Adjudication Procedures for instructions on use of the Provider Inquiry Line). If coverage of an admission has not been approved, the facility should call us to speak to a live representative, and we can contact the referring physician directly to resolve the issue. We’re available 24 hours a day, 7 days a week to accept precertification requests. When a request for medical services is received from the physician via telephone or fax, the care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of the level of care. When appropriate, the precertification nurse will assist the physician in identifying alternate levels of care as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, an Anthem reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member’s needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the requesting provider will be afforded the opportunity to discuss the case with our medical director.

If the precertification documentation is incomplete or inadequate, the preauthorization nurse will request the referring provider to submit the additional necessary documentation and refer the case to the medical director.

If the medical director denies coverage of the request, the appropriate denial letter (including the member’s appeal rights) will be mailed to the requesting provider, member’s primary care provider and member.
9.2 Emergent Admission Notification Requirements

We prefer immediate notification by network hospitals of emergent admissions. Network hospitals must notify us of emergent admissions within one business day. Our Medical Management staff will verify eligibility and determine benefit coverage, and an Anthem reference number will be issued to the hospital.

We’re available 24 hours a day, 7 days a week to accept emergent admission notification at our National Customer Care department at 1-844-396-2330 (phone) or 1-800-964-3627 (fax).

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets nationally recognized standards of care, Anthem will notify the hospital of authorization.

If the notification documentation provided is incomplete or inadequate, we will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the attending provider will be afforded the opportunity to discuss the case with our medical director prior to receiving the written determination. The appropriate denial letter will be mailed to the hospital and admitting physician with information about appeal rights and our process.

9.3 Nonemergent Outpatient and Ancillary Services — Precertification and Notification Requirements

We require precertification for coverage of selected nonemergent outpatient and ancillary services (see chart below). To ensure timeliness of the authorization, the expectation of the facility and/or provider is that the appropriate Precertification Request Form is submitted (found on our provider website) including the following information:

- Member name and ID
- Name, telephone number and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans, and medications)

The table below contains precertification and notification requirement guidelines. These requirements are not all-inclusive and are subject to change. Please visit our provider website for code-specific requirements.
9.4 Precertification/Notification Coverage Guidelines

For services that require precertification, we use nationally recognized standards of care.

We are staffed with clinical professionals who coordinate services provided to members and are available 24 hours a day, 7 days a week to accept precertification requests. When a request for medical services is received from the physician via fax, the precertification assistant will verify eligibility and benefits, which will then be forwarded to the nurse reviewer.

The nurse will review the request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received meets medical necessity criteria, an Anthem reference number will be issued to the referring physician. If the request is a stat/urgent request (expedited service authorization), the decision will be made within one business day.

If the precertification documentation is incomplete or inadequate, the nurse will request additional necessary documentation.

If the medical director denies the request for coverage, the attending provider will be afforded the opportunity to discuss the case with our medical director prior to the determination. The appropriate notice of proposed action, along with the member’s appeal and fair hearing rights and process, will be mailed to the requesting provider, the member’s primary physician, the facility and the member.

9.5 Inpatient Reviews

Hospitalists
Anthem contracts with hospitalists groups to manage all adult nonpregnant, nonbehavioral, adult admissions in Clark County. PCPs may admit and manage their own members. Otherwise, admissions should be directed to the contracted groups. Discharge summaries will be sent from the hospital to your office upon discharge.

Inpatient Admission Reviews
All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day of the notification of the admission. Our Utilization Review clinician determines the member’s medical status through, facility medical records, communication with the hospital’s Utilization Review department on site review. Appropriateness of stay is documented, and concurrent review is initiated. Cases may be referred to the medical director, who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to our case management staff for possible coordination or case management.
Inpatient Concurrent Review
Each network hospital will have an assigned Utilization Management (UM) clinician. Each UM clinician will conduct a concurrent review of the hospital medical record to determine the authorization of coverage for a continued stay.

When our UM clinician reviews the medical records, he or she also reviews any discharge planning needs. The UM clinician will conduct continued-stay reviews daily or as often as the clinical situation requires.

We will authorize covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization are made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days or is predetermined by state law. Examples of confinement and/or treatment include the following: ICU, CCU, behavioral health rehabilitation and C-section/vaginal deliveries. Exceptions are made by the medical director.

When the clinical information received meets medical necessity criteria, approved days and bed-level coverage will be communicated to the hospital for the continued stay.

If medical necessity criteria are not met for the ongoing inpatient stay, the medical director will afford the attending physician the opportunity to discuss the case prior to making a determination. If the decision is to deny the request by the medical director, the appropriate notice of action will be faxed and mailed to the hospital and attending physician, along with the appeal process.

9.6 Discharge Planning
Discharge planning is designed to assist you in the coordination of the member discharge when acute care (hospitalization) is no longer necessary.

Our UM clinician will help coordinate discharge planning needs with the hospital utilizations review/case management staff and attending physician. The attending physician is expected to coordinate with the member’s PCP/PCS regarding follow-up care after discharge. The PCP/PCS is responsible for contacting the member to schedule all necessary follow-up care. In the case of a behavioral health discharge, the attending physician is responsible for ensuring that the member has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.

When additional/ongoing care is necessary after discharge, we work with you to plan the member’s discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as skilled nursing facility or in the home with home health.

Discharge plan authorizations follow nationally recognized standards of care. Precertifications include and are not limited to home health, DME, pharmacy, follow-up visits to practitioners or outpatient procedures.
9.7 Confidentiality of Information

Utilization Management, Case Management, Disease Management Centralized Care Unit, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected health information (PHI) obtained during review, is kept confidential in accordance with applicable laws, including HIPAA. Information is used for the purposes defined above. Information is shared only with entities who have the authority to receive such information and only with those individuals who need access to such information to conduct utilization management and related processes.

9.8 Misrouted Protected Health Information

Providers and facilities are required to review all member information received from Anthem to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please call our Provider Services team at 1-844-396-2330 for help.

9.9 Emergency Services

We do not discourage members from using the 911 emergency system or deny access to emergency services. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

**Emergency medical condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect, in the absence of immediate medical attention, to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency response is coordinated with community services including the police, fire and EMS departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services and local mental health authorities if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law by other appropriately licensed personnel under the supervision of, or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member’s chart the results of the emergency medical screening examination. We will compensate you for the screening, evaluations and examination that are
reasonable and calculated to help the health care provider determine whether or not the member’s condition is an emergency medical condition.

If there is concern surrounding the transfer of a member (for example, the member may not be stable enough for discharge or transfer, or the risks of an unstable transfer may outweigh the medical benefits), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on us. If the emergency department is unable to stabilize and release the member, we will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, our concurrent review nurse will implement the concurrent review process to ensure coordination of care. The transferring facility should make all attempts to transfer our members to an in-network facility.

9.10 Urgent Care/After-Hours Care

We require our members to contact their PCP/PCS in situations where urgent, unscheduled care is necessary. If you are unable to see the member, you can refer the member to one of our participating urgent care centers. If it is during nonbusiness hours, a member can be seen by a provider participating in after-hours care. Precertification with us is not required for a member to access a participating urgent care center or a provider participating in after-hours care. If you’re interested in participating in the after-hours care program, please contact Provider Services at 1-844-396-2330.
10 QUALITY MANAGEMENT

10.1 Quality Management Program

Overview
We maintain a comprehensive Quality Management program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. You and our members have opportunities to make recommendations for areas of improvement. The Quality Management program goals and outcomes are available upon request to members and you by calling the local Quality Management department at 1-702-228-1308. Studies are planned across the continuum of care and service, with ongoing proactive evaluation and refinement of the program.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the health plan’s specific population occurs on an annual basis. This includes not only age/gender distribution, but also a review of utilization data — inpatient, emergent/urgent care and office visits by type, cost and volume. This information is used to define areas that are high-volume or that are problem-prone.

There is a comprehensive committee structure in place with oversight from our governing body. Not only are the traditional medical advisory committee (MAC) and credentialing committee in place, but a Consumer Advisory Council is also an integral component of the quality management committee structure.

We adopt and disseminate clinical practice guidelines (CPGs) for medical nonpreventive, acute and chronic conditions, behavioral health conditions and preventive health conditions. These guidelines are based on current research and national standards. Guidelines are updated at a minimum of every two years or sooner if new information is identified. These guidelines can be downloaded and printed from https://mediproviders.anthem.com/nv. You may request a copy of our CPGs by calling Provider Services at 1-844-396-2330, Monday through Friday from 8 a.m. to 5 p.m. Pacific time.

HEDIS is one of the most widely used set of health care performance measures in the United States. Both Anthem and the Nevada Department of Healthcare Finance and Policy use HEDIS to measure utilization, quality of care and compliance with CPGs. Each year, HEDIS information is collected through claims and encounter data. If claims or encounter data is not available, medical practices may be requested to provide clinical records for additional data collection. Chart data collection may be conducted onsite or via fax beginning in February of each year. HEDIS-like measures are used for provider quality incentive programs.

Provider compliance with CPGs and HEDIS quality measurements is monitored by the Anthem Quality Improvement staff using encounter data, claims and during routine medical record review. The quality staff and/or medical director are available to provide reports and educational assistance to maximize opportunities for improvement. See Appendix B for the HEDIS Measures Desktop Reference for Medical Providers.
Quality of Care
All physicians, advanced registered nurse practitioners and physician assistants (PA) are evaluated for compliance with pre-established standards as described in our credentialing program.

Review standards are based on medical community standards, external regulatory and accrediting agencies requirements, and contractual compliance. These reviews are shared with the practitioners to allow them to increase individual and collaborative rates for members.

Reviews are accomplished by Quality Management (QM) coordinators and associate professionals who strive to develop relationships with providers and hospitals that will positively impact the quality of care and services provided to our members. The results are submitted to our QM department and incorporated into a profile.

Our quality program includes review of quality of care issues identified for all care settings. QM staff use member complaints, reported adverse events and other information to evaluate the quality of service and care provided to our members.

10.2 Quality Management Committee
The purpose of the quality management committee (QMC) is to maintain quality as a cornerstone of our culture, to be an instrument of change through demonstrable improvement in care and service, to provide a mechanism and forum for interdepartmental participation in the QM program, to integrate and coordinate quality improvement (QI) in care and service throughout Anthem, and to demonstrate quantifiable improvement in care and service.

The QMC’s responsibilities are to:

- Establish strategic direction and monitor and support implementation of the QM program.
- Establish processes and structure that ensure NCQA compliance/accreditation.
- Review, monitor and evaluate program compliance against Anthem, state and federal accreditation standards.
- Review planning, implementation, measurement and outcomes of clinical/service QI studies.
- Coordinate communication of quality management activities throughout the health plan.
- Review HEDIS data and action plans for improvement.
- Review and approve the annual QM program description.
- Review and approve the annual work plans for each service delivery area.
- Provide oversight, review and compliance of delegated services.
- Provide oversight and review of subordinate committees.
- Receive and review reports of utilization review decisions and take action when appropriate.
- Analyze member Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and provider satisfaction survey responses and develop action plans for improvement.
- Assure interdepartmental collaboration, coordination and communication of QI activities.
- Monitor continuity of care between medical and behavioral health services.
- Monitor the plan’s operational indicators through the plan’s senior staff.
- Monitor accessibility and availability with cultural assessment and competency.
- Make information available about our network hospitals actions to improve safety.
- Make information available about our QI program to members and providers.
- Assure provider involvement through direct input from the medical advisory committee or other mechanisms that allow provider involvement.

**Use of Performance Data**
Practitioners and providers must allow Anthem to use performance data in cooperation with our quality improvement program and activities.

*CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.*

### 10.3 Medical Advisory Committee

The Medical Advisory Committee (MAC) has multiple purposes. The MAC assesses levels and quality of care provided to members and recommends, evaluates and monitors standards of care. The MAC identifies opportunities to improve services and clinical performance by establishing, reviewing and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk and problem-prone conditions. The MAC oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care. The MAC conducts a systematic process for network maintenance through the credentialing/recredentialing process. The MAC advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer review process, the QM program and the Utilization Review program. It oversees and makes recommendations regarding health promotion activities.

This committee’s responsibilities are to:
- Utilize an ongoing peer review system to monitor practice patterns to assess levels and quality of care and to identify appropriateness of care for improvement/risk prevention activities.
- Approve clinical protocols/guidelines that help ensure the delivery of quality care and appropriate resource utilization.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Consider/act in response to provider sanctions.
- Provide oversight and approve recommendations of credentialing subcommittee decisions to credential/recredential providers for participation in the plan.
- Approve credentialing/recredentialing policies and procedures; QM policies and procedures, utilization management policies and procedures; disease/case management policies and procedures.
- Oversee member access to care.
- Oversee compliance of delegated services.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

We welcome your suggestions and invite you to participate in this committee. Please contact your Provider Relations representative or call the health plan at **1-702-228-1308**.
10.4 Credentialing

To participate in the Medicaid managed care program, a provider must have applied for enrollment in the Nevada Medicaid program and be a licensed provider by the state before signing a contract with us.

Our credentialing policies and procedures incorporate the current NCQA Standards and Guidelines for the Accreditation of MCOs as well as DHCFP requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom it contracts.

Each provider agrees to submit for verification all requested information necessary to credential or recredential physicians providing services in accordance with the standards we’ve established. Each provider will cooperate with us as necessary to conduct credentialing and recredentialing pursuant to our policies, procedures and rules.

Credentialing Requirements
Each provider, applicable ancillary/facility and hospital will remain in full compliance with our credentialing criteria as set forth in its credentialing policies and procedures and all applicable laws and regulations. Each practitioner will complete the Nevada Uniform Credentialing Form NDOI-901, which is located at http://doi.nv.gov/uploadedFiles/doi_nvgov/_public-documents/Insurers/Uniform%20Credentialing.pdf, and the organizational providers (for example, ancillary/facility and hospital) will complete our application form upon request. Each provider will comply with other such credentialing criteria as we may establish.

Credentialing Procedures
We’re committed to operating an effective, high-quality credentialing program. We credential the following provider types: medical doctors, doctors of osteopathy, doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of chiropractic, physician assistants, optometrists, dentists, nurse practitioners, certified nurse midwives, licensed professional counselors/social workers, psychologists, physical/occupational therapists, speech/language therapists and other applicable or appropriate mid-level providers, as well as hospitals and allied services (ancillary) providers.

During recredentialing, you must show evidence of satisfying these policy requirements and must have satisfactory results relative to our measures of quality of health care and service.

We’ve established a credentialing committee and a medical advisory committee (MAC) for the formal determination of recommendations regarding credentialing decisions. The credentialing committee makes decisions regarding participation of initial members and their continued participation at the time of recredentialing. The oversight rests with the MAC.

Our credentialing policy is revised periodically based on input from several sources, including but not limited to the credentialing committees, the health plan medical director, our chief medical officer, and state and federal requirements. The policy will be reviewed and approved as needed but at a minimum annually.

The provider application contains your actual signature that serves as an attestation of the credentials summarized on and included with the application. Your signature also serves as a release of information
to verify credentials externally. We’re responsible for externally verifying specific items attested to on
the application. Any discrepancies between information included with the application and information
obtained by us during the external verification process will be investigated and documented and may be
grounds for refusal of acceptance into the network or termination of an existing provider relationship.
The signed agreement documents compliance with our managed care policies and procedures.

You have the right to inquire about the status of your application. You may do so by the following
methods:
1) telephone
2) facsimile
3) contacting the Credentialing department directly via email at NVCredentialing@anthem.com
4) in writing

As an applicant for participation with Anthem, each provider has the right to review information
obtained from primary verification sources during the credentialing process to the extent that is not a
violation of state or federal regulations. Upon notification from us, you have the right to explain
information obtained that may vary substantially from that provided and to provide corrections to any
erroneous information submitted by another party. You must submit a written explanation or appear
before the credentialing committee if deemed necessary.

Currently, the following verifications are completed, as applicable, prior to final submission of a
practitioner file to the health plan medical director or credentialing committee. To the extent allowed
under applicable law or state agency requirements, per NCQA Standards and Guidelines, the medical
director has authority to approve clean files without input from the credentialing committee. All files not
designated as a clean file will be presented to the credentialing committee for review and decision
regarding participation.

In addition to the submission of an application and the execution of a Participating Provider Agreement,
the following must be reviewed and approved by the credentialing committee or the medical director.

1. Board Certification. Verification by referencing the American Medical Association (AMA)
   Provider Profile, American Osteopathic Association (AOA), the American Board of Medical
   Specialties (ABMS), American Board of Podiatric Surgery (ABPS), and/or American Board of
   Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPM).
2. Verification of Education and Training. Verification by referencing board certification, the
   appropriate state-licensing agency or the educational institution.
3. Verification of Work History. The practitioner must submit a curriculum vitae documenting
   work history for the past five years. Any gaps in work history greater than six months must be
   explained in written format and brought to the attention of the medical director and credentialing
   committee as applicable.
4. Hospital Affiliations and Privileges. To the extent allowed under applicable law or state agency
   requirements, verification of clinical privileges in good standing at an Anthem network hospital
   may be accomplished by the use of an attestation signed by you. If attestation is not acceptable,
   hospital admitting privileges in good standing are verified for the practitioner. This information
   is obtained in the form of a written letter from the hospital, roster format (multiple practitioners),
   internet access or by telephone contact. The date and name of the person spoken to at the hospital
   are documented.
5. **State Licensure or Certification.** Verification of state license information to ensure that the practitioner maintains a current legal license or certification to practice in the state. This information can be verified by referencing data provided to us by the state via roster, telephone, written verification or through the internet.

6. **DEA Number.** Verification of the Drug Enforcement Administration (DEA) number to ensure that the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the DEA certificate or by referencing the National Technical Information Service (NTIS) data. If the practitioner is not required to possess a DEA certificate but does hold a state controlled substance certificate, the Controlled Dangerous Substance (CDS) certificate is verified to ensure the practitioner is currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the CDS certificate or by referencing CDS online or internet data if applicable.

7. **Professional Liability Coverage.** To the extent allowed under applicable law or state agency requirements, verification of malpractice coverage may be accomplished by the use of an attestation signed by the provider indicating the name of the carrier, policy number, coverage limits and the effective and expiration dates of such malpractice coverage. If attestation is not acceptable, the practitioner’s malpractice insurance information is verified by obtaining a copy of the professional liability insurance face sheet from the practitioner or from the malpractice insurance carrier. Practitioners are required to maintain professional liability insurance in specified amounts.

8. **Professional Liability Claims History.** Verification of an applicant’s history of professional liability claims, if any, is reviewed by the health plan’s credentialing committee to determine whether acceptable risk exposure exists. The review is based on information provided and attested to by the applicant and information available from the National Practitioner’s Data Bank (NPDB). The credentialing committee’s policy is designed to give careful consideration to the medical facts of the specific cases, total number and frequency of claims in the past five years, and the amounts of settlements and/or judgments.

9. **CMS Sanctions.** Verification that the practitioner’s record is clear of any sanctions by Medicare/Medicaid. This information is verified by accessing the NPDB.

10. **Disclosures — Attestation and Release of Information.** Our Provider Application will require responses to the following:
    - Reasons for the inability to perform the essential functions of the position with or without accommodation
    - Any history or current problems with chemical dependency, alcohol or substance abuse
    - History of license revocations, suspension, voluntary relinquishment, probationary status or other licensure conditions or limitations
    - History of conviction of any criminal offense other than minor traffic violations
    - History of loss or limitation of privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
    - History of complaints or adverse action reports filed with a local, state or national professional society or licensing board
    - History of refusal or cancellation of professional liability insurance
    - History of suspension or revocation of a DEA or CDS certificate
    - History of any Medicare/Medicaid sanctions
    - Attestation by the applicant of the correctness and completeness of the application
Any issue identified must be explained in writing. These explanations are presented with your application to the credentialing committee.

11. The NPDB is queried against members and our contracted providers. The NPDB will provide a report for every practitioner queried. These reports are shared with the medical director and the credentialing committee for review and action as appropriate. The appropriate state-licensing board/agency is queried to verify any restrictions/sanctions made against the practitioner’s license. All sanctions are investigated and documented, including the health plan’s decision to accept or deny the applicant’s participation in the network.

12. Recredentialing. At the time of recredentialing (every three years), information for PCPs/PCSs from quality improvement activities and member complaints is presented for credentialing committee review.

You will be notified by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the providers. You have the right to review the information submitted in support of the credentialing and recredentialing process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee if so requested.

The decision to approve or deny initial participation will be communicated in writing within 60 days of the credentialing committee’s decision. To the extent allowed under applicable law or state agency requirements per NCQA Standards and Guidelines, the medical director may render a decision regarding the approval of clean files without benefit of input from the credentialing committee. In the event your continued participation is denied, you will be notified by certified mail. If continued participation is denied, you will be allowed 30 days to appeal the decision.

Credentialing — Organizational Providers
The provider application contains your actual signature that serves as an attestation that the health care facility agrees to the assessment requirements. Providers requiring assessments are as follows: hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting. Your signature also serves as a release of information to verify credentials externally.

Currently, the following steps are completed in addition to the application and Network Provider Agreement before approval for participation of a hospital or organizational provider.

State licensure is verified by obtaining a current copy of the state license from the organization or by contacting the state-licensing agency. Primary source verification is not required. Any restrictions to a license are investigated and documented, including the decision to accept or deny the organization’s participation in the network.

We contract with facilities that meet the requirements of an unbiased and recognized authority. Hospitals (acute, transitional or rehabilitation) should be accredited by The Joint Commission (TJC), Health Care Facilities Accreditation Program or the AOA. The Commission on Accreditation of Rehabilitation Facilities may accredit rehabilitation facilities. Home health agencies should be accredited by TJC or the Community Health Accreditation Program. Nursing homes should be
accredited by TJC. TJC or the Accreditation Association for Ambulatory Health Care should accredit ambulatory surgical centers. If facilities, ancillaries or hospitals are not accredited, we will accept a copy of a recent state or CMS review in lieu of performing an on-site review. If accreditation or copy of a recent review is unavailable, an on-site review will be performed.

- A copy of the malpractice insurance face sheet is required. Organizations are required to maintain malpractice insurance in the amounts specified in the provider contract and according to Anthem policy.
- We will track a facility’s/ancillary’s reassessment date and reassess every 36 months as applicable. Requirements for recredentialing of organizational providers are the same for reassessment as they are for the initial assessment.

The organization will be notified either by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted by the organization.

Organizations have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee if so requested.

The decision to terminate an organization’s participation will be communicated in writing via certified mail.

**Peer Review**
The peer review process provides a systematic approach for monitoring the quality and appropriateness of care.

Peer review responsibilities are to:
- Participate in the implementation of the established peer review system.
- Review and make recommendations regarding individual provider peer review cases.
- Work in accordance with the executive medical director.

Should investigation of a member grievance result in concern regarding a physician’s compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician, and consults and informs the MAC and peer review committee. The medical director informs the physician of the committee’s decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, which include the MAC.

The peer review policy is available upon request.
**Member Safety**
We believe every member has the right to receive the highest quality of care in every health care setting. Improving the safety of health care delivery saves lives, reduces costs and increases members’ confidence that they are receiving the quality medical care they deserve. It is our intent to work with hospitals and physicians to create a culture of safety in order to minimize the occurrence of events that negatively impact member safety.

We’ve adopted a provider preventable-conditions-and-never-events policy intended to help keep our members safe. Our provider preventable-conditions-and-never-events policy will be applied to all provider types.

A provider preventable condition is an undesirable or preventable medical condition the member did not have upon entering a health care facility but acquired while in the medical custody of the facility. Known risks associated with the procedure are not considered provider preventable conditions.

DHCFP has defined provider preventable conditions to include but not be limited to the following:
- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
- Manifestations of poor glycemic control
- Catheter-associated urinary tract infection
- Catheter-associated vascular infection
- Surgical site infection following coronary artery bypass graft, bariatric surgery, orthopedic procedures
- Deep vein thrombosis/pulmonary embolism associated with total knee replacement or hip replacement surgery, other than in pediatric and/or obstetric members
- Surgery or other invasive procedure performed on the wrong body part
- Surgery or other invasive procedure performed on the wrong member
- Wrong surgical procedure performed on the member

Never events are errors in medical care that are clearly identifiable, preventable and serious in their consequences for members. These errors should never occur in health care. These errors may occur in inpatient settings as well as other settings, including but not limited to outpatient hospital settings, nursing facility settings or ambulatory care settings.

Anthem defines never events as:
- The surgery or other invasive procedure is performed on the wrong body part.
- The surgery or other invasive procedure is performed on the wrong member.
- The wrong surgical/invasive procedure is performed on the member.

You are expected to furnish us with information about conditions that are present on admission (POA) using POA indicators. POA indicators will not negatively impact provider reimbursement.
You will also be expected to self-report incidents of provider preventable conditions and never events. We will closely review admissions with potential provider preventable conditions or never events through claims review, medical director review of cases, concurrent review, member complaints, outpatient prior authorizations, case management sources, etc. Once a potential provider preventable condition or never event is identified, the case will be investigated to the extent necessary to verify whether a provider preventable condition or never event has occurred.

We will not reimburse providers for additional inpatient days at a facility or subsequent outpatient services that directly and exclusively result from a provider preventable condition. We also will not reimburse providers for inpatient or outpatient care as a direct result of a never event. If, as a direct result of the provider preventable condition or never event, the member requires services that are in addition to other medically necessary services at the appropriate level of care, payment to providers will be reduced to exclude the costs of the additional services. Payment reductions and denials will be limited to the added cost of the member care directly resulting from the provider preventable condition or never event.

If a provider preventable condition or never event is caused by one provider or facility (primary provider) and is then treated at a different facility or provider (secondary provider), payment will not be denied to the secondary provider. We will make appropriate payments to the secondary provider and pursue recovery of all money in full, including but not limited to legal expenses and other recovery costs from the primary provider. This recoupment may be recovered directly from the primary provider or through subrogation of the injured member’s settlement. The anticipated costs of long-term health care consequences to the member that are directly related to the provider preventable condition or never event will also be considered in all recoveries.

We will report such incidents to the Nevada DHCFP as required or upon request.
11 PROVIDER DISPUTE PROCEDURES

11.1 Provider Administrative Denial

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions or lack of precertification.

11.2 Provider Administrative Appeal Procedure

If you are dissatisfied with an administrative denial, you may file an administrative appeal by submitting a written request with supporting documentation as to why the administrative requirements were met. A form to file an appeal can be found in Appendix A of this manual.

An administrative appeal must be filed within 90 calendar days from the date on the administrative denial notice.

Administrative appeals can be submitted through Availity at http://www.availity.com

The administrative appeals can be mailed to the following address:
  Anthem Blue Cross and Blue Shield Healthcare Solutions
  Appeals Department
  P.O. Box 62429
  Virginia Beach, VA 23466-2429

You may file a verbal dispute but must follow up with a written request within 10 calendar days of filing the verbal dispute. The written request must include the contact log number provided by the NCC or Provider Relations associate when the oral dispute was filed.

If the written request is not received within the specified time frame, the dispute will be closed, and no review will take place. A letter will be mailed to you explaining that your required written follow-up was not received and your dispute has been closed. The letter will further explain that if your written request is received prior to the timely filing limit, a review will take place, but it will be considered a new request. The new receipt date will be used for calculating the required 30-calendar day turnaround time for determination.

We will render a decision and send a determination letter within 30 calendar days of receiving the administrative appeal. If we uphold our original decision, we will mail you a letter. This letter will include information about your rights to request a fair hearing from the state within 90 calendar days of the date on the final determination letter. If we overturn our decision, the claim will be reprocessed, or you will be notified of the action that needs to be taken.

You will not be penalized for filing an administrative appeal.
11.3 Provider Grievance (Complaint) Procedures

Anthem maintains a system for the resolution of provider grievances including a process for the notice and appeal of any dissatisfaction expressed by a provider verbally or in writing to Anthem. Provider grievances will be resolved in a fair and timely manner.

Grievance: An expression of dissatisfaction about any matter or aspect of the health plan or its operations that is not included in medically necessary denials.

Provider: Any physician, hospital, facility or other health care professional who is licensed or otherwise authorized to provide health care services in the state or jurisdiction in which they are furnished.

You can file a grievance (complaint) in writing via letter or fax to:
Anthem Blue Cross and Blue Shield Healthcare Solutions
Provider Relations Department
9133 W. Russell Road
Las Vegas, NV 89148
Fax: 1-866-495-8711

Anthem ensures that punitive or retaliatory action is not taken against a provider who files a grievance or against a provider who supports a member’s grievance.

Anthem National Customer Care representatives are available to receive inquiries over the phone. The representatives will attempt to resolve all inquiries at the time of the initial call. If they cannot resolve an inquiry to a provider’s satisfaction, they refer the inquiry to the appropriate area for resolution.

Anthem will thoroughly investigate each provider grievance using applicable statutory, regulatory, contract provisions, collecting all pertinent facts from all parties and applying the health plan’s written policies and procedures.

The investigation and final resolution for each grievance will be completed within 90 calendar days of the date of receipt.

A grievance resolution letter is sent to the provider that contains, at a minimum, the following:
- All information considered in investigating the grievance
- Findings and conclusions based on the investigation
- The disposition of the grievance

11.4 Provider Payment Disputes

Claims Payment Inquiries or Appeals
Our Provider Experience program helps you with claims payment and issue resolution. Just call 1-844-396-2330, select the Claims prompt, and we’ll connect you with a dedicated resource team called the Provider Service Unit (PSU) to ensure:
- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
Significantly improved turnaround time of inquiry resolution.

Increased outreach communication to keep you informed of your inquiry status.

**Claims Correspondence vs. Payment Appeal**

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

The following table also provides guidance on issues considered claim correspondence and should not go through the payment appeal process.

<table>
<thead>
<tr>
<th>Type of Issue</th>
<th>What Do I Need to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejected claim(s)</td>
<td>Use the EDI Hotline at <strong>1-800-590-5745</strong> when your claim was submitted electronically but was never paid or was rejected. We’re available to assist you with setup questions and help resolve submission issues or electronic claims rejections.</td>
</tr>
</tbody>
</table>
| EOP requests for supporting documentation                                  | Submit a Claim Correspondence form, a copy of your EOP and the supporting documentation to:  
| (sterilization/hysterectomy/abortion consent forms, itemized bills, and invoices) | Anthem Blue Cross and Blue Shield Healthcare Solutions Claims Correspondence  
P.O. Box 61599  
Virginia Beach, VA 23466-1599 |
| EOP requests for medical records                                           | Submit a Claim Correspondence form, a copy of your EOP and the medical records to:  
|                                                                            | Anthem Blue Cross and Blue Shield Healthcare Solutions Claims Correspondence  
P.O. Box 61599  
Virginia Beach, VA 23466-1599 |
| Need to submit a corrected claim due to errors or changes on original submission | Submit a Claim Correspondence form and your corrected claim to:  
|                                                                            | Anthem Blue Cross and Blue Shield Healthcare Solutions Claims Correspondence  
P.O. Box 61599  
Virginia Beach, VA 23466-1599  
Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. |
| Submission of coordination of benefits/third-party liability information    | Submit a Claim Correspondence form, a copy of your EOP and the COB/TPL information to:  
|                                                                            | Anthem Blue Cross and Blue Shield Healthcare Solutions Claims Correspondence  
P.O. Box 61599  
Virginia Beach, VA 23466-1599 |
| Emergency room payment review                                               | Submit a Claim Correspondence form, a copy of your EOP and the medical records to:  
|                                                                            | Anthem Blue Cross and Blue Shield Healthcare Solutions Claims Correspondence  
P.O. Box 61599  
Virginia Beach, VA 23466-1599 |

**Payment Appeals**

A payment appeal is any dispute between you and Anthem for reason(s) including:

- Contractual payment issues.
- Inappropriate or unapproved referrals initiated by providers.
• Retrospective review.
• Disagreements over reduced or zero-paid claims.
• Authorization issues.
• Timely filing issues.
• Other health insurance denial issues.
• Claim code editing issues.
• Duplicate claim issues.
• Retroeligibility issues.
• Experimental/investigational procedure issues.
• Claim data issues.

You will not be penalized for filing a payment appeal. No action is required by the member.

Our procedure is designed to afford providers access to a timely payment appeal process. We have a two-level appeal process for provider to dispute claim payments. If a provider is dissatisfied with the resolution of a first-level appeal, we afford the provider the option to file a second-level appeal.

If you disagree with a previously processed claim or adjustment, you may submit to us a verbal or written request for reconsideration.

The payment appeal for reconsideration, whether verbal or written, must be received by Anthem within 90 calendar days of the Explanation of Payment (EOP) paid date or recoupment date.

In a situation where a problem has been identified that affects multiple claims and/or multiple providers or in a situation where we’ve identified an issue that has caused multiple underpayments, we will consider claims for reprocessing with dates of service 90 days prior to the received date of the original provider payment dispute for network providers. After this time period has lapsed, underpaid claim adjustments will be made on an exception basis.

Due to the nature of appeals, some cannot be accepted verbally and therefore must be submitted in writing. The following table provides guidance for determining the appropriate submission method.

<table>
<thead>
<tr>
<th>Issue Type</th>
<th>Verbal Allowed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denied for timely filing</td>
<td>If Anthem made an error per your contract, verbal is allowed.</td>
</tr>
<tr>
<td>Denied for no authorization</td>
<td>• If you know an authorization was provided and Anthem made an error, verbal is allowed.</td>
</tr>
<tr>
<td></td>
<td>• If you have paper proof, written is required.</td>
</tr>
<tr>
<td>Retrospective authorization issue</td>
<td>If requesting retro review, written is allowed.</td>
</tr>
<tr>
<td>Denied for need of additional medical records (Denials issued for this reason are considered nonclean claims and will not be logged as appeals. These will be treated as inquiries/correspondence.)</td>
<td>• Written is required if records have not been received previous to call.</td>
</tr>
<tr>
<td></td>
<td>• If records were previously sent and you know they were received and on file, verbal is allowed.</td>
</tr>
<tr>
<td>You feel you were not paid according to your contract</td>
<td>Verbal is allowed.</td>
</tr>
<tr>
<td>The member doesn’t have other health insurance, but the claim was denied for other health insurance</td>
<td>Verbal is allowed.</td>
</tr>
<tr>
<td>Claim code-editing denial</td>
<td>Written is required.</td>
</tr>
<tr>
<td>Issue Type</td>
<td>Verbal Allowed?</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Denied as duplicate</td>
<td>Verbal is allowed.</td>
</tr>
<tr>
<td>Claim denied related to provider data issue</td>
<td>Verbal is allowed.</td>
</tr>
<tr>
<td>Retro-eligibility issue</td>
<td>Verbal is allowed.</td>
</tr>
<tr>
<td>Experimental procedure denial</td>
<td>Written is required.</td>
</tr>
<tr>
<td>Claims data entry error; data elements on the claim on file does not match the claim you submitted</td>
<td>Verbal is allowed.</td>
</tr>
<tr>
<td>Second-level appeal</td>
<td>Must be provided in writing; verbal is not accepted.</td>
</tr>
</tbody>
</table>

If after reviewing this table you determine a verbal appeal is allowed, call the Provider Service Unit (PSU) at **1-844-396-2330**.

If the appeal must be submitted in writing, or if you wish to use the written process instead of the verbal process, the appeal should be submitted to:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Payment Appeals
P.O. Box 61599
Virginia Beach, Virginia 23466-1599

Written appeals with supporting documentation can also be submitted via the Payment Appeal tool on the Anthem provider website. When inquiring on the status of a claim, if a claim is considered appealable due to no or partial payment, a dispute selection box will display. Once this box is clicked, a web form will display for you to complete and submit. If all required fields are completed, you will receive immediate acknowledgement of your submission.

When using the online tool, supporting documentation can be uploaded by use of the attachment feature on the web dispute form and will attach to the form when submitted.

When submitting the appeal verbally or in writing you need to provide:

- A listing of disputed claims.
- A detailed explanation of the reason for the appeal.
- Supporting statements for verbal appeals and supporting documentation for written; written appeals should also include a copy of the EOP and an Appeal Request form.

Verbal appeals received by the PSU are logged into the appeal database. Written payment appeals are received in our Document Management Department (DMD) and date-stamped upon receipt. The DMD scans the appeal into our document management system, which stamps the image with the received date and the scan date. Once the dispute is scanned, it is logged into the appeal database by the Intake team within the DMD.

Once the appeal is logged, it is routed in the database to the appropriate appeal unit. The appeal associates work appeals by demand, drawing items based on first-in, first-out criteria for routing appeals.

The appeal associate will:

- Review the appeal and determine the next steps needed for the payment appeal.
• Make a final determination if able based on the issue or route to the appropriate functional area(s) for review and determination.
• Ensure a determination is made within 30 calendar days of the receipt of the payment appeal.
• Contact you via your preferred method of communication (phone, fax, email or letter) and provide the payment information, if overturned, or further appeal rights are upheld or partially upheld. Your preferred method of communication is determined from the PSU agent requesting this information during your call or your selection on the Appeal Request form. If no preference is provided, a letter will be mailed to you.

If your claim(s) remains denied or partially paid or you continue to disagree, you may file a second-level appeal in writing. Second-level verbal appeals will not be accepted. The second-level appeal must be received by Anthem within 30 calendar days from the date of the first-level decision/resolution letter. Second-level appeals received after this will be upheld for untimely filing and will not be considered for further payment. You must submit a written second-level dispute to the centralized address for disputes. A more senior appeal associate, or one that did not complete the first-level review, will conduct the second-level review.

If additional information is submitted to support payment, the denial is overturned. Otherwise, the appeal associate conducts the review as per the steps in the first-level process.

Once the dispute is reviewed for the second level, the appeal associate will notify you of the decision via your preferred method of communication within 30 calendar days of receipt of the second-level payment appeal.

A licensed/registered nurse will review payment appeals received with supporting clinical documentation when medical necessity review is required. We will apply established clinical criteria to the payment appeal. After review, we will either approve the payment dispute or forward it to the medical director for further review and resolution.

11.5 Provider State Fair Hearing Process

As an Anthem participating provider, you have the right to request a state fair hearing from the DHCFP when you have exhausted our internal dispute (appeal) system without receiving a wholly favorable resolution decision.

You may request a state fair hearing after exhausting our appeals process in the following situations only:
• Reduction, suspension or termination of a previously authorized service
• Denial of limited authorization of a previously authorized service
• The denial for disenrollment for good cause
• Denial, in whole or in part, of payment for a service
• Demand for recoupment
• Failure of Anthem to meet specified time frames (for example, authorization, claims processing, appeal resolution)
The request for a state fair hearing must be submitted in writing within 120 calendar days from the date of our notice of decision letter. You may ask for a fair hearing from DHCFP by completing the Provider State Fair Hearing form and sending it with our notice of decision to:

Nevada Division of Health Care Financing and Policy
Hearings Unit
1100 E. William St., Suite 102
Carson City, NV 89701
Hearings Unit: 1-775-684-3604

In addition to the signed Provider State Fair Hearing form and our Notice of Decision letter, please supply the following required documentation:

- A copy of the Anthem Notice of Decision letter
- A copy of the Remittance Advice page(s) showing the denial
- A copy of the original signed claim or service requested
- Any documentation to support the issue (for example, prior authorization, physician’s notes, ER reports)

After you ask for a fair hearing by submitting the Provider State Fair Hearing form and all required documentation to the DHCFP hearings supervisor, you will receive a letter telling you the date and time of the scheduled hearing preparation meeting (HPM). The HPM will be held at the earliest possible date after DHCFP receives your fair hearing request and all required documentation. The HPM will be held by phone and is scheduled in an attempt to resolve your dispute prior to conducting the formal fair hearing. If after the HPM your dispute is not resolved, a formal fair hearing with the Department of Administration Appeals Office will be scheduled.

You may represent yourself or be represented at the fair hearing by legal counsel or your authorized designate. **You, your legal representative or your authorized designate must be present at the formal fair hearing.** You must sign the Provider State Fair Hearing form where required, and it must be furnished to the Medicaid office along with all required documentation prior to the hearing.

After the fair hearing, you and your legal representative or authorized designate will be notified by certified mail of the hearing officer’s decision. The decision of the hearing officer is final.

For more information, the fair hearing process for providers is cited at NRS §422.306 and is described in the DHCFP Medicaid Services Manual, chapter 3100.

**Expedited State Fair Hearing:** If a recipient sends in a fair hearing request to the DHCFP with clinical documentation that supports the urgency of the request and requests the hearing to be expedited, the hearings unit will send the clinical documentation for medical review by an impartial, third party physician. If the physician determines the time otherwise permitted for a standard fair hearing decision, one hundred and twenty days (120) days, could jeopardize the individual’s life, health or ability to attain, maintain or regain maximum function, a hearing decision will be issued within three working days. The MCO clinician (physician) and MCO attorney will need to represent themselves at the expedited fair hearing as is the current process for standard fair hearings. The expedited fair hearings are all held telephonically due to time constraints. If the recipient does not receive an expedited fair hearing, the hearing request will be treated as a standard fair hearing request. Expedited fair hearings will be held
by sister agency, the Division of Welfare and Supportive Services (DWSS). Please see the updated Medicaid Service Manual, “Chapter 3100: Hearings” for details.

Note: Providers may file an expedited request only in cases where the recipient is unable to act on their own behalf, either because of physical incapacity or mental incapacity. Additional documentation may be required to demonstrate the incapacity on a case by case basis. (MLT 03/18 MSM Chapter 3100)

The Provider State Fair Hearing form can be found in Appendix A of this manual.

11.6 Provider Reconsideration Process

You have the right to interact with the medical director or peer reviewer following an adverse determination of health care service requiring medical necessity determinations.

The reconsideration and peer-to-peer process is intended to provide a mechanism for you to request a review of a decision to deny coverage of health care services for reasons of medical necessity or appropriateness. This process would also include cases where denial was made in the following circumstances:

- Disapproval of full or partial payment for a requested health care service
- Approval of health care services at a lesser scope or duration than the requested services
- Disapproval of requested services and approval of services of an alternative health care service

For your request to be accepted, the requested service must arise from a denial of service or treatment due to a failure to meet medical necessity guidelines. You’re not required to have the consent of the member in seeking a reconsideration of an original denial.

In reconsidering the decision, the medical director may request input from a specialist provider. If the medical director who made the initial denial is unavailable, another acting medical director will review the request on behalf of the original medical director. If we uphold our original decision, we will send you a letter with our decision. This letter will include your appeal rights. If you do not agree with our decision, you may request a verbal appeal. The verbal appeal must be followed with a written request within 10 calendar days unless the case qualifies for an expedited appeal.

Reconsideration

Reconsideration is a written request from the provider asking to re-review a denied or reduced authorization request. For a Reconsideration request, the provider is responsible to provide additional medical information (e.g., intensity of service, severity of illness, risk factors) that might not have been submitted with the original/initial request that supports the level of care/services requested.

Peer-to-Peer

Peer-to-peer reviews are a clinician-to-clinician discussion, which give a member’s treating or ordering practitioner the opportunity to discuss a medical necessity denial decision with an appropriate health plan Medical Director (or appropriate practitioner). This can occur anytime during the review process, but most often occurs after a denial is issued. The discussion must occur between the medical director/physician advisor and the provider who is directly involved in the member’s care to participate.
in the peer-to-peer review. Of note, a discussion between a health plan Medical Director (or appropriate practitioner) and an advisor who is not involved directly in the care of a member does not qualify as a peer-to-peer.
12 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

12.1 Electronic Submission

We encourage the submission of claims electronically through Electronic Data Interchange (EDI). Network providers must submit claims within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services. Non-network providers must submit claims within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services. Emergency transportation providers must submit claims within 365 days from the last date of service. Electronic claims submission is available through:

- Change Healthcare is SB765 for professional and 12B20 for institutional.
- Availity is 00265.
- SDS — please contact the clearinghouse.

The advantages of electronic claims submission are as follows:

- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for automatic adjudication of claims

The guide for EDI claims submission is located at https://mediproviders.anthem.com/nv. The EDI claim submission guide includes additional information related to the EDI claim process.

To initiate the electronic claims submission process or obtain additional information please contact Availity.

Availity serves as our electronic data interchange (EDI) partner for all electronic data and transactions.

Methods to exchange EDI transmissions with the Availity EDI Gateway:

1. **Already exchanging EDI files?** You can use your existing Clearinghouse or Billing Company for your Healthy Blue transmissions. *(Please work with them to ensure connectivity to the Availity EDI Gateway)*
2. Become a Direct Trading Partner with the Availity EDI Gateway
3. Use Direct single claim entry through the Availity Portal

Providers, Billing services and Clearinghouses who are **not** currently exchanging EDI transactions can register with Availity.

The **Availity Welcome Application** is your map to setting up your business for exchanging EDI transactions Availity.
Already registered with Availity?
Use your existing login and choose: My Providers > Enrollments Center.

Additionally, the following will guide you through the transition:
- Use the EDI Connectivity Services Startup Guide for detailed instructions.
- Use Availity’s EDI Companion Guide

Your organization can exchange the following transactions through the Availity EDI Gateway:
- 837 — Institutional Claims
- 837 — Professional Claims
- 837 — Dental Claims
- 835 — Electronic Remittance Advice
- 276/277 — Claim Status - Batch
- 270/271 — Eligibility Request – Batch
- 278 — Precertification/Preauthorization

Electronic Funds Transfer (EFT) Registration
To register or manage account changes for EFT only, use the EnrollHub™, a CAQH Solutions™ enrollment tool (https://solutions.caqh.org/bpas/Default.aspx?ReturnUrl=/bpas/default.aspx/%22), a secure electronic EFT registration platform. This tool eliminates the need for paper registration, reduces administrative time and costs, and allows you to register with multiple payers at one time.

If you were previously registered to receive EFT only, you must register using EnrollHub to manage account changes.

Electronic Remittance Advice (ERA) Registration
You can also use Availity link below to register and manage ERA accounts.
https://apps.availity.com/availity/web/public.elegant.login

Navigate to My Providers > Enrollments Center > ERA Enrollment
Note: If you were previously registered to receive ERA, you must register using Availity to manage ERA account changes.

Choose to suppress (or enable) paper remittance vouchers through our Provider Paper Suppression Form. (https://anthem-int.columncloud.com/SR/paperSuppressionSR.jsp)

Contacting Availity
If you have any questions please contact Availity Client Services at 1-800-AVAILITY (1-800-282-4548) Monday through Friday 8:00 a.m. to 7:30 p.m. (Eastern).
12.2 Paper Claims Submission

You also have the option of submitting paper claims. All claims should be submitted on original red claim forms (not black and white or photocopied forms), laser printed or typed (not handwritten) in a large, dark font. Network providers must submit a properly completed UB-04 CMS-1450 or CMS-1500 (08-05) within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services. Non-network providers must submit properly completed claims within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services. Emergency transportation providers must submit claims within 365 days from the last date of service. Exceptions to these timely filing requirements are in cases of coordination of benefits (COB)/subrogation or in cases where a member has retroactive eligibility. For cases of COB/subrogation, the time frames for filing a claim will begin on the date the third-party documents a resolution of the claim.

CMS-1500 (08-05) and UB-04 CMS-1450 forms are available from CMS at https://www.cms.hhs.gov. CMS-1500 (08-05) and UB-04 CMS-1450 must include the following information (HIPAA-compliant where applicable):

- Member’s ID number
- Member’s name
- Member’s date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- Procedures, services or supplies rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Provider’s TIN
- Provider’s name according to contract
- Anthem provider number
- NPI of billing and rendering provider when applicable
- CLIA Identification number when applicable (CMS-1500 only)
- COB/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI/API
- Any other state-required data

We cannot accept claims with alterations to billing information. Claims that have been altered will be returned to you with an explanation of the reason for the return. We will not accept claims from you if you submit entirely handwritten claims.

Paper claims must be submitted to the following address:
Anthem Blue Cross and Blue Shield Healthcare Solutions
Nevada Claims
P.O. Box 61010
Through claims and encounter data submissions, HEDIS information is collected. This includes but is not limited to the following:

- Preventive services (for example, EPSDT, well-child visits, immunizations, mammography, Pap smears)
- Prenatal and postpartum care
- Acute and chronic illnesses
- Others listed in Appendix B — HEDIS Measures Desktop Reference for Medical Providers

Compliance is monitored by Anthem Utilization Management and Quality Improvement staff, coordinated with the medical director and reported to the quality management committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization.

12.3 Website Submission

Participating providers have the option to use the claim submission tools available on our provider website. You will have the ability to data enter claims on a preformatted CMS-1500 and UB-04 claim template. Provider offices and facilities that are able to create HIPAA-compliant ANSI 837 4010A1 claim transactions will have the ability to upload the claims on the provider website. To take advantage of the direct submission of ANSI 837 claim files, please contact the EDI Hotline at 1-800-590-5745.

12.4 International Classification of Diseases, 10th Revision (ICD-10) Description

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.
12.5 Encounter Data

We maintain a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to us for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) claim form unless we’ve approved other arrangements. Data will be submitted in a timely manner but no later than 180 days from the date of service.

The encounter data will include the following:
- Member’s name (first and last name)
- Member’s date of birth
- Provider’s name according to contract
- Anthem provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)
- Provider’s TIN
- NPI/API number

Through claims and encounter data submissions, HEDIS information is collected. This includes, but is not limited to, the following:
- Preventive services (for example, childhood immunization, mammography, Pap smears)
- Prenatal care (for example, LBW, general first trimester care)
- Acute and chronic illness (for example, ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by our Utilization Management and Quality Improvement staff, coordinated with the medical director and reported to the quality management committee on a quarterly basis. The PCP/PCS is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination.

12.6 Claims Adjudication

We’re dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Institutional claims should be submitted using EDI submission methods or a UB-04 CMS-1450 and provider services using the CMS-1500.

Providers must use HIPAA-compliant billing codes when billing us. This applies to both electronic and paper claims. When billing codes are updated, you’re required to use appropriate replacement codes for submitted claims. We will not pay any claims submitted using noncompliant billing codes.
Anthem reserves the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

For claims payment to be considered, network providers must adhere to the following time limits:
- Submit claims within 180 days from the date the service is rendered or, for inpatient claims filed by a hospital, submit within 180 days from the date of discharge.
- Claims for members whose eligibility has not been added to the state’s eligibility system must be received within 180 days from the date when the eligibility is added and we’re notified of the eligibility/enrollment.
- Claims submitted after the 180-day filing deadline will be denied.
- If other health insurance exists, the claim for services may be submitted up to 180 days from the date on the EOP for network providers.

For claims payment to be considered, non-network providers and emergency transportation providers must adhere to the following time limits:
- Submit claims within 365 days from the date the service is rendered or, for inpatient claims filed by a hospital, submit within 365 days from the date of discharge.
- Claims for members whose eligibility has not been added to the state’s eligibility system must be received within 365 days from the date the eligibility is added and we’re notified of the eligibility/enrollment.
- Claims submitted after the 365-day filing deadline will be denied.
- If other health insurance exists, the claim may be filed up to 365 days from the date on the EOP.

After filing a claim with us, review the weekly EOP. If the claim does not appear on an EOP within 30 calendar days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim online at https://mediproviders.anthem.com/nv or call the Provider Inquiry Line at 1-844-396-2330. If the claim is not on file with us, for network providers, resubmit your claim within 180 days from the date of service and, for non-network providers and emergency transportation providers, resubmit your claim within 365 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

### 12.7 Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:
- Is timely submitted by provider.
- Is accurate.
- Is submitted on a HIPAA-compliant standard claim form, including a CMS-1500 (08-05) or UB-04 CMS-1450 or successor forms thereto or the electronic equivalent of such claim form.
- Requires no further information, adjustment or alteration by the provider or by a third party in order to be processed and paid by us.
- Is not from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

Claims with errors originating from the state’s claim system are considered clean.
Clean claims are adjudicated to a paid or denied status within 30 calendar days of receipt. If we do not pay the claim within 30 calendar days of adjudicating the clean claim to an approved or denied status, we will pay all applicable interest as required by law.

We produce and send an EOP, which delineates the status of each claim that has been adjudicated during the previous claim cycle. If a claim is partially or totally denied due to lack of submission of required information, the remittance advice will specifically identify the required information or documentation necessary to complete claim processing. Upon receipt of the requested information from you, we must complete processing of the clean claim within 30 calendar days.

Paper claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic Data Interchange (EDI) claims that are determined to be unclean will be returned to our contracted clearinghouse that submitted the claim.

In accordance with Nevada Revised Statute requirements, we will adjudicate 100% of clean claims within 30 days of receipt to an approved or denied status. In accordance with federal requirements, 90% of these will be paid within 30 days of receipt. To further meet NRS requirements, we will pay at least 95% of claims within 30 days of the date they are approved or at least 90% of the total dollar amount for approved claims. In addition, to further meet federal requirements, 99% of all the claims will be paid within 90 days. The date of receipt is the date we receive the claim as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

12.8 Claims Status

You should use https://mediproviders.anthem.com/nv or call the automated Provider Inquiry Line at 1-844-396-2330 to check claims status. You should also use the claims status information available for claims that were electronically submitted through a clearinghouse for information on accepted and rejected claims.

12.9 Provider Reimbursement

Electronic Funds Transfer and Electronic Remittance Advice

We offer electronic funds transfer (EFT) and electronic remittance advice (ERA) with online viewing capability. You can elect to receive our payments electronically through direct deposit to your bank account. In addition, you can select from a variety of remittance information options including:

- ERA presented online and printed in your location.
- HIPAA-compliant data file for download directly to your practice management or member accounting system.
- Paper remittance printed and mailed by us.

Some of the benefits you may experience include:

- Faster receipt of payments from us.
- The ability to generate custom reports on both payment and claim information based on the criteria specified.
Online capability to search claims and remittance details across multiple remittances.
Elimination of the need for manual entry of remittance information and user errors.
Ability to perform faster secondary billing.

To register for ERA/EFT, visit our website at https://mediproviders.anthem.com/nv.

**PCP/PCS Reimbursement**
We reimburse PCPs/PCSs according to their contractual arrangement.

**Specialist Reimbursement**
Reimbursement to network specialty care providers and network providers not serving as PCPs/PCSs is based on their contractual arrangement with us.

Specialty care providers will obtain PCP/PCS and our approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the PCP’s/PCS’s referral or beyond the scope of self-referral permitted under this program.

**Overpayment Process**
Refund notifications may be identified by two entities, Anthem and its contracted vendors or the providers. Anthem researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Anthem, Anthem will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment and submits a refund, a completed Refund Notification Form specifying the reason for the return must be included. This form can be found on the provider website at https://mediproviders.anthem.com/nv. The submission of the Refund Notification Form will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, please call Provider Services at 1-844-396-2330 and select the appropriate prompt.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Member Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act.

The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding
cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act including treble damages. To avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled “Reporting and Returning Overpayments — Deadline for Reporting and Returning Overpayments,” codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Global Payment for Obstetrical Services
A global payment will be paid to the delivering obstetrician when the member has been seen seven or more times. If the obstetrician has seen the member less than seven times, the obstetrician will be paid according to the Medicaid FFS visit-by-visit schedule.

Included services are:
- Prenatal visits.
- Office visits.
- All postpartum visits.
- Radiology services.
- CBC.
- Urinalysis.
- Pregnancy tests.
- One ultrasound.
- Fetal stress test when performed in the physician’s office.

Appropriate CPT codes include 59400, 59510, 59610 and 59618.

12.10 Coordination of Benefits and Third Party Liability
State-specific guidelines will be followed when COB procedures are necessary. We agree to use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members in our plan.

If primary insurance exists for a member, providers are required to bill a member’s primary health plan (PHP) prior to billing Anthem. Providers are required to follow other payers’ billing requirements. If the other payer denies a claim because the provider did not follow their requirements, Anthem will also deny the claim. Providers may not collect payment from a member because the provider did not comply with the policies of the PHP and/or Anthem.

If the provider does not participate in a member’s PHP, the provider must refer the member to the PHP. Anthem will deny payment for services if the member elects to seek treatment from a provider not participating in the PHP network. If the Medicaid member is informed by a provider not authorized by
the PHP that both the PHP and Anthem may deny payment for the services, and the member then voluntarily elects to receive services from a provider who does not participate in the member’s PHP, the member assumes the responsibility to pay for the services personally.

Anthem becomes the primary payer under the following conditions:
If the PHP does not cover a service, Anthem becomes the primary health insurance and is responsible within the scope of Anthem rules.

When PHP has exhausted: The provider must provide to Anthem the EOB from the primary carrier showing the services that are exhausted and/or a letter explaining the benefit determination or member termination from the plan.

Anthem and our providers agree the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members. When we’re aware of these resources prior to paying for a medical service, we’ll avoid payment by either rejecting a provider’s claim and redirecting you to bill the appropriate insurance carrier (unless certain pay and pursue circumstances apply — see below), or if we do not become aware of the resource until sometime after payment for the service was rendered, by pursuing postpayment recovery of the expenditure. You must not seek recovery in excess of the Medicaid payable amount or the amount agreed upon in the provider agreement with Anthem.

The circumstances are:
- When the services are for preventive pediatric care, including EPSDT
- If the claim is for prenatal or postpartum care or if service is related to OB care
- Designated behavioral health services (typically not covered by major medical health plans) if the billed services contain one of the following procedure codes:
  - H0043-H0044 (supported housing)
  - H2014-H2018 (skills training, community support and psychosocial rehab)
  - H2023-H2027 (employment support)
  - H0038 (peer support)
  - T1016, T2022, T2023, H0036, H0037, H0039, H0049, H2015, H2016 (behavioral health case management services)
  - H0031 (mental health assessments)
  - H0019 (behavioral health residential without room and board)
  - S9484, S9485 (crisis intervention)
- Any service rendered to a child of an absent parent (for example, primary coverage is through a noncustodial parent after a divorce)

We’ll also avoid payment of trauma-related claims where third-party liability (TPL) resources are identified prior to payment. Otherwise, we’ll follow a pay-and-pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched postpayment to determine likely cases, with multiple letters and phone calls being made to document the appropriate details. The filing of liens and settlement negotiations are handled internally and externally via our subrogation vendor.

We will require members to cooperate in the identification of any and all other potential sources of payment for services.
Any questions or inquiries regarding paid, denied or pending claims should be directed to Provider Services at 1-844-396-2330.

12.11 Billing Members

Overview
Before rendering services, you should always inform members the cost of services not covered by Anthem or Nevada Medicaid will be the member’s responsibility.

If you choose to provide services not covered by Anthem or Nevada Medicaid, you:
- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Will obtain the member’s signature on the Client Acknowledgment Statement (below) specifying the member will be held responsible for payment of services.
- Understand you may not bill for or take recourse against a member for denied or reduced claims for services within the amount, duration and scope of benefits of the Medicaid program.

Our members must not be balance-billed for the amount above that which is paid by Anthem for covered services.

In addition, you may not bill or charge members a fee for any of the following:
- Failure to timely submit a claim, including claims not received by us
- Failure to submit a claim to us for initial processing within the 180-day filing deadline for network providers or the 365-day deadline for non-network or emergency transportation providers
- Failure to submit a corrected claim within the clean claim submission period
- Failure to appeal a claim within the 180-day payment dispute period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Your errors made in claims preparation, claims submission or the appeal/dispute process
- Failure to submit a claim to us within specified time frames for those services covered with other health insurance
- No-show or cancelled appointments
- The first copy of their medical records

Please see 42 CFR § 438.106 and Nevada Medicaid Service Manual § 105.3 as support for these Anthem policies.

Client Acknowledgment Statement
You may bill our member for a service that has been denied as not medically necessary or not a covered benefit only if both of the following conditions are met:
- The member requests the specific service or item.
• The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

“I understand that, in the opinion of (provider’s name), the services or items I have requested to be provided to me on (dates of service) may not be covered under Anthem as being reasonable and medically necessary for my care or be an Anthem-covered benefit. I understand Anthem has established the medical necessity standards for the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Anthem medically necessary standards for my care or are not covered benefits.”

Signature: _________________________________________________

Date: _________________________________________________