Provider orientation and training

HealthKeepers, Inc. for Anthem HealthKeepers Plus and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus)

Professional, facility, behavioral health and ancillary providers
Agenda

• Who we are
• Member eligibility
• Medicare vs. Medicaid
• Dual members
• Dual-Eligible Special Needs Plans (D-SNP)
• Benefits grid
• Provider supports
• Provider communications
• Provider manual
• Public provider website
• Secure provider website

• Provider responsibilities
• Contracting and credentialing
• Program integrity: fraud, waste and abuse
• Cultural competency
• Interpreter services
• Americans with Disabilities Act (ADA) training
• Access and availability
• Verifying member eligibility
Agenda (cont.)

- Balance billing
- Critical incidents/quality of care
- Member supports
- Claims/grievances and appeals
- Preauthorizations
- Nonemergent medical transportation
- Laboratory services
- Pharmacy
- Key contact information
- Department of Medical Assistance Services (DMAS) links
Who we are

As a leader in managed health care services for the public sector, HealthKeepers, Inc. helps low-income families, children, pregnant women and people with disabilities get the care they need.

We help coordinate physical and behavioral health care and offer disease management programs, education and access to care.
1 in 8 Americans

- Nearly 40 million total medical members in affiliated health plans
- Over 73 million total lives served

- 51 million service calls
- 264.6 billion benefits paid
- 749.3 million claims processed

14 states
- BC or BCBS licensed plans (14)
- BC or BCBS licensed plans + Medicaid presence (6)
- Medicaid presence (13)

20 states and DC
- Medicaid presence

Anthem
Healthkeepers Plus
Offered by Healthkeepers, Inc.
Our experience

Together, HealthKeepers, Inc. and its Anthem, Inc. health plan affiliates serve more than 6.7 million people in state-sponsored health plans.

• Operating in 20 states with 28 years of service
• Serving members with complex needs in nine states for the past 20 years
  – Almost 358,000 members enrolled in long-term services and supports (LTSS) programs
• Managing fully integrated physical health, mental health and substance use disorder services for 6 million members in 20 markets
Our experience (cont.)

• A flagship health plan
  – MCO since inception of managed care (over 20 years)
  – Serving over 370,000 Virginia Medicaid members
    • Over 308,000 Medallion members, including 48,000 Medicaid Expansion (MedX) members
    • Over 65,000 Anthem CCC Plus members, including 5,000 MedX members
2018 Virginia Community Activity

Our Foundation partners with thousands of caring associates, as well as national and local nonprofit organizations, that share our commitment to improving lives and communities. We do this by supporting initiatives that positively affect the conditions and social determinants addressed in our Healthy Generations program, including maternal health, heart health, diabetes prevention, active lifestyles, cancer prevention, behavioral health efforts and programs that benefit people with disabilities. To learn more, visit www.anthem.foundation.

VIRGINIA FAST FACTS:

- Trained 3,465 local residents in Hands-Only CPR
- Engaged 500 Southwest Virginians in smoking cessation programs
- Increased physical activity levels among 200 athletes with physical disabilities
- Educated 1,500 kids through healthy active lifestyle programming that improved their physical activity levels and fruit & vegetable consumption
- Worked with 300 pregnant women to reduce the preterm birth rate

**TOTAL STATE OPEN ACTIVITY**

- **$3.6M**
- **$2M** ACTIVE FOUNDATION GRANTS
- **$728,000** COMMUNITY SPONSORSHIPS
- **$349,000** ASSOCIATE PROGRAMS+
- **8,164** ASSOCIATE VOLUNTEER HOURS
- **$5 MATCH AND $10 VOLUNTEER HOUR**

*All dollar amounts have been rounded.*

*Associate Program Value includes Dollar for Dollar donations plus Foundation matching funds for Down rewards donated, associated value for voluntary. Anthem Gifts Fund and Structure Fund grants.*
Member eligibility and benefits
Medallion 4.0, CCC Plus and MedX regions
Member eligibility — CCC Plus

Medicaid members eligible for CCC Plus include members who:

- Are eligible in the Aged, Blind and Disabled (ABD) and Health and Acute Care Program (HAP) coverage groups. This includes ABD and HAP individuals previously enrolled in the Medallion 3.0 program.

- Receive Medicare benefits and full Medicaid benefits (dual-eligible). This includes members who were enrolled in the Commonwealth Coordinated Care (CCC) program. The CCC program was discontinued on January 1, 2018.

- Receive Medicaid LTSS in a facility or through the Commonwealth Coordinated Care Plus Waiver.
Member eligibility — CCC Plus (cont.)

Medicaid members eligible for CCC Plus include members who:

- Are enrolled in the Developmental Disabilities (DD) Waivers — the Community Living Waiver, Family and Individual Supports Waiver, and Building Independence Waiver. These members will enroll for their nonwaiver services only. Their DD Waiver services will continue to be covered through Medicaid fee-for-service.
Member eligibility — Medallion 4.0

Medicaid members eligible for Medallion 4.0 include members who:

• Are eligible for Temporary Assistance for Needy Families (TANF) benefits.

• Are enrolled in the current Children’s Health Insurance Program (CHIP) and eligible for Family Access to Medical Insurance Security (FAMIS) benefits.

• Are enrolled in foster care or adoption assistance.
Member eligibility — Medicaid Expansion (MedX)

Eligibility for MedX:
• Virginia residents ages 19 to 64
• Not already enrolled in or eligible for Medicare
• Must meet income requirements, which vary by household size

You may be eligible if you make less than:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Yearly</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$16,754</td>
<td>$1,397</td>
</tr>
<tr>
<td>2</td>
<td>$22,715</td>
<td>$1,894</td>
</tr>
<tr>
<td>3</td>
<td>$28,677</td>
<td>$2,391</td>
</tr>
<tr>
<td>4</td>
<td>$34,638</td>
<td>$2,887</td>
</tr>
<tr>
<td>5</td>
<td>$40,600</td>
<td>$3,384</td>
</tr>
<tr>
<td>6</td>
<td>$46,562</td>
<td>$3,881</td>
</tr>
<tr>
<td>7</td>
<td>$52,523</td>
<td>$4,378</td>
</tr>
<tr>
<td>8</td>
<td>$58,485</td>
<td>$4,875</td>
</tr>
<tr>
<td>Additional person add</td>
<td>$5,962</td>
<td>$497</td>
</tr>
</tbody>
</table>
# Medicare vs. Medicaid

<table>
<thead>
<tr>
<th>What is it?</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>A federal health insurance program for people who are:</td>
<td>• 65 or older</td>
<td>A joint federal and state program that helps pay health care costs for certain people and families with limited income and resources</td>
</tr>
<tr>
<td>• Under 65 with certain disabilities</td>
<td>• Of any age and have end-stage renal disease (ESRD)</td>
<td>Different programs under the Medicaid umbrella are designed to help specific populations</td>
</tr>
<tr>
<td>Who governs it?</td>
<td>Federal government</td>
<td>State governments</td>
</tr>
</tbody>
</table>

Medicare and Medicaid were never meant to work together, creating gaps and overlaps in care.
**Anthem CCC Plus dual members**

**Dual eligible/unaligned members**
Dual eligible Anthem CCC Plus members when **only** Medicaid is covered

- **FFS**
  - Medicare + Medicaid = Dual
  - MA Plan + Medicaid = Dual

**Dual citizens/aligned members**
Dual eligible Anthem CCC Plus members when **both** Medicaid and Medicare are covered

- **Anthem** + **Anthem** = Dual
Dual-Eligible Special Needs Plans (D-SNP)

• A D-SNP plan is a type of Medicare Advantage plan for people who qualify for both Medicare and Medicaid (duals).
• D-SNP covers all Medicare-covered services to close the gaps in care not covered for Anthem CCC Plus members.
• Anthem CCC Plus members are not required to join a D-SNP. They can have original fee-for-service Medicare. They can also elect to join another D-SNP.
• All DMAS-approved CCC Plus plans were required to have a companion D-SNP.
D-SNP (cont.)

• As of January 1, 2018, the D-SNP program offered by HealthKeepers, Inc. became available in 84 cities and counties.
  – Anthem MediBlue Dual Advantage
• As of January 1, 2019, Anthem MediBlue Dual Advantage is statewide (with the exception of Accomack and Lee counties).
D-SNP (cont.)

• By electing the same health plan for CCC Plus and D-SNP, members become “dual citizens” and the coordination of care and benefits are simplified as we facilitate the delivery of benefits between both plans.
D-SNP and CCC Plus

Medicare is **always** the primary payer.

Medicaid is **always** the payer of last resort.

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**D-SNP**
- Inpatient hospital
- ER and urgent care
- Preventive care
- Prosthetics
- Inpatient psych
- Outpatient psych
- Physician office visits
- Vision
- DME
- Prescription drugs
- Lab services
- ESRD
- Diabetic monitoring and supplies
- Dialysis

**CCC Plus**
- Custodial nursing home
- Adult day health
- Some non-Medicare covered OTC drugs
- Transportation
- Personal care attendants
- Home modification
- Housing support
- Social services
- Medicare copays
- Hospital and SNF when Medicare is exhausted
- Behavioral health support
- Incontinence supplies

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Medicare is **always** the primary payer. Medicaid is **always** the payer of last resort.
Virginia 2019 service area
<table>
<thead>
<tr>
<th>Service</th>
<th>Covered for Medallion?</th>
<th>Covered for FAMIS?</th>
<th>Covered for CCC Plus?</th>
<th>Covered for MedX? (* in addition to those services covered under Medallion or CCC Plus)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral health: inpatient, outpatient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home health services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital services (inpatient and outpatient)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lab and radiology</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medical supplies and equipment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Obstetric and gynecologic services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physician services and screenings</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rehabilitation services: inpatient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Therapy (speech, occupational and physical)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transportation: emergency</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transportation: nonemergency</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Vision services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Annual adult wellness exams</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Mental health services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotherapy (individual, family and group)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community mental health rehabilitation services (CMHRS)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
## Benefits grid (cont.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Covered for Medallion?</th>
<th>Covered for FAMIS?</th>
<th>Covered for CCC Plus?</th>
<th>Covered for MedX? (* in addition to those services covered under Medallion or CCC Plus)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction recovery treatment services (ARTS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically managed intensive inpatient services</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medically managed intensive inpatient withdrawal management</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinically managed high-intensity residential services</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinically managed residential withdrawal management</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinically managed population-specific, high-intensity residential services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinically managed low-intensity residential services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ARTS partial hospitalization</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ARTS intensive outpatient services</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ambulatory withdrawal management (with or without extended on-site monitoring)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medication-assisted treatment (methadone in opioid treatment program; buprenorphine/nalox in opioid treatment program)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Substance abuse case management/care coordination</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Outpatient ARTS individual, family and group counseling services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Peer recovery supports</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Screening, Brief Intervention and Referral to Treatment services</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
## Benefits grid (cont.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Covered for Medallion?</th>
<th>Covered for FAMIS?</th>
<th>Covered for CCC Plus?</th>
<th>Covered for MedX? (* in addition to those services covered under Medallion or CCC Plus)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early intervention services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targeted care coordination/service coordination services</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Early intervention initial assessments for service planning and development and annual review of the individual family services plan (IFSP)</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>IFSP team treatment activities</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Developmental services (individual and/or group)</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Center-based early intervention services (individual and/or group)</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Early intervention physical therapy (individual and/or group)</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Early intervention occupational therapy (individual and/or group)</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Early intervention speech language pathology (individual and/or group)</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Developmental nursing (individual and/or group)</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Behavioral therapy services</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Case management for high-risk infants</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Dental screenings</td>
<td>X³</td>
<td>X³</td>
<td>X⁴</td>
<td>X³</td>
</tr>
<tr>
<td>Dental varnish</td>
<td>X³</td>
<td>X³</td>
<td>X⁴</td>
<td>X³</td>
</tr>
<tr>
<td>Hearing services</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Immunizations</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Private duty nursing</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Periodic health screenings</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
<tr>
<td>Vision services</td>
<td>X³</td>
<td>X³</td>
<td>X</td>
<td>X³</td>
</tr>
</tbody>
</table>
### Benefits grid (cont.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Covered for Medallion?</th>
<th>Covered for FAMIS?</th>
<th>Covered for CCC Plus?</th>
<th>Covered for MedX? (* in addition to those services covered under Medallion or CCC Plus)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-stay hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized care</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Personal care (agency-directed and consumer-directed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite care (agency-directed and consumer-directed)</td>
<td></td>
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<tr>
<td>Adult day health care</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Personal emergency response systems</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled private duty nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Assistive technology</td>
<td></td>
<td></td>
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<tr>
<td>Environmental modifications</td>
<td></td>
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<tr>
<td>Service facilitations</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Transition services</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**LTSS: CCC Plus only**

*Notes:*

3. These services will be covered under FAMIS/Medallion 4.0.

4. Dental services for members age 21 and younger are provided through Smiles for Children, a dental benefit administrator contracted with DMAS. Upon request, eligible managed LTSS members over 21 years of age can receive routine and preventive dental care, including exams, cleanings and X-rays.

This is a grid of covered services; however, it should not be considered a comprehensive listing. Providers should refer to the provider manual for a complete list.
Provider supports
Your support system

We support you through many different departments as you provide care to our members, including:

• Our Provider Relations team.
• Our Medical Management staff.
• Provider Services.

For assistance with claim issues, member enrollment, general inquiries and MedX, call Provider Services Monday to Friday from 8 a.m. to 8 p.m. ET:

• For Medallion assistance: 1-800-901-0020
• For Anthem CCC Plus assistance: 1-855-323-4687
Provider Relations

Our regionalized Provider Relations staff serves the following functions:

• Provider education and training
• Engaging providers in quality initiatives
• Building and maintaining the provider network
• Offering support for claims and billing questions and issues

Please attempt to resolve any issues by contacting Provider Services first. If additional assistance is needed, you can then contact your local Provider Relations representative.
Provider Relations team

• Professional/facility
  – Tiffani Jelani (Tidewater): Tiffani.Jelani@anthem.com
  – Jerron Dennis (Central): Jerron.Dennis@anthem.com
  – Angie Clayton (Northern):
    Angelia.Clayton@anthem.com
  – Shannon White (Western/Charlottesville):
    Shannon.White@anthem.com
  – Sara Martin (Roanoke/Alleghany and Southwest):
    Sara.Martin@anthem.com
Provider Relations team (cont.)

- **Ancillary, DME, etc.**
  - Bernard Christmas (statewide):
    Bernard.Christmas@anthem.com

- **Behavioral health**
  - John Bachand (Central and Western/Charlottesville):
    John.Bachand@anthem.com
  - Beth Condyles (Northern):
    Elizabeth.Condyles@anthem.com
  - Annette Powell (Tidewater):
    Annette.Powell@anthem.com
  - Deborah Tankersley (Roanoke/Alleghany and Southwest):
    Deborah.Tankersley@anthem.com
Provider communications

We’ll tell you about any business changes and important updates through a variety of communications. Expect to see bulletins, network updates, letters and fliers via fax and/or posted on our provider website.

Provider newsletter:
https://mediproviders.anthem.com/va/Pages/communications-updates.aspx
Provider manual

The **provider manual** is a key support resource for:

- Preauthorization requirements.
- An overview of covered services.
- The member eligibility verification process.
- Member benefits.
- Access and availability standards.
- The grievances and appeals process.
Our public provider website

Our provider website is available to all providers, regardless of participation status, at https://mediproviders.anthem.com/va.
The following are available on our public website, meaning registration and login **are not** required for access:

- Claims forms
- Precertification Lookup Tool
- Provider manual
- *Clinical Practice Guidelines*
- News and announcements
- Formulary
Our secure provider website

The following are available on our secure website, meaning registration and login are required for access:

• Preauthorization submission
• Preauthorization status lookup
• Pharmacy preauthorization
• PCP panel listings
• Member eligibility verification
• Claim status
Our secure provider website (cont.)

- Availity training
  - Once registered and logged in, users can access help topics and training.
    - Find Help: takes users to help topics
    - Payer Help: takes users to the search catalogue where they can type in topics for additional guidance
    - Get Trained: takes users to the Availity Learning Center where they can register for live and/or on-demand recorded webinars
Our secure provider website (cont.)

• Go to Interactive Care Reviewer (ICR) for information on preauthorizations. The ICR team conducts monthly webinars.

Interactive Care Reviewer

Submit inpatient and outpatient precertification requests online with Interactive Care Reviewer

The Interactive Care Reviewer (ICR) offers a streamlined precertification process. This online tool is available to ordering and servicing physicians and facilities requesting inpatient and outpatient medical and behavioral health services* for many members covered by Anthem Blue Cross and Blue Shield. You also can inquire to find information on a pre-certification previously submitted via phone, fax, ICR or other online tool.


To learn more about ICR, attend a FREE webinar: register now.
## Availity

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multiple payers</strong></td>
<td>Availity offers a single sign-on with access to multiple payers.</td>
</tr>
<tr>
<td><strong>No charge</strong></td>
<td>Anthem CCC Plus and Anthem HealthKeepers Plus transactions are available at no charge to providers.</td>
</tr>
<tr>
<td><strong>Accessible</strong></td>
<td>Functions are available 24/7 from any computer with internet access.</td>
</tr>
<tr>
<td><strong>Simple</strong></td>
<td>The standard screen format makes it easy to find the necessary information needed and increases staff productivity.</td>
</tr>
<tr>
<td><strong>Compliant</strong></td>
<td>Availity is compliant with HIPAA regulations.</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>Live, web-based and prerecorded training webinars are available to users at no cost. FAQ and comprehensive help topics are available online as well.</td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td>Availity Client Services is available at <strong>1-800-AVAILITY (1-800-282-4548)</strong>, Monday through Friday from 8 a.m. to 7 p.m. ET.</td>
</tr>
<tr>
<td><strong>Reporting</strong></td>
<td>User reporting allows the primary access administrator to track associate work.</td>
</tr>
</tbody>
</table>
Provider processes and responsibilities
Your responsibilities

As a participating provider, you have certain responsibilities related to working with HealthKeepers, Inc. and its members. You’re responsible for:

• Providing services to your patients without any discrimination whatsoever.

• Notifying us when you reach a full panel and are no longer accepting any new patients.

• Stressing the importance of an advance directive to your patients.

• Working with us to meet professionally accepted state and national standards of care.
Your responsibilities (cont.)

You’re responsible for:

• Collaborating with the member’s care coordinator.
• Providing culturally competent care.
• Reviewing all Medicaid manuals, memoranda, and other related CCC Plus and Medallion program documents.
• Being familiar with marketing practice guidelines and the responsibility of the provider when representing the contractor.

Please refer to the provider manual for a complete list.
Contracting and credentialing

- Refer to https://www.anthem.com/provider/getting-started to initiate the contracting and credentialing process.
- HealthKeepers, Inc. credentials health care practitioners, behavioral health practitioners and health delivery organizations.
- HealthKeepers, Inc. uses Council for Affordable Quality Healthcare (CAQH) to collect and verify a health care professional’s qualifications, including certification, training, licensure and registration to practice.
  - Register with CAQH (if you are not already registered). You may self-register by visiting https://proview.caqh.org. This is a secure and private website.
  - Authorize HealthKeepers, Inc. so we can access your credentialing information. If you are already registered with CAQH, you will need to give us permission to review your information.
  - If you need assistance, please review the New Provider Quick Reference Guide or call the CAQH provider help line at 1-888-599-1771.
  - Review and update your application. Please ensure all sections of the application are complete and accurate.
Contracting and credentialing (cont.)

- The credentialing process typically takes 45 days from the time the Credentialing department receives your completed CAQH application.
- Contact your regional Provider Relations representative if you have any questions.
Recredentialing

- HealthKeepers, Inc. recredits network providers every three years. If your CAQH application is current and complete at that time, no additional effort on your part may be required. If your CAQH application is expired or missing information, the Credentialing department will contact you to update the information.
  - If you do not update your CAQH application or supply the required information for recredentialing by the due date, your application will be considered incomplete and will result in an administrative termination from the network.
Program integrity: fraud, waste and abuse

• Always confirm the recipient’s identity.
• Ensure the services you render are necessary, completely documented in the medical records and billed appropriately.
• If you suspect or witness fraud, waste or abuse, tell us immediately by:
  – Calling the Fraud and Abuse Hotline at 1-800-368-3580, Monday through Friday, from 8 a.m. to 6 p.m. ET.
  – Contacting your Provider Relations representative or by calling Provider Services at 1-800-901-0020 and Anthem CCC Plus Provider Services at 1-855-323-4687.

*Read more about reporting fraud, waste and abuse in your provider contract or provider manual.*
Cultural competency

We foster a strong cultural competency within our company and provider networks. By practicing cultural competency, you:

• 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.
Cultural competency (cont.)

Cultural barriers between you and your patients can:

• Impact your patient’s level of comfort. This may increase fear of what you might find upon examination.

• Result in a different understanding of our health care system.

• Cause a fear of rejection of your patient’s personal health beliefs.

• Impact your patient’s expectation of you and of the treatment plan.
Cultural competency (cont.)

Refer to our *Cultural Competency Training* at https://mediproviders.anthem.com/va > Manuals, Directories, Training & More > Anthem HealthKeepers Plus Manuals, Directories, Training, & Resources > *Cultural Competency Training*. 
Interpreter services

Face-to-face interpreter services can be scheduled for Medallion members by calling 1-800-901-0020 and for Anthem CCC Plus members by calling 1-855-323-4687.

This request should be made five business days in advance.

These services are available 24/7 at no charge.
The ADA Training Presentation can be found on our public provider website at https://mediproviders.anthem.com/va. Providers are required to adhere to all provisions of the ADA to ensure that physical, communication and programmatic barriers don't hinder patients with disabilities from obtaining all covered services. Some requirements are:

- Providing flexibility in scheduling.
- Providing interpreters or translators for members who are deaf or hard of hearing.
Some requirements are:

• Having an understanding of disability-competent care.

• Ensuring individuals with disabilities and their companions, if applicable, are provided with reasonable accommodations to ensure effective communication (including auxiliary aids and services).

• Ensuring office space complies with *ADA* requirements.
Access and availability

You must arrange to provide care as expeditiously as the member’s health condition requires and according to each of the following appointment standards:

<table>
<thead>
<tr>
<th>Appointment purpose</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>Immediately upon member’s request</td>
</tr>
<tr>
<td>Urgent medical condition</td>
<td>Within 24 hours of the member’s request</td>
</tr>
<tr>
<td>Routine primary care services</td>
<td>Within 30 calendar days of the member’s request</td>
</tr>
</tbody>
</table>
| Maternity care                       | First trimester — within seven calendar days of member’s request  
                                       | Second trimester — within seven calendar days of member’s request  
                                       | Third trimester — within three business days of member’s request  
                                       | High-risk pregnancies — within three business days of identification of high risk to the contractor or maternity provider, or immediately if an emergency exists |
| Behavioral health services           | Expeditiously as the member’s condition requires and within no more than five business days from the contractor's determination that coverage criteria are met |
| LTSS                                 | Expeditiously as the member’s condition requires and within no more than five business days from the contractor's determination that coverage criteria are met |
Access and availability (cont.)

• This standard does not apply to appointments for:
  – Routine physical examinations.
  – Regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days.
  – Routine specialty services (for example, dermatology, allergy care, etc.).

Please review the provider manual for all additional standards.
Enrollment: Medallion 4.0 and FAMIS

DMAS and the Department of Social Services determine the eligibility and enrollment for Medallion 4.0 and FAMIS members. The process is as follows:

1. Managed health care plan options are shared with individuals and families eligible for enrollment.

2. Eligible members enroll in the plan of their choice and select a PCP. If the member has not selected a PCP, a PCP is assigned to the member.

3. The enrollment broker informs HealthKeepers, Inc. of new member enrollment and of any changes in member eligibility, status or contact information (such as an address change) that occur after enrollment.
Enrollment: Medallion 4.0 and FAMIS (cont.)

The process is as follows:

4. Providers are given notice of new members assigned to their care through monthly eligibility reports. Providers can access these reports by logging into the secure website at https://mediproviders.anthem.com/va > Login.

5. HealthKeepers, Inc. sends each new Anthem HealthKeepers Plus member an ID card within five business days of receiving the new member enrollment file. New members also receive a new member packet with program information and a member handbook.
If a member fails to renew their coverage and later reapplies and is approved, the member will automatically return to the same health care plan and PCP that they had prior to disenrollment, if available. Members may choose to switch plans.

To support the member enrollment process, PCPs are encouraged to maintain open panels. An open panel is the commitment by contracted providers to accept new Anthem HealthKeepers Plus members.

Cover Virginia: https://www.coverva.org/eligibility
Verifying eligibility

You can verify member eligibility by:

- Calling the DMAS automated response system at 1-800-884-9730 or 1-800-772-9996.
- Contacting Provider Services at 1-800-901-0020 and Anthem CCC Plus Provider Services at 1-855-323-4687.
Anthem HealthKeepers Plus member ID cards

- All Medallion 4.0 members will have a YTD prefix.
• Medicaid-only members will have a PCP listed.

• For dual members, providers must require members to provide their Medicare/Medicare Advantage card and their Anthem CCC Plus card.

• D-SNP members enrolled in the Medicare Advantage plan (Anthem MediBlue Dual Advantage) and enrolled in Anthem CCC Plus will not have PCP information listed.
Anthem MediBlue Dual Advantage member ID cards
Balance billing

• You may **not** balance bill our members.
• You must complete the notification/authorization process before providing noncovered services.
• A simple, standard financial waiver is not sufficient to bill a Medicaid member.
Quality Management critical incidents and quality of care

• Our clinical Quality Management (QM) department ensures that we are providing access to quality health care and services.

• Clinical QM staff continually analyze provider performance and member outcomes for improvement opportunities. In addition, they systematically identify, investigate and resolve quality of care and critical incident issues, as well as track and trend issues for reporting and recredentialing purposes.
QM critical incidents and quality of care (cont.)

- All providers treating Anthem CCC Plus and Anthem HealthKeepers Plus members must participate in critical incident reporting.
- Providers should act to prevent further harm to individuals and respond to any emergency needs of the member. This includes conducting an internal critical incident investigation and submitting an investigative report within 24 hours.
- If it’s an emergency situation, please dial 911. Once the member is safe, submit the report form immediately.
- HealthKeepers, Inc. will track critical incidents and quality of care concerns as needed. When warranted, our Medical Advisory Committee and QM Committee will review them.
• Please note, critical incident reporting is **required** by DMAS. Failure to follow these guidelines may result in corrective actions being taken.

• A critical incident is defined as “an occurrence involving the care, supervision or actions involving a member that is adverse in nature or has the potential to have an adverse impact on the health, safety and welfare of the member or others.”

• Critical incidents include but are not limited to: Medication errors; a severe injury or fall; theft; suspected or known physical abuse, mental abuse or neglect; financial exploitation; and the death of a member (not primarily related to the natural course of the patient’s illness or underlying condition).
QM critical incidents and quality of care (cont.)

• A quality of care incident is defined as any incident that calls into question the competence or conduct of a health care provider while providing medical services and has adversely affected or could adversely affect the health or welfare of a member. These are considered less critical than sentinel events.

• A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.
QM critical incidents and quality of care (cont.)

• Report critical incidents within **24** hours by calling Provider Services at **1-800-901-0020** and Anthem CCC Plus Provider Services at **1-855-323-4687**, or by emailing a quality of care or critical incident report form to:
  – cccpluscis@anthem.com for Anthem CCC Plus members.
  – qoc-hkp@anthem.com for Medallion 4.0 members.

• The person, agency or entity making the initial report can do so verbally within **24** hours but must submit a follow-up written report within **48** hours.
QM critical incidents and quality of care (cont.)

• The form is located on our provider website at https://mediproviders.anthem.com/va > Medical > Provider Forms.
Member supports
Member rights and responsibilities

• You must respect the rights of all Anthem HealthKeepers Plus members.
• Anthem HealthKeepers Plus members have the right to receive timely, quality care and be treated with dignity and respect.
• You’re required to adhere to both DMAS guidelines, Anthem HealthKeepers Plus guidelines and Anthem CCC Plus guidelines for issuing letters and notices.

Refer to the provider manual for a complete list of member rights and responsibilities.
Whole Person Circle of Health

- Food Security
- SDOH/Care Plan
- Gainful Employment
- Education
- Navitate & Advocate
- Stable Housing
- Targeted Engagement
- Transportation
- Risk Assessment
- Customer Service
Each Anthem CCC Plus member has a care manager and an ICT that provides person-centered coordination and care coordination for members. The ICT consists of the following:

- Member and/or their designee
- Designated care manager
- Primary care physician
- Behavioral health professional
- Member’s home care aide or LTSS provider
- Other providers, either as requested by the member or their designee, or as recommended by the care manager or primary care physician and approved by the member and/or their designee
Care coordination — Medallion

Each Medallion member has the option of working with a care manager that provides person-centered coordination and care coordination for members. The Care Management team consists of the following:

- Member and/or their designee
- Designated care manager
- Primary care physician
- Behavioral health professional
- Other providers, either as requested by the member or their designee, or as recommended by the care manager or primary care physician and approved by the member and/or their designee
24/7 NurseLine

- Members can call the 24/7 NurseLine for health advice 7 days a week, 365 days a year at 1-800-901-0020 and at 1-855-323-4687 for Anthem CCC Plus members.
- Registered nurses answer members’ questions and help them decide how to take care of any health problems.
- If medical care is needed, our nurses can help a member decide where to go.
Disease management

• Disease Management is based on a system of coordinated care interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions. Disease Management services use a holistic, member-centric care coordination approach that allows case managers to focus on members’ multiple needs.
  – To refer members, call 1-888-830-4300.
We offer programs for members living with the following:

- Asthma
- Bipolar disorder
- Congestive heart failure and coronary artery disease
- Chronic obstructive pulmonary disease
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder
- Schizophrenia
- Substance use
Claims, grievances and appeals
Submitting claims

We accept paper claims, but we encourage you to submit claims on our website or by using electronic data interchange (EDI):

• Submit both CMS-1500 and UB-04 claims on our website.
• Submit 837 batch files and receive reports through the website at no charge. You must register for this service first.
• Use a clearinghouse via EDI. Using our electronic tool helps reduce claims and payment processing expenses and offers:
  – Faster processing than paper.
  – Enhanced claims tracking.
  – Real-time submissions directly to our payment system.
  – HIPAA-compliant submissions.
  – Reduced claim rejections and adjudication turnaround time.
Submitting claims (cont.)

For paper claims, submit a properly completed claim for all services performed or items/devices provided to:

HealthKeepers, Inc.
Claims
Mailstop: VA2000-S110
P.O. Box 27401
Richmond, VA 23279

There is a filing limit of 365 days from the date of service (unless otherwise stated in your contract). It’s your responsibility to ensure electronic claims are completed and submitted without rejection to us.
Rejected vs. denied claims

- There are two types of notices you may get in response to your claim submission — rejected or denied.
  - Rejected claims do not enter the adjudication system because they have missing or incorrect information.
  - Denied claims go through the adjudication process but are denied for payment.
- You can find claims status information on the website or by calling Provider Services at 1-800-901-0020 and Anthem CCC Plus Provider Services at 1-855-323-4687.
- If you need to appeal a claim decision, please submit a copy of the EOP, letter of explanation and supporting documentation.
Electronic payment services

We encourage you to enroll in electronic funds transfers (EFTs) and electronic remittance advices (ERAs). Enrolling gives you the benefit of:

- Receiving ERAs and importing the information directly into your practice management or patient accounting system.
- Routing EFTs to the bank account of your choice.
- Creating your own custom reports within your office.
- Accessing reports 24/7.

If you are interested in the Virtual Credit Card (VCC) Program, all questions about the process, including if you want to opt out of participating in the VCC Program, should be sent to Comdata at 1-800-833-7130. The Comdata call center is open 7 a.m. to 6 p.m. ET.
Electronic payment services (cont.)

ERA

• Please use Availity to register and manage account changes for ERA:
  – 1-800-282-4548
  – https://www.availity.com

• If you were previously registered to receive ERA, you must register using Availity to manage account changes.

EFT

• Please use EnrollHub for all EFT enrollment adds or changes or contact the CAQH Provider Help Desk:
  – 1-844-815-9763
  – https://solutions.caqh.org/bpas
Electronic payment services (cont.)

EFT (cont.)

• To register or manage account changes for EFT only, use EnrollHub, a CAQH solutions enrollment tool, 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. No other action is needed.
Provider appeals

• **Claims payment disputes**: Provider claims payment disputes are for issues with reimbursement(s) to health care providers for medical services that have already been provided.

• **Medical appeals**: There are separate and distinct appeal processes for our members and providers, that depend on the services denied or terminated. Refer to the denial letter issued to determine the correct appeals process.
Claims payment disputes

• All providers have three distinct levels of claims payment disputes available to them. Those levels are as follows:
  – First level: reconsideration
  – Second level: formal appeal
  – Third level: state appeal

• Reconsiderations can be submitted to HealthKeepers, Inc. via Availity, by mail or by calling Provider Services at 1-800-901-0020 and Anthem CCC Plus Provider Services at 1-855-323-4687.
Claims payment disputes (cont.)

• All formal appeals should be submitted to HealthKeepers, Inc. in writing.
• Providers have 365 days from the date of adverse determination to submit a first-level dispute.

Please refer to the public provider website for additional claims payment disputes information.
Claims recoveries

• HealthKeepers, Inc. has a Cost Containment team that reviews previously paid claims to determine if claims were paid appropriately.

• When the Cost Containment team identifies claims that were previously paid inappropriately or overpaid, it will notify the provider via a refund request letter.

• The refund request letter explains to providers their options to refund the money or allow claims to offset.
Claims recoveries (cont.)

• The provider is given approximately 70 days to respond to the initial refund request letter.
• If the provider has not responded within 70 days, claims will typically begin to offset within 30 days.
• If the provider wishes to dispute the recovery, the refund request letter includes information about how to dispute the recovery. When disputing a recovery, providers should never use a 151 reconsideration form or 151 reconsideration process.
• Providers should dispute their recovery per the guidance on the refund request letter before contacting Provider Services or their Provider Relations representative.
Claims recoveries (cont.)

- We follow DMAS guidance on recoveries, and HMS is the recovery audit contractor (RAC) for DMAS.
- For more information on Virginia RAC — HMS, visit http://hms.com/us/va-providers/home.
Claims recoveries (cont.)

- For non-coordination of benefits (COB) recoveries, the state’s RAC guidelines allow a three-year lookback period.
- For Commercial COB recoveries, the state’s RAC guidelines allow a three-year lookback period.
- For Medicare COB recoveries, the federal guidelines allow a four-year lookback period.
  - For the four-year lookback period for Medicare COB recoveries, we follow the following Federal Regulation: 42 CFR405.980 and 405.986.
Medical necessity appeals

• A member, a member’s authorized representative or a provider acting on behalf of a member may file an appeal.
• HealthKeepers, Inc. affords a member or a member’s authorized representative one level of medical necessity appeal.
• In addition to the formal appeals process, HealthKeepers, Inc. also affords a member or a member’s authorized representative the right to have a reconsideration and peer-to-peer (P2P).
Medical necessity appeals (cont.)

Although medical necessity criteria, such as MCG Guidelines, are reviewed with each level of care request, these items are only guidelines and just one factor that is considered in level of care medical necessity reviews.

Because each level of care review represents a unique clinical scenario that may not be fully described by the above-mentioned guidelines, other considerations, including but not limited to things such as practice patterns and professional experience and judgement, may also be factored into each final level of care medical necessity determination.
Medical necessity appeals (cont.)

• Below is the address for Central Appeals Processing:

  HealthKeepers, Inc.
  P.O. Box 62429
  Virginia Beach, VA 23466

• For expedited appeals, the provider can call Provider Services at 1-800-901-0020 and Anthem CCC Plus Provider Services at 1-855-323-4687.
Reconsiderations and P2Ps

• Reconsiderations are an informal process to dispute a medical necessity adverse decision.

• The requesting practitioner must contact the health plan within three business days of issuance of the initial determination letter and if no other reconsiderations or P2Ps have occurred.

• If the request is received by the health plan after three business days of the issuance of the initial determination letter, the practitioner will be required to follow the formal appeals process outlined on slide 96.
Reconsiderations and P2Ps (cont.)

- All reconsiderations are conducted via a P2P. In order to initiate the reconsideration process, the requesting practitioner contacts the health plan to request a reconsideration discussion.
  - A P2P is the process of giving 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 at any time during the review process.
  - For P2Ps, the provider should call the health plan at 1-844-533-1994, ext. 106-103-5169.
  - All P2Ps have to be conducted with the member’s attending physician.
Reconsiderations and P2Ps (cont.)

- All urgent pre-service and all concurrent reconsiderations shall occur within one business day of receipt of the reconsideration request.
- All nonurgent pre-service and all post-service reconsiderations shall occur within seven business days of receipt of request.
Standard and expedited appeals

- All formal appeals must be submitted in writing except for expedited appeals.
- A member, a member’s authorized representative or a provider acting on behalf of a member may file an appeal. The following time frames apply:
  - For an appeal of standard service authorization decisions, Medallion members must file an appeal, either orally or in writing, within 60 calendar days of the date on the notice of action.
  - FAMIS members must file within 60 calendar days from the date on the notice of action. This also applies to a member’s request for an expedited appeal.
Standard and expedited appeals (cont.)

– Anthem CCC Plus members must file within 60 calendar days from the date on the notice of action. This also applies to a member’s request for an expedited appeal.

– To complete the appeal, standard resolution of appeal must occur within 30 calendar days from the date of receipt of the appeal unless HealthKeepers, Inc., the member or DMAS approves an extension of 14 calendar days.

– Resolution of an expedited appeal occurs as expeditiously as the medical condition requires, but no later than 72 hours from receipt of the appeal.
Preauthorization and notification

Preauthorization is required for:
• All inpatient elective admissions.
• Nonemergency facility-to-facility transfers.
• Select nonemergent outpatient and ancillary services.
• Nonparticipating providers, except for emergent services.
• All home health care services (for example, skilled nursing visits, speech therapy, physical therapy, occupational therapy, social workers and home health aides).

Note: This list is not all-inclusive. For a complete list, refer to the Precertification Lookup Tool on our provider website.
Preauthorization is not required for:

- Custodial nursing facility care.
- Office visits for participating providers (some specialists are limited based on provider group).
- Most in-office specialty services.
- Evaluation and management-level testing and procedures.
- Emergency room visits or observation.
- Physical therapy evaluations provided at outpatient facilities.
- Early and Periodic Screening, Diagnostic and Treatment.
Preauthorization and notification (cont.)

We have a **Precertification Lookup Tool** on our provider website. Use our Precertification Lookup Tool to:

- Determine if a service requires preauthorization.
- Find additional information regarding preauthorization for DME, vision, transportation and other ancillary services.
- Search by your market, the program in which the member participates or the CPT® code. If you don’t know the exact code, you can also search by description.
Medallion preauthorization requests

Use Availity to submit all preauthorization requests.

You can also fax preauthorization requests to 1-800-964-3627 for initial, inpatient admissions and outpatient services. However, please note these exceptions:

- Fax to 1-866-920-4096 for home health, skilled nursing, therapies, hospice, DME and outpatient services.
- Fax to 1-866-920-4095 for concurrent review clinical documentation (inpatient).
- Fax to 1-844-864-7853 for LTSS services, including nursing home custodial care, Personal Emergency Response System (PERS), personal care attendant (PCA), respite care and adult day care.
- Fax to 1-866-920-4095 for long-term acute care, acute inpatient rehabilitation and skilled nursing facilities.
- Fax to 1-877-434-7578 for behavioral health inpatient services.
- Fax to 1-866-877-5229 for behavioral health outpatient (including CMHRS) services.
Medallion preauthorization requests (cont.)

You may also call Provider Services at 1-800-901-0020.

If the authorization request is for radiology services being offered by AIM Specialty Health®, submit a request at www.providerportal.com or call 1-800-714-0040.
AIM Specialty Health preauthorization requests

Below are the services that AIM Specialty Health provides to Virginia Medicaid members:

- Radiology benefit management
- Cardiology
- Sleep studies/approval for PAP machine and treatment supplies
- Radiation oncology
Anthem CCC Plus preauthorization requests

Use Availity to submit all preauthorization requests.

You can fax preauthorization requests to 1-800-964-3627 for initial, inpatient admissions and outpatient services. However, please note these exceptions:

- Fax to **1-844-864-7858** for home health, skilled nursing, therapies, hospice, DME and outpatient services.
- Fax to **1-866-920-4095** for concurrent review clinical documentation (inpatient).
- Fax to **1-844-864-7853** for LTSS services, including nursing home custodial care, PERS, PCA, respite care and adult day care.
- Fax to **1-866-920-4095** for long-term acute care, acute inpatient rehabilitation and skilled nursing facilities.
- Fax to **1-877-434-7578** for behavioral health inpatient services.
- Fax to **1-866-877-5229** for behavioral health outpatient (including CMHRS) services.
Anthem CCC Plus preauthorization requests (cont.)

You may also call Provider Services at 1-855-323-4687 for preauthorization requests, or if the authorization request is for radiology services being offered by AIM Specialty Health, submit a request at www.providerportal.com or call 1-800-714-0040.
Our service providers

Lab services: If you have questions about LabCorp and its subsidiaries’ services, need to set up a LabCorp account, obtain supplies, or discuss LabCorp testing options, call LabCorp at 1-800-762-4344.

Other service partners: In addition to lab services, we partner with other service vendors to offer additional support to our members:

• DentaQuest: 1-800-341-8478
• EyeMed: 1-800-776-8364
• Southeastrans: 1-877-892-3988 (Medallion members)/1-855-325-7581 (Anthem CCC Plus members)
Nonemergent medical transportation

• Southeastrans Member Services
  – 1-877-892-3988 (Medallion members)
  – 1-855-325-7581 (Anthem CCC Plus members)
• All routine trips require five days’ business notice.
• Members can be transported for urgent, same-day appointments. However, Southeastrans will need to confirm appointment before scheduling the trip.
• Stretcher transportation requires a letter of medical necessity.
• If the member needs additional education about their transportation benefits, they can contact Member Services at 1-800-901-0020 and Anthem CCC Plus Member Services at 1-855-323-4687.
Laboratory services

- Unless authorization is obtained, all lab services must be performed by LabCorp, except for ARTS services.
- Lab tests that appear on the physician office list can be performed in a physician’s office without preauthorization. The hospital outpatient department cannot be used for lab tests unless the services are authorized or the hospital outpatient lab has a subcontract with LabCorp.
- Testing sites must have a Clinical Laboratory Improvement Amendments certificate or a waiver.
Pharmacy

The *Preferred Drug List* and formulary are available on our website at https://mediproviders.anthem.com/va.

Preauthorization is required for:
- Nonformulary drug requests.
- Brand-name medications when generics are preferred.
- High-cost injectable and specialty drugs.
- Any other drugs identified in the formulary as needing preauthorization.

*This list is not all-inclusive and is subject to change.*
Pharmacy (cont.)

• The following are preauthorization request methods:
  – Phone: 1-855-323-4687
  – Fax: 1-844-512-7020
  – webPA: https://www.covermymeds.com

• Medical injectable requests may be faxed to: 1-844-512-7022.

• P2P reviews: Submit a P2P request marked urgent to pharmacyreviewerssharedmailbox@anthem.com.
Pharmacy (cont.)

• Pharmacy appeals
  – To file an appeal in writing, send a letter requesting an appeal to:
    HealthKeepers, Inc.
    Central Appeals Processing
    P.O. Box 62429
    Virginia Beach, VA 23466-2429
To request an appeal by phone (if not urgent, requester will be asked to follow up in writing to address above):

- Medallion members and providers: 1-800-901-0020
- Anthem CCC Plus members and providers: 1-855-323-4687
Medallion key contact information

• Provider and Member Services: 1-800-901-0020
• 24/7 NurseLine: 1-800-901-0020 (TTY 711)
• Preauthorization phone: 1-800-901-0020
• Pharmacy preauthorization phone: 1-800-901-0020
• Website: https://mediproviders.anthem.com/va
• Paper claims submission:
  HealthKeepers, Inc.
  Claims
  P.O. Box 27401
  Richmond, VA 23279
Anthem CCC Plus key contact information

- Provider and Member Services: 1-855-323-4687
- 24/7 NurseLine: 1-855-323-4687 (TTY 711)
- Preauthorization phone: 1-855-323-4687
- Pharmacy preauthorization phone: 1-855-323-4687
- Website: https://mediproviders.anthem.com/va
- Paper claims submission:
  HealthKeepers, Inc.
  Claims
  P.O. Box 27401
  Richmond, VA 23279
DMAS links

- http://www.dmas.virginia.gov/#/med4presentations
- http://www.dmas.virginia.gov/#/med4 (Medallion 4.0 website)
- https://www.virginiamanagedcare.com (Medallion Managed Care)
- https://cccplusva.com/home (CCC Plus Managed Care)
- M4.0Inquiry@dmas.virginia.gov (DMAS email for Medallion 4.0 inquiries)
DMAS links (cont.)

- CCCPlus@dmas.virginia.gov (DMAS email for CCC Plus inquiries)
- http://coverva.org/expansion (MedX)
Questions?
https://mediproviders.anthem.com/va

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