Provider orientation

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

- Who we are
- Provider support staff and communications
- Website access/registration
- Key provider responsibilities
- Credentialing
- Fraud, waste and abuse
- Cultural competency
- Access and availability
- Verifying member eligibility
- Balance billing and patient pay
- Critical incident reporting
- Updating your information

- Member benefits and supports
- Pharmacy program
- Care coordination and quality and disease management
- Member rights and responsibilities
- Claim submissions
- Electronic payment services
- Grievances and appeals
- Preauthorization and notification
- Laboratory services
- Long-term services and supports
- Avoiding delayed authorizations
- Key contact information
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.
Our experience

Together, HealthKeepers, Inc. and its Anthem, Inc. health plan affiliates serve more than **6.5 million** people in state-sponsored health plans.

- **Operating in 20 states**
  - A leading provider of health care solutions for public programs

- **Over 25 years in service**
  - Access to high-quality, coordinated care for low-income families, seniors and people with disabilities

- **Serving members with complex needs in eight states**
  - 292,000 members enrolled in long-term services and supports programs
Commonwealth Coordinated Care Plus (CCC Plus) program

• CCC Plus is a new, statewide Medicaid managed long-term services and supports (LTSS) program that will serve approximately 214,000 individuals with complex care needs through an integrated delivery model across the full continuum of care.

• Care coordination is at the heart of the CCC Plus high-touch, person-centered program, which is focused on improving quality, access and efficiency.
## CCC Plus coverage area

<table>
<thead>
<tr>
<th>Region</th>
<th>Go-live date</th>
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</thead>
<tbody>
<tr>
<td>Tidewater</td>
<td>8/1/17</td>
</tr>
<tr>
<td>Central</td>
<td>9/1/17</td>
</tr>
<tr>
<td>Western/Charlottesville</td>
<td>10/1/17</td>
</tr>
<tr>
<td>Roanoke/Alleghany</td>
<td>11/1/17</td>
</tr>
<tr>
<td>Southwest</td>
<td>11/1/17</td>
</tr>
<tr>
<td>Northern and Winchester</td>
<td>12/1/17</td>
</tr>
</tbody>
</table>
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.
• Specialized teams to help you with your claim questions.
• Provider Services.

Call Anthem CCC Plus Provider Services at 1-855-323-4687 for assistance with claim issues, member enrollment and general inquiries. Hours of operation are Monday to Friday from 8 a.m. to 8 p.m. ET.
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

You can always contact your local Provider Relations representative with any questions you may have.
Provider communications

The provider manual is a key support resource for:

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

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.
Our provider website

• Our provider website is available 24/7 to all providers, regardless of participation status, at https://mediproviders.anthem.com/va.
• Registration is required to perform many key transactions.
• You’ll need a Medicaid ID for HealthKeepers, Inc. to register.
Our provider website (cont.)

• The tools on the site allow you to:
  – Perform many common authorization and claims transactions.
  – Check member eligibility.
  – Update your practice information.
  – Manage your account.
  – Access our reimbursement policies.

• As a participating provider, you can also:
  – Submit preauthorization requests and claims.
  – Access provider forms.
Our public provider website

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
- Provider directory
- Fraud, waste and abuse resources
- Formulary
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
### Availity

<table>
<thead>
<tr>
<th>Multiple Payers</th>
<th>Availity offers a single sign-on with access to multiple payers.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Charge</strong></td>
<td>Anthem CCC 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</strong> (<strong>1-800-282-4548</strong>), Monday through Friday from 7 a.m. to 6 p.m. CT.</td>
</tr>
<tr>
<td><strong>Reporting</strong></td>
<td>User reporting allows the primary access administrator to track associate work.</td>
</tr>
</tbody>
</table>
- The registration process is easy.
- Multiple resources and trainings about site navigation are available.
Provider processes and responsibilities
Your responsibilities

As a participating provider, you have certain responsibilities related to getting members the care they need. 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.
- Collaborating with the member’s care coordinator.
- Providing culturally competent care.

Please refer to your provider manual for a complete list.
Credentialing

- HealthKeepers, Inc. credentials health care practitioners, behavioral health practitioners and health delivery organizations (HDOs).
- We notify applicants of their right to review the information submitted supporting their credentialing applications. If credentialing information can’t be verified or if there is a discrepancy in the credentialing information obtained, our staff will contact the practitioner or HDO within 30 calendar days of identifying the issue.
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 calling 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.

Refer to our cultural competency training at https://mediproviders.anthem.com/va > Manuals, Directories, Training & Resources for additional information.
Interpreter services

Telephonic interpreter services are available for Anthem CCC Plus members at **1-855-323-4687**. These services are available 24/7 at no charge.
Access and availability standards

It’s our responsibility to make sure our members have access to primary care services for:

• Routine care services.
• Urgent and emergency services.
• Specialty care services for chronic and complex care.

We make sure our providers respond to members’ needs in a timely manner by conducting telephonic surveys that confirm providers are meeting these standards.
Appointment standards

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>

* This standard does not apply to appointments for: 1) routine physical examinations, 2) regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days or 3) routine specialty services (for example, dermatology, allergy care, etc.). Please review the provider manual for all additional standards.
Verifying eligibility

You can verify member eligibility by:


• Calling the Department of Medical Assistance Services (DMAS) automated response system at 1-800-884-9730 or 1-800-772-9996.

• Logging in to Availity at https://www.availity.com.

• Contacting Anthem CCC Plus Provider Services at 1-855-323-4687.
Member ID cards

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

[Member Name]
Identification Number

PCP Name
PCP Phone
Medicaid ID

Group Number: HKP00200
BC/BS Plan: 923
Rx Bin Number: 003858
Rx PCN Number: A4
Rx Group Number: WQWA

PCP/PCP Specialist: $0/$0
Outpatient: $0
Inpatient: $0
Emergency: $0
Rx: $0/$0

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Members: When submitting requests, always include your identification number from the face of this card. Possession or use of this card does not guarantee payment. In an emergency, go to the nearest facility or call 911.

Providers: Please submit claims to your BCBS plan. To ensure proper claim processing, please include the 3-digit prefix that precedes the patient's identification number listed on the front of this card.

Claims Filing Address: Post Office Box 27401
Richmond, VA 23227

Contact directly with this group

Contractor ID: 0047003753

www.anthem.com/famedicaid

Member Services: 1-855-323-4867
Provider Services: 1-855-323-4867
Care Coordinator: 1-855-323-4867
TTY: 711
24/7 Nursing: 1-855-323-4867
Mental Health Services: 1-855-323-4867
Authorization: 1-855-323-4867
Smiles for Children*: 1-888-912-3466
Transportation Services: 1-855-253-6061
Rx Services: 1-888-824-9898

*Contact directly with this group

HealthKeepers, Inc.
P.O. Box 27401
Mail Drop VA2002-N508
Richmond, VA 23227

Heathkeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
Balance billing

- You may **not** balance bill our members.
- You must complete the notification/authorization process before providing noncovered services.
Patient pay/financial responsibility

- Some members have a patient pay, also referred to as financial responsibility, which must be met before Medicaid reimbursement for services is available. It’s your responsibility to collect the member’s patient pay amount.

- DMAS has the responsibility for determining the patient-pay amount. This includes a portion of members eligible for Medicaid on the following bases:
  - Members in an institutional setting
  - Members enrolled in the 1915(c) home- and community-based services (HCBS) waiver
Patient pay/financial responsibility (cont.)

- Through the DMAS eligibility and enrollment files, the state will notify us of any applicable patient pay amounts. This information will be made available to you, and you’re required to collect this amount from the member.

- Providers will bill gross/full charges. We’ll adjudicate the claim and deduct the patient pay amount. If the sum of any applicable, third-party payment and a member’s financial responsibility equals or exceeds the reimbursement amount established for services, we’ll make no payment to the provider.
Critical incident reporting

We have a critical incident reporting and management system. All contracted providers **must** participate in critical incident reporting.

- Report critical incidents to us within 24 hours. The person, agency or entity making the initial report can do so verbally at first but must submit a follow-up written report within 48 hours. Submit reports via email to cccpluscis@anthem.com.

- Act within 24 hours to prevent further harm to any and all members and respond to any emergency needs of the member. This includes conducting an internal critical incident investigation and submitting an investigation report by the end of the next business day.
Critical incident reporting (cont.)

A critical incident, also known as a major incident, includes but is not limited to:

- Medication errors.
- Severe injury or fall.
- Theft.
- Suspected physical or mental abuse or neglect.
- Financial exploitation.
- Death of a member.

We’ll track critical incidents and, if warranted, present them to our medical advisory committee and/or quality management committee for review.
Practice Profile Update Form

- Practice and provider name
- Site, billing/remit, email address, phone and fax number
- Tax ID (new, signed contract required)
- Add or term provider
- NPI, Medicare and Medicaid numbers
- Council for Affordable Quality Healthcare (CAQH) numbers for new providers
Member eligibility, benefits and supports
Member eligibility

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 currently enrolled in the Medallion 3.0 program.

• Receive Medicare benefits and full Medicaid benefits (dual-eligible). This includes members enrolled in the Commonwealth Coordinated Care (CCC) program.

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

Medicaid members eligible for CCC Plus include members who:

• Are enrolled in the Developmental Disabilities (DD) waivers — the Community Living, Family and Individual Supports, and Building Independence Waivers. These members will enroll for their non-waiver services only. Their DD waiver services will continue to be covered through Medicaid fee-for-service.
Covered benefits

- Physician office visits — inpatient and outpatient services
- Outpatient medical services and supplies
- Prescription benefits
- Preventive services, wellness and education
- Initial health assessments (IHAs)
- Durable medical equipment and supplies
- Emergency services
- Care coordination and utilization management
- Pharmacy benefits through Express Scripts, Inc.

For more detailed information, refer to your provider manual at https://mediproviders.anthem.com/va.
24/7 NurseLine

• Members can call the 24/7 NurseLine for health advice 7 days a week, 365 days a year at 1-855-323-4687 (TTY 711).
  – The phone number is also listed on the member ID cards.
• 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.
Care coordination and the interdisciplinary care team (ICT)

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 his or her 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 his or her designee, or as recommended by the care manager or primary care physician and approved by the member and/or his or her designee
Quality management

• Our Clinical Quality Management (QM) department ensures we’re providing access to quality health care and services. Clinical QM staff continually analyzes provider performance and member outcomes for improvement opportunities.

• Our solutions are focused on:
  – Improving the quality of clinical care.
  – Increasing clinical performance.
  – Offering effective member and provider education.
  – Ensuring the highest member and provider satisfaction possible.
Disease management

The Disease Management Centralized Care Unit (DMCCU) 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. DMCCU 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.
Disease management

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 abuse
Member rights and responsibilities

• You must respect the rights of all Anthem CCC Plus members.
• Anthem CCC 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 and Anthem CCC Plus guidelines for issuing letters and notices.

Refer to your provider manual for a complete list of member rights and responsibilities.
Claims, grievances and appeals
Submitting claims

We accept paper claims, but we encourage you to submit claims on our website or 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. for Anthem CCC Plus
Claims
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 Anthem CCC Plus Provider Services at 1-855-323-4687.
- If you need to appeal a claim decision, please submit a copy of the *Explanation of Payment (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.
Electronic payment services (cont.)

Want to enroll, update or change your electronic payment services?

<table>
<thead>
<tr>
<th>For…</th>
<th>Go to…</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERAs only</td>
<td><a href="http://www.anthem.com/edi">www.anthem.com/edi</a></td>
</tr>
<tr>
<td>EFTs and ERAs (both) or</td>
<td><a href="https://solutions.caqh.org/bpas/Default.aspx">https://solutions.caqh.org/bpas/Default.aspx</a></td>
</tr>
<tr>
<td>EFTs only</td>
<td></td>
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</tbody>
</table>

EDI Hotline: 1-800-590-5745
Grievances and appeals

• **Grievances:** A grievance is your expressed dissatisfaction about any matter except a payment dispute or a proposed adverse medical action. A grievance can be submitted either by any member or a physician, hospital, facility or other health care professional licensed to provide health care services.

• **Appeals:** Provider appeals 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, which depend on the services denied or terminated. Refer to the denial letter issued to determine the correct appeals process.
Preauthorization and notification
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).

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.
- EPSDT

Note: This list is not all-inclusive. For a complete list, refer to the Precertification Lookup Tool on our provider website.
We have a Precertification Lookup Tool on our provider website at [https://mediproviders.anthem.com/va/pages/pluto.aspx](https://mediproviders.anthem.com/va/pages/pluto.aspx). Use our Precertification Lookup Tool to:

- Determine if a service requires preauthorization.
- Find additional information regarding preauthorization for durable medical equipment, 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.
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 1-888-280-3725 for therapies, home health, durable medical equipment and discharge planning.
- Fax 1-888-280-3726 for concurrent review clinical documentation (inpatient).

You may also call Anthem CCC Plus Provider Services at 1-855-323-4687. 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
- Davis Vision: 1-800-933-9371
- Southeastrans: 1-855-253-6861
Laboratory services

• Notification or preauthorization is not required if lab work is performed in a physician’s office, participating hospital’s outpatient department (if applicable) or by one of our preferred lab vendors (for example, LabCorp and their approved subsidiaries).

• Testing sites must have Clinical Laboratory Improvement Amendments (CLIA) certificate or a waiver.
Pharmacy

The *Preferred Drug List* and formulary are available on our website. Preauthorization is required for:

- Nonformulary drug requests.
- Brand-name medications when generics are available.
- 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.
Long-term services and supports
Continuity of care: LTSS

• We’ll honor all previously approved authorizations made by DMAS or the member’s previous MCO for the duration of the service authorization or the first 90 calendar days the member is enrolled in Anthem CCC Plus, whichever comes first.

• If the service authorization ends prior to when the initial health risk assessment (HRA) is completed, the continuity of care period continues until:
  – The HRA is completed.
  – A new person-centered individual care plan has been implemented.
Continuity of care: residential providers

Members using a residential provider at the time of enrollment will have continued access to that residential care facility, even on a non-network basis. Members cannot be made to move to another residential provider unless the following conditions are met:

• The member or his/her representative specifically requests to transition.
• The member or his/her representative provides written consent to the move based on quality or other concerns we raise.

Any Anthem CCC Plus issues about the current residential provider’s status as either contracted or noncontracted will not be grounds for moving a member to another residential provider.
Consumer Choice Option

We have contracted with the fiscal/employer agent Public Partnerships, LLC (PPL) to provide the following services to enrollees who choose the Consumer Choice Option program:

• Criminal background checks for attendant employees with appropriate follow-up and communication to appropriate individuals

• Payroll expenses for authorized hours actually worked by attendant employees, inclusive of employer share of state and federal taxes net patient pay

• Withholding patient-pay amounts from employees’ checks
  – Payments or payroll to PPL will be the net of the patient-pay amount.

• Taking claims payment for authorized eligible services provided by attendant employees
Adult day health care (ADHC)

<table>
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<tr>
<th>Codes for ADHC</th>
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</thead>
<tbody>
<tr>
<td><strong>Service</strong></td>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>ADHC</td>
<td>S5102</td>
</tr>
<tr>
<td>Transportation</td>
<td>A0120</td>
</tr>
</tbody>
</table>

If a member attends fewer than six hours on any given day, it’s considered a half day of services.
Nursing facilities

- Authorization for skilled care must be in place prior to rendering services.
- If the member leaves the facility, we request notification to our case manager.
- Custodial claims can be billed with the following revenue codes:

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
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<tbody>
<tr>
<td>Room-Board / semi-private</td>
<td>0120</td>
</tr>
<tr>
<td>Subacute care, general classification</td>
<td>0190</td>
</tr>
<tr>
<td>Hospital bed-hold</td>
<td>0185</td>
</tr>
</tbody>
</table>

- Skilled claims can be billed with RUG codes.
- Bed-hold claims can be billed to let us know a member left. Please note this is nonreimbursable in Virginia.
Pre-admission screening (PAS)

- Prior to admission to a nursing facility and anytime there’s a significant change in status, members will receive a PAS by the state or its designee. We’ll work with the state or its designee responsible for implementation and oversight of the PAS process.
- The PAS process must be completed prior to a facility admission.
## Top 11 reasons for delayed authorizations

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitting an authorization request with:</td>
<td>Always include the:</td>
</tr>
<tr>
<td>• No Anthem CCC Plus member ID number</td>
<td>• Member’s Anthem CCC Plus ID number.</td>
</tr>
<tr>
<td>• The member’s name spelled incorrectly</td>
<td>• Member’s name (spelled correctly).</td>
</tr>
<tr>
<td>• No member DOB</td>
<td>• Member’s DOB.</td>
</tr>
<tr>
<td>Submitting an authorization request with missing date spans</td>
<td>Always include first and last date through which you are requesting the</td>
</tr>
<tr>
<td></td>
<td>authorization request (not to exceed 12 months).</td>
</tr>
<tr>
<td>Submitting an authorization request that’s missing the provider ID</td>
<td>Make certain the provider ID is always included on the authorization</td>
</tr>
<tr>
<td></td>
<td>request.</td>
</tr>
<tr>
<td>Sending the entire list of Anthem CCC Plus members instead of sending</td>
<td>Send only those members for whom an authorization is required.</td>
</tr>
<tr>
<td>ONLY the members who need a new authorization</td>
<td></td>
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</tbody>
</table>
## Top 11 reasons for delayed authorizations (cont.)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
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<tbody>
<tr>
<td>Requesting a copy of the authorization when a copy has already been</td>
<td>Nursing facilities should coordinate authorization requests with their</td>
</tr>
<tr>
<td>sent to the nursing facility’s home office (or not sending a copy of</td>
<td>home offices and also send a copy to DMAS.</td>
</tr>
<tr>
<td>the authorization to DMAS)</td>
<td></td>
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<td></td>
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<tr>
<td>Not providing notification when a member transfers to another facility</td>
<td>Send notification when a member leaves a nursing facility or transfers to</td>
</tr>
<tr>
<td>or is discharged</td>
<td>another facility. That way, when a new facility requests authorization,</td>
</tr>
<tr>
<td></td>
<td>the member will not still show as being in the original facility.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Submitting an authorization request that has illegible handwriting</td>
<td>Ensure the authorization request is legible. Try to have a second reader</td>
</tr>
<tr>
<td></td>
<td>confirm it’s legible.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Submitting an authorization request that does not contain a contact</td>
<td>Ensure the authorization request has a phone or fax number to facilitate</td>
</tr>
<tr>
<td>phone or fax number</td>
<td>a return of the authorization and clarifications as necessary.</td>
</tr>
</tbody>
</table>
### Top 11 reasons for delayed authorizations (cont.)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitting an authorization request with a provider name that is not consistent with the provider name indicated on the contract and credentialing application</td>
<td>Be sure the authorization request is in the legal name as represented on the contract.</td>
</tr>
<tr>
<td>Calling our utilization managers with claim issues and getting redirected to Provider Services (taking utilization managers’ time)</td>
<td>Call your Provider Relations representative or Provider Services for assistance with claims issues or questions.</td>
</tr>
<tr>
<td>Requesting an authorization for services at home (and member shows as still being in the nursing facility)</td>
<td>Send notification when a member leaves the nursing home so a home health agency or primary care office provider can properly request authorization.</td>
</tr>
</tbody>
</table>
Key contact information

- Anthem CCC Plus Provider and Member Services: **1-855-323-4687**
- 24/7 NurseLine: **1-855-323-4687 (TTY 711)**
- Preauthorization phone: **1-855-323-4687**
- Preauthorization fax: **1-800-964-3627**
- Pharmacy preauthorization phone: **1-855-577-6317**
- Website: [https://mediproviders.anthem.com/va](https://mediproviders.anthem.com/va)
- Paper claims submission:
  
  HealthKeepers, Inc. for Anthem CCC Plus
  
  Claims
  
  P.O. Box 27401
  
  Richmond, VA 23279
Questions?
Thank you

https://mediproviders.anthem.com/va
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