Provider orientation and training

HealthKeepers, Inc. for Anthem HealthKeepers Plus, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus)

Professional, facility, behavioral health providers & ancillary

Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.
Agenda

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- Website access/registration
- Key provider responsibilities
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- Fraud, waste and abuse
- Cultural competency
- ADA Training
- Access and availability
- Verifying member eligibility
- Balance billing and patient pay
- Critical incident reporting
- Member Eligibility
- Updating your information

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- Care coordination and quality and disease management
- Member rights and responsibilities
- Claim submissions
- Rejected vs. Denied Claims
- Electronic payment services
- Grievances and appeals
- Claims Appeals and Recoveries
- Preauthorization and notification
- Laboratory services
- Pharmacy
- Long-term services and supports
- 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 with 25 years of service**
  – A leading provider of health care solutions for public programs
  – Access to high-quality, coordinated care for low-income families, seniors and people with disabilities

• **Serving members with complex needs in eight states**
  – Over 300,000 members enrolled in long-term services and supports programs

• **A flagship health plan**
  – MCO since inception of managed care (over 20 years)
  – Largest MCO
  – Serving over 320,000 Virginia Medicaid members
Medallion 4.0 program

- All the same services and benefits as Medallion 3.0 with a few additions:
  - Community mental health and rehab services (CMHRS)
  - Early intervention
  - Pediatric residential treatment (April 1, 2019)
  - Foster care therapeutic case management (April 1, 2019)
- Approximately 800,000 members eligible for the current program (prior to expansion).
- Regional roll-out beginning August 1, 2018, with Tidewater and ending December, 2018.
- Members will be auto-assigned and redistributed via DMAS algorithms and rules.
CCC Plus program

- CCC Plus is a statewide Medicaid managed long-term services and supports (LTSS) program that serves 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.
Medallion 4.0 and CCC Plus regions
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 Provider Services at 1-800-901-0020 (Medallion 4.0) and 1-855-323-4687 (CCC Plus) 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 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

• **Ancillary, DME, and so on**
  – 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

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.

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 public provider website

• Our provider website is available 24/7 to all providers, regardless of participation status, at https://mediproviders.anthem.com/va.
Our public provider website (cont.)

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
Our secure provider website - Availity

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 (cont.)

- The registration process is easy.
- Multiple resources and trainings about site navigation are available.
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.
Availity offers a single sign-on with access to multiple payers.

CCC Plus and Medallion 4.0 transactions are available at no charge to providers.

Functions are available 24/7 from any computer with internet access.

The standard screen format makes it easy to find the necessary information needed and increases staff productivity.

Availity is compliant with HIPAA regulations.

Live, web-based and prerecorded training webinars are available to users at no cost. FAQ and comprehensive help topics are available online as well.

Availity Client Services is available at 1-800-AVAILITY (1-800-282-4548), Monday through Friday from 7 a.m. to 6 p.m. CT.

User reporting allows the primary access administrator to track associate work.
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.
• 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 your provider manual for a complete list.
Contracting and credentialing

- Contact your regional Provider Relations representative to initiate the contracting process and/or to inquire about the status of an application.

- 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.
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 Provider Services at 1-800-901-0020 (Medallion 4.0) and 1-855-323-4687 (CCC Plus).

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, as well as face to face interpreter services, can be scheduled for Anthem HealthKeepers Plus members by calling 1-800-901-0020 (Medallion 4.0) and 1-855-323-4687 (CCC Plus). These services are available 24/7 at no charge.
Americans with Disabilities Act (ADA) training

- *The ADA Training Presentation* can be found on our public Provider website at [https://mediproviders.anthem.com/va](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.
  - 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 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.
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:
- 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, and so on).

Please review the provider manual for all additional standards.
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 (Medallion 4.0) and 1-855-323-4687 (CCC Plus).
Member ID cards - Medallion

- All Medallion 3.0 members will have either a YTD, YTE or YTF prefix.
- All Medallion 4.0 members will have a YTD prefix.
Member ID cards — CCC Plus

- Medicaid-only members will have a PCP listed.
- D-SNP members enrolled in the Medicare Advantage Plan (MediBlue) and enrolled in CCC Plus will not have PCP information listed.
- For dual members, providers must require members to provide their Medicare/Medicare Advantage card and their CCC Plus card.
Balance billing

- You may **not** balance bill our members.
- You must complete the notification/authorization process before providing noncovered services.
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 for CCC Plus and QOC-HKP@anthem.com for Medallion 4.0.

- 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.
Member eligibility, benefits and supports
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 that 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.
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 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 TANF or CHIP benefits.
- Are enrolled in the current Medallion 3.0 program and the current FAMIS program.
Covered benefits

- Physician office visits — inpatient and outpatient services
- Outpatient medical services and supplies
- Prescription benefits
- Preventive services, wellness and education
- Initial health assessments
- DME and supplies
- Emergency services
- Care coordination and utilization management
- Pharmacy benefits through Express Scripts, Inc.
- Outpatient Behavioral Health and CMHRS

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 **1-800-901-0020 (Medallion 4.0)** and **1-855-323-4687 (CCC Plus)**.
- 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) — CCC Plus

Each 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
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 his or her designee
• Designated care manager
• Primary care physician
• Behavioral health professional
• 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.
Quality of care (QOC) issue referral process

QOC definition:

• A medical, social, environmental, or economical event that has the potential to have an adverse effect on the health and welfare of our internal and external customers, members, or the organization

Purpose:

• To ensure quality and appropriateness of care and services rendered by monitoring for potential QOC issues on an ongoing basis to our members

• To systematically identify, investigate, and resolve QOC issues as well as track and trend issues for reporting and recredentialing purposes
QOC issue referral process (cont.)

- QOC event categories include, but are not limited to:
  - Sentinel event: an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Such events are called sentinel because they signal the need for immediate investigation and response.
  - Examples include:
    - Inpatient death unrelated to the natural course of patient’s illness or underlying condition.
    - Inpatient major permanent loss of function unrelated to the natural course of patient’s illness or underlying condition.
    - Delayed or missed diagnosis or treatment.
    - Unplanned admission to hospital after outpatient procedure.
    - Unplanned subsequent return to surgery for same procedure.
QOC issue referral process (cont.)

- Never events: occurrences that should never happen in a hospital that are usually preventable, including the following:
  - Surgical: wrong body part, wrong patient, unintended retention of a foreign object in a patient after surgery
  - Product or device: death associated with the use of contaminated drugs or devices
  - Patient protection: infant discharged to the wrong person, patient suicide or attempted suicide, patient disappearance
  - Care management: patient death/disability associated with medication error, stage 3/4 pressure ulcers acquired after admission to a healthcare facility
  - Environmental: death/disability from burns, falls, electric shock
  - Criminal: patient abduction, sexual/physical assault
QOC issue referral process (cont.)

The *QOC Issue Referral Form* is found on the Provider website at:


All QOC issues should be completed electronically and submitted via Outlook to qoc-hkp@anthem.com. Please label the email **QOC Issue**.
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 (cont.)

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 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, Anthem HealthKeepers Plus guidelines, and 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:

Medallion or CCC Plus
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 (Medallion 4.0) and 1-855-323-4687 (CCC Plus).
- 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.
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>
</tr>
</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.

- **Claims 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.
Claims Appeals

- All providers have three distinct levels of claims appeals 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, mail or by calling Provider Services at 1-800-901-0020 (Medallion 4.0) and 1-855-323-4687 (CCC Plus).
- 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 appeal.
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 the providers its 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.
• 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 RAC (recovery audit contractor) for DMAS. See below:
  – HMS FY2017 Annual Report: [https://rga.lis.virginia.gov/Published/201s7/RD421/PDF](https://rga.lis.virginia.gov/Published/201s7/RD421/PDF)

  • For Non-COB recoveries, the State’s RAC guidelines allow a 3-year lookback period.
  • For Commercial COB recoveries, the State’s RAC guidelines allow a 3-year lookback period.
  • For Medicare COB recoveries, the Federal guidelines allow a 4-year lookback period.
    – For the 4-year lookback period for Medicare COB recoveries, we follow the following Federal Regulation: 42 CFR 405.980 and 405.986.
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.
• Early and Periodic Screening, Diagnostic, and Treatment.

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. 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.
Use Availity to submit all prior authorization 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, 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 1-800-505-1193 for behavioral health outpatient (including CMHRS) services.
Preauthorization requests — Medallion (cont.)

You may also call Provider Services at 1-800-901-0020. 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.
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 **1-800-505-1193** for behavioral health outpatient (including CMHRS) services.
Preauthorization requests — CCC Plus

You may also call 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: 1-800-901-0020 (Medallion 4.0) 1-855-253-6861 (CCC Plus)
Laboratory services

• Unless authorization is obtained, all lab services must be performed by LabCorp except for ARTS 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 its approved subsidiaries).
• Testing sites must have a Clinical Laboratory Improvement Amendments certificate or a waiver.
The Preferred Drug List and formulary are available on our website*:
https://mediproviders.anthem.com/va/Pages/home.aspx

Prior authorization 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.)

- Prior authorization 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
- Peer-to-peer (P2P) reviews: submit a P2P request marked Urgent to pharmacyreviewerssharedmailbox@anthem.com
Pharmacy (cont.)

- Appeals
  - To file a basic appeal, send a letter asking for an appeal to:
    Central Appeals Processing
    HealthKeepers, Inc. for Anthem HealthKeepers Plus
    PO Box 62429
    Virginia Beach, VA 23466-2429
  - For urgent appeals, call 1-800-901-0020
Key contact information - Medallion

- 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](https://mediproviders.anthem.com/va)
- Paper claims submission:

  Claims  
  HealthKeepers, Inc. for Anthem HealthKeepers Plus  
  P.O. Box 27401  
  Richmond, VA 23279
Key contact information — CCC Plus

• 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
• Pharmacy preauthorization phone: 1-855-323-4687
• Website: https://mediprovders.anthem.com/va
• Paper claims submission:

Claims
HealthKeepers, Inc. for Anthem HealthKeepers Plus
P.O. Box 27401
Richmond, VA 23279
DMAS Links

- [http://www.dmas.virginia.gov/#/med4presentations](http://www.dmas.virginia.gov/#/med4presentations)
- [http://www.dmas.virginia.gov/#/med4](http://www.dmas.virginia.gov/#/med4) (Medallion 4.0 Website)
- [https://www.virginiamanagedcare.com](https://www.virginiamanagedcare.com) (Medallion Managed Care)
- [https://cccplusva.com/home](https://cccplusva.com/home) (CCC Plus Managed Care)
- [M4.0Inquiry@dmas.virginia.gov](mailto:M4.0Inquiry@dmas.virginia.gov) (DMAS e-mail for Medallion 4.0 inquiries)
- [CCCPlus@dmas.virginia.gov](mailto:CCCPlus@dmas.virginia.gov) (DMAS e-mail for CCC Plus inquiries)
- [http://coverva.org/expansion/](http://coverva.org/expansion/) (Expansion)
Questions?
Thank you