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CHAPTER 1: INTRODUCTION

Welcome! Thank you for being part of the Anthem Blue Cross and Blue Shield (Anthem) network.

Overview
BadgerCare Plus and Medicaid Supplemental Security Income (SSI) participants have the option of selecting Anthem in all Wisconsin counties effective January 1, 2018.

Anthem represents a growing network of health care providers who make it easier for our members to receive quality care. We are committed to ensuring access to all necessary health care services and providing first-class customer service by encouraging coordination of medical care and emphasizing prevention and education.

We work with many local service and governmental agencies, including:
- Bureau of Milwaukee Child Welfare
- Local health departments
- Prenatal care coordination agencies
- School-based services providers
- Targeted care management agencies

There is strength in numbers; Anthem's health services programs, combined with those already available in our target service areas, are designed to supplement providers' treatment plans. Our programs also serve to help improve our members' overall health by informing, educating and encouraging self-care in the prevention, early detection and treatment of existing conditions and chronic disease.

About This Manual
This provider manual is designed for contracted Anthem providers, hospitals and ancillary providers. Our goal is to create a useful reference guide for you and your office staff. We want to help you navigate our managed health care plan to find the most reliable, responsible, timely and cost-effective ways to deliver quality health care to our members.

We recognize that managing our members' health can be a complex undertaking, requiring familiarity with the rules and regulations of a complex health care system. With this complexity in mind, we divided this manual into sections that reflect your questions, concerns and responsibilities before and after an Anthem member walks through your doors. The sections are organized as follows:
- Legal requirements
- Contact information
- Before rendering services
- After rendering services
- Operational standards, requirements and guidelines
- Additional resources

Legal Requirements
The information contained in this manual is proprietary, will be updated regularly and is subject to change. This section provides specific information on the legal obligations of being part of the Anthem network.
Contacts
This section is your reference for important phone and fax numbers, websites and mailing addresses.

Before Rendering Services
This section provides the information and tools you will need before providing services, including verifying member eligibility and a list of covered and noncovered services. The section also includes a chapter on the precertification process and coordination of complex care through case management.

We take pride in our proactive approach to health. The chapter on Health Services Programs details how we can partner with you to make the services you provide more effective. For example, the Initial Health Assessment is our first step in providing preventive care. And the health services programs under Disease Management Centralized Care Unit (DMCCU) allow us to collaborate with you to combat the most common and serious conditions and illnesses facing our members, including asthma, cardiovascular disease and diabetes.

After Rendering Services
At Anthem, our goal is to make the billing process as streamlined as possible. The After Rendering Services section provides guidelines and detailed coding charts for fast, secure and efficient billing and includes specific information about filing claims for professional and institutional services. In addition, the Member Transfers and Disenrollment chapter outlines the steps for members who want to change their primary care physician (PCP) assignment or transfer to another health plan. When questions or concerns come up about claims or adverse determination, our chapter on grievances and appeals will take you step-by-step through the process.

Operational Standards, Requirements and Guidelines
This section summarizes the requirements for provider office operations and access standards, thereby ensuring consistency when members need to consult with providers for referrals, coordination of care and follow-up care. Additional chapters detail provider credentialing, provider roles and responsibilities and enrollment and marketing guidelines. Chapters on clinical practice, preventive health guidelines and case management outline the steps providers should take to coordinate care and help members take a proactive stance in the fight against disease. And finally, we included a chapter documenting our commitment to participate in quality assessments that help Anthem measure, compare and improve our standards of care.

Additional Resources
To help providers serve a diverse and ever-evolving patient population, we designed the Cultural Diversity and Linguistic Services program to improve provider/member communications by providing tools and resources to help reduce language and cultural barriers. In addition, Anthem works with nationally-recognized health care organizations to stay current on the latest health care breakthroughs and discoveries. This manual provides easy links to access that information. We also provide forms and reference guides on a wide variety of subjects.

Accessing Information, Forms and Tools on Our Website
A wide array of tools, information and forms are accessible via the provider website at https://mediproviders.anthem.com/wi. To access additional information on any topic, select from the list of quick links on the left-hand side of the screen.

If you have any questions about the content of this manual, contact Provider Services: 1-855-558-1443. Hours: Monday to Friday, 8 a.m. to 5 p.m.
Websites
The Anthem website and this manual may contain links and references to internet sites owned and maintained by third-party sites. Neither Anthem nor its related affiliated companies operate or control, in any respect, any information, products or services on third-party sites. Such information, products, services and related materials are provided “as is” without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. Anthem disclaims all warranties, express or implied, including but not limited to implied warranties of merchantability and fitness. Anthem does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability or otherwise.
CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS

Proprietary Information
The information contained in this manual is proprietary. By accepting this manual, providers agree:

- To use this manual solely for the purposes of referencing information regarding the provision of medical services to BadgerCare Plus and Medicaid SSI enrollees who have chosen Anthem as their health care plan.
- To protect and hold the manual’s information as confidential.
- Not to disclose the information contained in this manual.

Privacy and Security
Anthem’s latest HIPAA-compliant privacy and security statement may be found on our website: https://mediproviders.anthem.com/wi. To access this statement, select Privacy Policies from the lower right corner of the provider page.

Throughout this manual, there are instances where information is provided as a sample or example. This information is meant to illustrate and is not intended to be used or relied upon.

There also are places within the manual where you may leave the Anthem site and link to another site operated by a third party. These links are provided for your convenience and reference only. Anthem and its subsidiary companies do not control such sites and do not necessarily endorse these sites. Anthem is not responsible for content, products or services.

When you link from the Anthem site to another site, you will be subject to the privacy policies (or lack thereof) of the other sites. We caution you to determine the privacy policy of such sites before providing any personal information.

Anthem uses the Secure eMail encryption tool to ensure that your members’ protected health information is kept private and secure. Secure eMail encrypts emails and attachments identified as potentially having protected health information. Providers also can use Secure eMail to send encrypted email to Anthem.

Updates and Changes
The provider manual, as part of your Provider Agreement and related addendums, is subject to change and may be updated at any time. In the event of an inconsistency between information in the manual and the Provider Agreement between you or your facility and Anthem Blue Cross and Blue Shield, the Provider Agreement shall govern.

In the event of a material change to the provider manual, we will make all reasonable efforts to notify you in advance of such change through web-posted newsletters and bulletins, email notifications, fax communications, and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive.

This manual is not intended to be a complete statement of all Anthem policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications, as referenced above.

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

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

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

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

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

If you or your patient believe that Anthem has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our grievance coordinator via:
- Mail: N17 W 24340 Riverwood Drive, Waukesha, WI 53188
- Phone: 1-262-523-4920

Equal Program Access on the Basis of Gender
Anthem provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Anthem must also treat individuals consistently with their gender identity, and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (that is, race, color, national origin, gender, gender identity, age or disability). Anthem may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.
CHAPTER 3: CONTACTS
When you need the correct phone number, fax number, website or street address, the information should be right at your fingertips. With that in mind, we have compiled the most-used contacts for you and your office staff for Anthem Blue Cross and Blue Shield (Anthem) services and support.

Anthem and Wisconsin State Contacts

<table>
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<th>Contact</th>
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| **Behavioral Health Services** | Anthem Medical Management  
Phone: **1-855-558-1443**  
TTY: **711**  
Hours: Monday to Friday, 7 a.m. to 5 p.m.  
Fax: **1-877-434-7578** (inpatient) **1-800-505-1193** (outpatient) |
| **Case Management Referrals** | Anthem Medical Management  
Phone: **1-855-558-1443**  
TTY: **711**  
Hours: Monday to Friday, 7 a.m. to 5 p.m.  
Fax: **1-800-964-3627** |
| **Claims: Electronic Processing** | EDI Solutions Help Desk: **1-800-470-9630**  
Hours: Monday to Friday, 8 a.m. to 5 p.m.  
Payer Identification Number: Professional: **00950**  
Institutional: **00450** |
| **Claims: Payment Status** | Anthem Provider Services  
Phone: **1-855-558-1443**  
Hours: Monday to Friday, 8 a.m. to 5 p.m.  
Website (secure provider website): **https://mediproviders.anthem.com/wi**. On the right side of the page, select Login. |
| **Claims: Appeals/Correspondence** | Anthem Blue Cross and Blue Shield  
Correspondence/Appeals  
P.O. Box 61599  
Virginia Beach, VA 23466-1599  
Anthem Provider Services  
Phone: **1-855-558-1443**  
Hours: Monday to Friday, 8 a.m. to 5 p.m.  
Utility management appeals: To file an authorization appeal, the member’s authorized representative or the provider acting on behalf of the member must notify us within 60 days of the date on the Notice of Action denial letter. Mail authorization appeals to: |
| | Anthem Blue Cross and Blue Shield  
Central Appeals Processing  
P.O. Box 62429  
Virginia Beach, VA 23466-2429 |
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<td><strong>Claims:</strong> Overpayment Recovery and Refund Procedure</td>
<td>Anthem Blue Cross and Blue Shield&lt;br&gt;P.O. Box 933657&lt;br&gt;Atlanta, GA 31193-3657</td>
</tr>
<tr>
<td><strong>Credentialing and Recredentialing</strong></td>
<td>Phone: <strong>1-855-558-1443</strong>&lt;br&gt;Email: <a href="mailto:Credentialing@Anthem.com">Credentialing@Anthem.com</a></td>
</tr>
<tr>
<td><strong>Dental Services:</strong>&lt;br&gt;Members who live in Kenosha, Milwaukee, Ozaukee, Racine, Washington or Waukesha Counties</td>
<td>For all services (including precertification) providers and members should contact DentaQuest.&lt;br&gt;Website: <a href="http://www.DentaQuestgov.com">www.DentaQuestgov.com</a>&lt;br&gt;Provider Services: <strong>1-855-453-5287</strong>&lt;br&gt;Fax: <strong>1-262-834-3589</strong>&lt;br&gt;DentaQuest&lt;br&gt;12121 N. Corporate Parkway&lt;br&gt;Mequon, WI 53092</td>
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<tr>
<td><strong>Dental Services:</strong>&lt;br&gt;All other counties</td>
<td>For all services (including precertification) providers and members should contact ForwardHealth:&lt;br&gt;• Phone: <strong>1-800-947-9627</strong> (providers)&lt;br&gt;• Phone: <strong>1-800-362-3002</strong> (members)&lt;br&gt;• Hours: Monday to Friday, 7 a.m. to 6 p.m.&lt;br&gt;• Website: <a href="http://www.forwardhealth.wi.gov">www.forwardhealth.wi.gov</a></td>
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<td><strong>Fraud and Abuse Department</strong></td>
<td>Anthem Provider Services&lt;br&gt;Phone: <strong>1-855-558-1443</strong>&lt;br&gt;Hours: Monday to Friday, 8 a.m. to 5 p.m.</td>
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<td><strong>Grievances and Appeals Department</strong></td>
<td>For grievances and appeals (including claims), contact Anthem Provider Services:&lt;br&gt;Phone: <strong>1-855-558-1443</strong>&lt;br&gt;Hours: Monday to Friday, 8 a.m. to 5 p.m.&lt;br&gt;Fax: <strong>1-800-964-3627</strong>&lt;br&gt;Written correspondence:&lt;br&gt;BadgerCare Plus and Medicaid Social Security Income (SSI)&lt;br&gt;Medicaid Managed Care Unit&lt;br&gt;P.O. Box 6470&lt;br&gt;Madison, WI 53716-0470</td>
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<td><strong>Hospital/Facility Admission Notification</strong></td>
<td>Anthem Medical Management&lt;br&gt;Phone: <strong>1-855-558-1443</strong>&lt;br&gt;TTY: <strong>711</strong>&lt;br&gt;Hours: Monday to Friday, 7 a.m. to 5 p.m.&lt;br&gt;Fax: <strong>1-800-964-3627</strong></td>
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<td><strong>Interpreter Services</strong></td>
<td>Anthem Member Services&lt;br&gt;Phone: <strong>1-855-690-7800</strong>&lt;br&gt;TTY: <strong>711</strong>&lt;br&gt;Hours: Monday to Friday, 8 a.m. to 5 p.m.&lt;br&gt;After hours, call 24/7 NurseLine: <strong>1-855-690-7800</strong>&lt;br&gt;TTY: <strong>711</strong>&lt;br&gt;Hours: 24 hours a day, 7 days a week</td>
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| **24/7 NurseLine**            | Phone: **1-855-690-7800**  
TTY: **711**  
Hours: 24 hours a day, 7 days a week |
| **Medical Management Department** | Phone: **1-855-558-1443**  
TTY: **711**  
Hours: Monday to Friday, 7 a.m. to 5 p.m.  
Fax: **1-800-964-3627** |
| **Member Services**            | For member grievances and appeals, interpreter services, personal information changes:  
Phone: **1-855-690-7800**  
TTY: **711**  
Hours: Monday to Friday, 8 a.m. to 5 p.m.  
After hours, call the 24/7 NurseLine: **1-855-690-7800**  
Spanish: **1-800-855-2884**  
TTY: **711**  
Hours: 24 hours a day, 7 days a week |
|                                 | Written correspondence:  
Anthem Blue Cross and Blue Shield  
Central Appeals Processing  
P.O. Box 62429  
Virginia Beach, VA 23466-2429 |
| **Member Eligibility**         | Verify eligibility through ForwardHealth or Anthem.  
ForwardHealth:  
• Phone: **1-800-947-9627**  
• WiCall automated voice response phone: **1-800-947-3544**  
• Hours: 24 hours a day, 7 days a week  
• Website: [www.forwardhealth.wi.gov](http://www.forwardhealth.wi.gov) |
|                                 | Anthem:  
• Provider Services phone: **1-855-558-1443**  
• Hours: Monday to Friday, 8 a.m. to 5 p.m.  
• Fax: **1-800-964-3627**  
• Provider website: [https://mediproviders.anthem.com/wi](https://mediproviders.anthem.com/wi)  
(Select [Login](https://mediproviders.anthem.com/wi) or [Register](https://mediproviders.anthem.com/wi) to access the secure site.) |
| **Pharmacy Questions and Prescriptions** | ForwardHealth  
Website: [www.forwardhealth.wi.gov](http://www.forwardhealth.wi.gov)  
**Providers:**  
Phone: **1-800-947-9627**  
Hours: Monday to Friday, 7 a.m. to 6 p.m. |
|                                 | **Members:**  
Phone: **1-800-362-3002**  
Hours: Monday to Friday, 8 a.m. to 6 p.m. |
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<tr>
<th>If you have questions about...</th>
<th>Contact</th>
</tr>
</thead>
</table>
| **Precertification:** Behavioral Health | Anthem Medical Management  
Phone: **1-855-558-1443**  
TTY: **711**  
Hours: Monday to Friday, 7 a.m. to 5 p.m.  
Inpatient: **1-877-434-7578** Outpatient: **1-800-505-1193** |
| **Precertification:** Dental | For dental services information refer to the dental services entry in this table. Breakdown is by county for DentaQuest or ForwardHealth. |
| **Precertification:** Medical | Anthem Medical Management  
Phone: **1-855-558-1443**  
TTY: **711**  
Hours: Monday to Friday, 7 a.m. to 5 p.m.  
Fax: **1-800-964-3627** |
| **Precertification:** Pharmacy | Phone: **1-855-558-1443**  
Hours: Monday to Friday, 7 a.m. to 6 p.m. |
| **Provider Services** | For advocate services, verification of eligibility and benefits, claims status checks, and EDI Information:  
Phone: **1-855-558-1443**  
Hours: Monday to Friday, 8 a.m. to 5 p.m.  
Fax: **1-800-964-3627** |
| **Transportation Services** (nonemergent) | Phone: **1-866-907-1493**  
TTY: **711**  
Hours: Monday to Friday, 7 a.m. to 6 p.m. |
| **Vision Services:** March Vision Care | Phone: **1-855-516-2724**  
TTY: **711**  
Hours: Monday to Friday, 8 a.m. to 5 p.m.  
Website: [www.marchvisioncare.com](http://www.marchvisioncare.com) |
| **Maternal and Child Health** | For early childhood intervention, call:  
Phone: **1-800-722-2295**  
Hours: 24 hours a day, 7 days a week  
Website: [www.dhs.wisconsin.gov/wic](http://www.dhs.wisconsin.gov/wic) |
CHAPTER 4: COVERED AND NONCOVERED SERVICES

Provider Services: 1-855-558-1443
Provider Services fax: 1-800-964-3627
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

**Covered Services**
The following grid lists the BadgerCare Plus and Medicaid SSI Program covered services, including notations for services requiring precertification. Because covered benefits periodically change, verify coverage before providing services.

<table>
<thead>
<tr>
<th>Services</th>
<th>BadgerCare Plus and Medicaid SSI Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory surgery centers</td>
<td>Coverage of certain surgical procedures and related lab services</td>
</tr>
<tr>
<td>Dental</td>
<td>Full coverage; some dental services require precertification.</td>
</tr>
<tr>
<td>Dental: Anthem, through its partner DentaQuest, covers dental services</td>
<td></td>
</tr>
<tr>
<td>Dental: ForwardHealth: Coverage in all other counties is through</td>
<td>Wisconsin Medicaid Fee-for-Service.</td>
</tr>
<tr>
<td>Dental: Full coverage; some dental services require precertification.</td>
<td></td>
</tr>
<tr>
<td>Disposable medical supplies (DMS)</td>
<td>Full coverage; some DMS requires precertification.</td>
</tr>
<tr>
<td>Durable medical equipment (DME)</td>
<td>Full coverage; all custom-made DME requires precertification.</td>
</tr>
<tr>
<td>Emergency room</td>
<td>Full coverage.</td>
</tr>
<tr>
<td>End-stage renal disease (ESRD)</td>
<td>Full coverage.</td>
</tr>
<tr>
<td>HealthCheck screenings for children</td>
<td>Full coverage of HealthCheck screenings and other services for individuals 20 years and under</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>Full coverage.</td>
</tr>
<tr>
<td>Home care services: home health, private duty nursing (PDN) and personal</td>
<td>Full coverage; requires precertification.</td>
</tr>
<tr>
<td>care service</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>Full coverage; requires precertification.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Full coverage.</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>Full coverage; requires precertification.</td>
</tr>
<tr>
<td>Mental health and substance abuse treatment: inpatient</td>
<td>Full coverage; requires precertification.</td>
</tr>
<tr>
<td>Mental health and substance abuse treatment: outpatient</td>
<td>Full coverage; some outpatient services require precertification.</td>
</tr>
<tr>
<td>Mental health and substance abuse treatment: day treatment</td>
<td>Full coverage; requires precertification.</td>
</tr>
<tr>
<td>Nursing home services</td>
<td>Full coverage; requires precertification.</td>
</tr>
<tr>
<td>Organ transplants</td>
<td>Requires precertification; cornea and kidney transplants are covered by Anthem. Other</td>
</tr>
<tr>
<td>Organ transplants</td>
<td>transplants may be covered by ForwardHealth. Please call Anthem Provider Services.</td>
</tr>
<tr>
<td>Outpatient hospital</td>
<td>Full coverage; some services require precertification.</td>
</tr>
<tr>
<td>Services</td>
<td>BadgerCare Plus and Medicaid SSI Coverage</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Physical therapy, occupational therapy, speech and language pathology therapy</td>
<td>Full coverage</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Full coverage</td>
</tr>
<tr>
<td>Prenatal/maternity care</td>
<td>Full coverage</td>
</tr>
<tr>
<td>Reproductive health service: family planning services</td>
<td>Full coverage (exceptions listed below)</td>
</tr>
<tr>
<td></td>
<td>Does not cover:</td>
</tr>
<tr>
<td></td>
<td>• Infertility treatments</td>
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<td></td>
<td>• Reversal of voluntary sterilization</td>
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<tr>
<td></td>
<td>• Surrogate parenting and related services including but not limited to:</td>
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<tr>
<td></td>
<td>o Artificial insemination</td>
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<tr>
<td></td>
<td>o Obstetrical care</td>
</tr>
<tr>
<td></td>
<td>o Labor or delivery</td>
</tr>
<tr>
<td></td>
<td>o Prescription and over-the-counter drugs</td>
</tr>
<tr>
<td>Prescription drugs (covered by ForwardHealth)</td>
<td>Members may fill prescriptions at any pharmacy that will accept the ForwardHealth ID card.</td>
</tr>
<tr>
<td>Radiology services</td>
<td>Full coverage; requires precertification</td>
</tr>
<tr>
<td>Transportation: ambulance</td>
<td>Full coverage of emergency transportation; nonemergency transportation is covered by ForwardHealth.</td>
</tr>
<tr>
<td>Vision Services: March Vision</td>
<td>Full coverage including eyeglass frames, lenses or contact lenses</td>
</tr>
</tbody>
</table>

**Noncovered Services**

Anthem does not cover:

- Care provided outside the United States, Canada and Mexico, including emergency services.
  - Anthem reimburses for emergency services provided to members in Canada and Mexico; however, payment for such services must be made to a financial institution or entity located within the United States. Nonemergency services in Canada or Mexico may be covered by Anthem per precertification policies, provided the financial institution receiving payment is located within the United States.
- Cosmetic surgery, including tattoo removal and ear lobe repair.
- Experimental or investigational procedures.
- Services that are not medically necessary.
- Sex change surgery or treatments.
- Surgery or drugs to enhance fertility.

Noncovered services also include any instance when the precertification for a service was not granted, or the service was provided before precertification was given.

**Services Requiring Precertification**

Precertification is always required for some categories of services, including inpatient hospital services and durable medical equipment rentals. To determine if a specific service requires precertification, enter the CPT code in our precertification tool online at [https://mediproviders.anthem.com/wi > Precertification](https://mediproviders.anthem.com/wi > Precertification).
Dental Services
Dental services are provided by two different health care entities, depending on where the member lives:

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Dental Services</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental coverage for the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha</td>
<td>DentaQuest</td>
<td>1-855-453-5287</td>
</tr>
<tr>
<td>Dental coverage for all other counties</td>
<td>ForwardHealth</td>
<td>1-800-947-9627</td>
</tr>
</tbody>
</table>

Vision Services
Anthem contracts with March Vision Care to provide covered routine and emergency vision services. Anthem covers the following services when performed by a March Vision Care-contracted provider or with precertification from March Vision Care by an out-of-network provider:
- Emergency vision services (immediately if trauma or eye conditions have turned to life-threatening conditions)
- Routine vision services

To arrange for vision services, call March Vision Care: 1-855-516-2724

Nonemergency Transportation Services
Nonemergency transportation is a benefit provided by ForwardHealth to Anthem members enrolled in BadgerCare Plus and Medicaid SSI. These services include bus and taxi rides for members needing help getting to medical appointments as well as special vehicle transportation for Anthem members in wheelchairs. Members should schedule nonemergency transportation a minimum of three days in advance. Phone: 1-866-907-1493

State-Covered Services
Some health services are not covered by Anthem and instead are covered under ForwardHealth. State-covered services include:
- Adaptive behavior assessment and treatment (autism)
- Chiropractic services
- Community support program services
- Comprehensive community services
- Organ transplants (other than cornea and kidney)
- Pharmacy (prescription drugs and some over-the-counter medications. Members may fill their prescriptions by presenting their ForwardHealth identification ID card to any pharmacy in the BadgerCare Plus network)
- Prenatal care coordination
- Targeted case management
- Tuberculosis services

For more information on state-covered services, contact ForwardHealth: 1-800-947-3544. Website: www.forwardhealth.wi.gov
CHAPTER 5: MEMBER ELIGIBILITY

Provider Services: 1-855-558-1443
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.
Website: https://mediproviders.anthem.com/wi
ForwardHealth WiCall: 1-800-947-3544
Hours of operation: 24 hours a day, 7 days a week
ForwardHealth website: www.forwardhealth.wi.gov

Overview
Anthem members enrolled in BadgerCare Plus and Medicaid SSI should carry and present a current ForwardHealth ID card when seeking services. The ForwardHealth ID card is issued by the state of Wisconsin. A member’s BadgerCare Plus enrollment and other health insurance must be verified by providers before services are delivered. Because eligibility can change, verify eligibility at each visit. Remember, claims submitted for services rendered to noneligible members are not eligible for payment. To prevent fraud and abuse, providers should confirm the identity of the person presenting the ID card.

Verifying Member Eligibility
Providers can verify member eligibility as follows:

- Contact ForwardHealth for real-time member enrollment and eligibility verification for all ForwardHealth programs 24 hours a day, 7 days a week. Or use the website to determine the member’s specific benefit plan and coverage:
  - ForwardHealth WiCall automated voice response: 1-800-947-3544 (24 hours a day, 7 days a week)
  - ForwardHealth website: www.forwardhealth.wi.gov
- Contact Anthem Provider Services to verify enrollment and benefits for our members:
  - Phone: 1-855-558-1443 (Monday to Friday, 8 a.m. to 5 p.m.)
  - Anthem’s secure provider website: https://mediproviders.anthem.com/wi (Select Login or Register to access the secure site).

ForwardHealth Member ID Card
The ForwardHealth member ID card includes the member’s name, 10-digit member ID, magnetic stripe, signature panel and the Member Services phone number. The card also has a unique, 16-digit card number on the front for internal program use. On the back of the card, there’s a toll-free number, which is for member use only, and an address to return a lost card to ForwardHealth. For more information about verification of ForwardHealth member enrollment and ID cards, providers may refer to the “Member Information” section of the ForwardHealth provider manual.

Note: Members do not receive a new ForwardHealth card if they’re enrolled in a state-contracted MCO or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Anthem Member ID Card
The front of the Anthem member ID card includes the Anthem ID number (which always begins with the alpha prefix ZRA), the name and phone number of the member’s PCP, and the PCP effective date. The back includes the mailing address for paper claims and important phone numbers.
CHAPTER 6: MEDICAL MANAGEMENT
Medical Management: 1-855-558-1443
Medical Management fax: 1-800-964-3627
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview
Anthem’s Medical Management program is a cooperative effort with providers to promote, provide and document the appropriate use of health care resources. Our goal is to provide the right care, to the right member, at the right time, in the appropriate setting.

The decision-making process is based on health plan and state guidelines as well as National Committee for Quality Assurance guidelines and reflects the most up-to-date Medical Management standards. Health care authorizations are based on the following:
- Benefit coverage
- Established criteria
- Community standards of care

The decision-making criteria used by the Medical Management department are evidence-based and consensus-driven. We update criteria periodically as standards of practice and technology change. We involve practicing physicians in these updates and then notify providers of changes through fax communications (such as provider bulletins) and other web postings and mailings. Based on sound clinical evidence, the Medical Management department provides the following service reviews:
- Precertifications
- Concurrent/continued stay reviews
- Post-service reviews

Decisions affecting coverage or payment for services are made in a fair, consistent and timely manner. The decision-making process incorporates nationally recognized standards of care and practice from sources including:
- American College of Cardiology
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- American Academy of Orthopedic Surgeons
- Cumulative professional expertise and experience

After a case has been reviewed, decisions and notification time frames will be given for service approval, modification and denial.

Please note: Decisions are based on appropriateness of care and service and existence of coverage. We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are no financial incentives for Medical Management decision-makers that encourage decisions resulting in under-utilization.

If you disagree with a decision and want to discuss the decision with the physician reviewer, call the Medical Management department: 1-262-523-2425.
You may download a copy of the guidelines from the provider website at https://mediproviders.anthem.com/wi. Or to request a hard copy, call Provider Services at 1-855-558-1443, and we will gladly mail one to you.

Services Requiring Precertification
To determine prior authorization requirements, use the lookup tool on the Precertification page of the provider website at https://mediproviders.anthem.com/wi/pages/precertification-forms.aspx.

Please note: Emergency hospital admissions do not require precertification. However, notification is required within 24 hours or the next business day.

Requesting Precertification
You may contact us with questions or precertification requests regarding health care services including:

- Routine, nonurgent care reviews.
- Urgent or expedited pre-service reviews.
- Urgent concurrent or continued stay reviews.

Interactive Care Reviewer
Our Interactive Care Reviewer (ICR) is the preferred method for submitting preauthorization requests, offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for our members. Additionally, providers can use this tool to make inquiries on previously submitted requests, regardless of how they were sent (phone, fax, ICR or other online tool). Capabilities and benefits of the ICR include:

- Initiating preauthorization requests online — eliminating the need to fax. The ICR allows detailed text, photo images and attachments to be submitted along with your request.
- Making inquiries on previously submitted requests via phone, fax, ICR or other online tool.
- Having instant accessibility from almost anywhere, including after business hours.
- Utilizing a dashboard that provides a complete view of all utilization management requests with real-time status updates, including email notifications if requested using a valid email address.
- Viewing real-time results for common procedures with immediate decisions.


You can access the ICR under Authorizations and Referrals on the Availity Web Portal. For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox and Safari. The ICR is not currently available for:

- Transplant services.
- Services administered by vendors, such as AIM Specialty Health and OrthoNet LLC. For these requests, follow the same preauthorization process you use today.

We will update our website as additional functionality and lines of business are added throughout the year.

Phone or Fax
You can also request precertification for medical or behavioral health concerns or report a medical admission by contacting the Medical Management department at 1-855-558-1443 or faxing to 1-800-964-3627. Behavioral health precertification requests may be faxed to 1-877-434-7578 for inpatient and 1-800-505-1193 for outpatient.
Staff will identify themselves by name, title or organization name.

The Medical Management department will return calls:
- On the same day when received during normal business hours.
- On the next business day when received after normal business hours.
- Within 24 hours for all routine requests.

Providers may fax the Medical Management department and include requests for:
- Urgent or expedited pre-service reviews.
- Nonurgent concurrent or continued stay reviews.

Faxes are accepted during and after normal business hours. Faxes received after-hours will be processed the next business day.

You may call Provider Services at 1-855-558-1443, 24 hours a day, 7 days a week.

To request precertification or report a medical admission, call the Medical Management department and have the following information ready:
- Member name and ForwardHealth ID number
- Diagnosis with the ICD code
- Procedure with the CPT code
- Date of injury or hospital admission and third-party liability information, if applicable
- Facility name, if applicable
- PCP
- Specialist or attending physician name
- Clinical justification for the request
- Level of care
- Lab, radiology and pathology test results
- Medications
- Treatment plan, including time frames
- Prognosis
- Psychosocial status
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

All providers, including physicians, hospitals and ancillary providers, are required to provide information to the Medical Management department. Obtain a separate precertification for each service requiring approval. Precertification is necessary whether an in-network or out-of-network provider performs the service. For the latest information about which services require precertification, go to https://mediproviders.anthem.com/wi > Precertification.

**Requests with Insufficient Clinical Information**

When the Medical Management department receives requests with insufficient clinical information, we will contact the provider with a request for the information reasonably necessary to determine medical necessity. We will make at least one attempt to contact the requesting provider to obtain this additional information. If we do not receive a response, the request will be reviewed with the information originally submitted and denied. A denial letter will be sent to both the member and the provider.
Utilization Management Appeals
When Anthem denies a request, both the member and provider receive a Notice of Action denial letter. To file an appeal, the member’s authorized representative or the provider acting on behalf of the member must notify us within 60 days of the date on the Notice of Action denial letter.

Utilization Management appeals must be filed in writing and mailed to:

Anthem Blue Cross and Blue Shield
Central Appeals Processing
P.O. Box 62429
Virginia Beach, VA 23466-2429

Urgent Requests
For urgent requests, the Medical Management department completes a pre-service review within 72 hours from receipt of the clinical information. Generally speaking, the provider is responsible for contacting us to request pre-service review for both professional and institutional services. However, the hospital or ancillary provider also should contact Anthem to verify pre-service review status for all nonurgent care before rendering services.

Emergency Medical Services
Anthem does not require precertification for treatment of emergency medical conditions. In the event of an emergency, members may access emergency services 24 hours a day, 7 days a week. If the emergency room visit results in the member’s admission to the hospital, providers must contact Anthem within 24 hours or the next business day.

Emergency Stabilization and Post-Stabilization
The emergency department’s treating provider determines the services needed to stabilize the member’s emergency medical condition. After the member is stabilized, the emergency department’s provider must contact the member’s PCP for authorization of further services. If the PCP does not respond within one hour, the necessary services will be considered authorized.

The emergency department should send a copy of the emergency room record to the PCP’s office within 24 hours. The PCP should:
- Review and file the chart in the member’s permanent medical record.
- Contact the member.
- Schedule a follow-up office visit or a specialist referral, if appropriate.

Concurrent Reviews

Concurrent Reviews: Hospital Inpatient Admissions
Hospitals must notify us of inpatient admissions within 24 hours of admission or by the next business day. Notify us about the following admissions:
- Behavioral health
- Medical care
- Substance abuse

After notification of an inpatient admission is received, we will send a request for clinical information supporting the admission’s medical necessity. Evidence-based criteria are used to determine medical necessity and the appropriate level of care.
Concurrent Reviews: Clinical Information for Continued-Stay Review

When a member’s hospital stay is expected to exceed the number of days authorized during pre-service review, or when the inpatient stay did not have pre-service review, the hospital must contact us for continued stay review. We require clinical reviews on all members admitted as inpatients to:

- Acute care hospitals.
- Intermediate facilities.
- Skilled nursing facilities.

We perform these reviews to assess medical necessity and determine whether the facility and level-of-care are appropriate. Anthem identifies members admitted as inpatients by:

- Facilities, providers, members, and/or member’s representatives reporting admissions.
- Claims submitted for services rendered without authorization.
- Pre-service authorization requests for inpatient care.

The Medical Management department will complete a continued-stay inpatient review within 24 hours of receipt of clinical information or sooner, consistent with the member’s medical condition. Medical management nurses will request clinical information from the hospital on the same day as notification regarding the member’s admission and/or continued stay. Providers should notify the health plan of an inpatient admission within 24 hours of the admission.

If the information meets medical necessity review criteria, we will approve the request within 24 hours of receipt of the information. We will send requests that do not meet medical policy guidelines to the physician adviser or medical director for further review. In addition to notifying providers of the decision within 24 hours, we will send written notification of denial or modification of the request to the member and the requesting provider.

Concurrent Reviews: Second Opinions

The following are important guidelines regarding obtaining a second opinion:

- The second opinion must be given by an appropriately qualified health care professional.
- The second opinion must come from a provider of the same specialty as the first provider.
- The secondary specialist may be selected by the member.
- When an appropriate specialist is not within Anthem’s network, Anthem will authorize a second opinion by a qualified provider outside of the network upon request by the member or provider.

A second opinion is a covered service, offered at no cost to our members.

Denial of Service

Only a medical or behavioral health provider with an active professional license or certification may deny services for lack of medical necessity including the denial of:

- Procedures
- Hospitalization
- Equipment

Nonmedical necessity determinations refer to services such as authorization requests where Utilization Management approval is sought. For example, a member is an inpatient for three days and the provider requests an additional stay that is rejected as medically unnecessary. Nonmedical necessity determinations are reviewed by the health plan’s Utilization Management team and the final determination is made by the health plan’s medical director not to cover the services.
When a request is determined to be not medically necessary, the requesting provider will be notified of the decision, the process for appeal and how to reach the reviewing physician for peer-to-peer discussion of the case.

To contact the physician clinical reviewers to discuss a decision, providers may call the Medical Management department: 1-262-523-2425.

**Referrals to Specialists**
The Medical Management department is available to assist providers in identifying a network specialist and/or arranging for specialist care. Specialists must be Wisconsin Medicaid-certified, whether in-network or out-of-network.

Authorization is:
- Required when referring a member to an out-of-network specialist.
- Required for an out-of-network referral when an in-network specialist is not available in the geographical area.
- Not required if referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.

Provider responsibilities include documenting referrals in the member’s chart and requesting the specialist to provide updates about diagnosis and treatment.

**Please note:** Obtain a precertification approval number before referring members to an out-of-network provider. For out-of-network providers, we require precertification for the initial consultation and each subsequent service.

**Additional Services: Behavioral Health**
Anthem is committed to providing a continuum of care management from initial contact to coordination of care and interventions. Our behavioral health case managers work closely with our medical case managers to support the behavioral health services needed by our members. The key to this support system is Anthem’s three-tiered system:
- Tier 1: Member Services and outreach calls to members
- Tier 2: Increased interaction with members to assist with provider referrals, problem-solving and removing obstacles to receiving treatment
- Tier 3: Intensive case management offering interventions on an episodic basis or triggered by a long length of stay, medical and behavioral health comorbidity, and/or multiple admissions

Contact the Medical Management department for more information and precertification of all behavioral health, facility-based care including but not limited to:
- Inpatient admissions
- Intensive outpatient program
- Emergency department visits
- Partial hospitalization programs
- Psychological testing
- Some outpatient services

Please have the following information ready when requesting a referral:
- Clinical information supporting the request
• Diagnosis with ICD code
• First date of outpatient service or date of hospital admission
• Procedure with CPT and/or HCPCS code(s)
• Specialist or attending provider name

**Additional Services: Vision Care**
Members have access to basic vision care services through March Vision Services. Providers may contact March Vision Services: 1-888-493-4070.

**Additional Services: Dental Care**
DentaQuest provides dental services to members in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties only. To obtain precertification of dental services for members in these counties, contact DentaQuest. Medically necessary inpatient or outpatient services rendered during the performance of a dental procedure may be covered. Phone: 1-855-453-5287

To obtain precertification of dental services for members in all other counties, please contact ForwardHealth Provider Services. Medically necessary inpatient or outpatient services rendered during the performance of a dental procedure may be covered. Phone: 1-800-947-9267
CHAPTER 7: HEALTH SERVICES PROGRAMS

Provider Services: 1-855-558-1443
Provider Services fax: 1-800-964-3627
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview
At Anthem, we are proud of our joint efforts with the community-based health organizations to maximize health care services for our members. These service organizations include:

- Bureau of Milwaukee Child Welfare
- Local health departments
- Prenatal care coordination agencies

Our approach is collaborative, results-oriented, community-based and member-centered. We encourage providers to work with these community organizations to coordinate care, ensure continuity, and provide culturally appropriate services to our members enrolled in BadgerCare Plus and Medicaid SSI. Our agreements offer clear guidelines for sharing clinical data that can help our members lead healthier lives.

The intent of our collaboration with our community partners is to supplement providers' treatment plans. When combined with our own health services programs, they can improve our members' overall health by informing, educating and encouraging self-care. The targeted programs are divided into four categories:

- Preventive care programs, including New Baby, New Life℠ for mothers-to-be and HealthCheck, a health screening and immunization program for members under the age of 21
- Health management programs, which promote knowledge and encourage self-care for specific medical conditions and chronic disease, including diabetes, asthma and heart disease
- Health education, including the 24/7 NurseLine, a phone line available 24 hours a day, 7 days a week for all health-related questions
- Telehealth, a unique health care delivery method utilizing computers and videoconferencing equipment to connect providers to specialists in different locations

HealthCheck
HealthCheck is Wisconsin's name for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. HealthCheck is a preventive health care program for all Anthem members enrolled in BadgerCare Plus and Medicaid SSI who are under the age of 21 and meet the physical exam requirements for programs such as:

- Head Start.
- Supplemental Nutrition Program for Women, Infants and Children (WIC).
- School physicals.

To be considered a comprehensive HealthCheck screen, the provider must assess and document the following:

- Complete health and developmental history, including anticipatory guidance
- Comprehensive unclothed physical exam
- Age-appropriate vision screening exam
- Age-appropriate hearing screening exam
- Oral assessment plus referral to a dentist beginning at 1 year of age
- Appropriate immunizations according to age and health history
- Appropriate laboratory tests, including blood lead level testing when age-appropriate
**HealthCheck: Provider Target Levels**

State of Wisconsin and federal requirements provide HealthCheck guidelines to which providers must adhere. Providers also must achieve a threshold of at least 80% of allowable screenings. For more information, see the Vaccines and Immunizations page on the Centers for Disease Control and Prevention (CDC) website: [www.cdc.gov](http://www.cdc.gov).

Comprehensive HealthCheck screenings limits for each member in a consecutive 12-month period are as follows:

- Birth to 1st birthday: six screenings
- 1st to 2nd birthday: three screenings
- 2nd to 3rd birthday: two screenings
- 3rd to 6th birthday: one screening/year
- 6th to 21st birthday: one screening every other year

Wisconsin’s ForwardHealth allows one screening per year.

We’ll provide you with complete information regarding the percentage of allowable HealthCheck screenings your clinic has completed. ForwardHealth has developed and makes available free-of-charge forms that meet the documentation requirements of the program. Use of these forms is optional and providers and clinics that have developed their own documentation systems may continue to do so. The provider’s documentation must demonstrate that all areas listed in the Preventive Care: HealthCheck section have been assessed and are included in the member’s medical record. For more information, go to ForwardHealth website at [www.forwardhealth.wi.gov](http://www.forwardhealth.wi.gov) and:

1. Select Providers.
2. Under Quick Links, select Forms.
3. Scroll down to the HealthCheck Forms section and select the form you need.

**HealthCheck: Provider Responsibilities**

- Document all health care screenings, immunizations, procedures, health education and counseling in the member’s medical record.
- Refer members to dentists, optometrists, ophthalmologists or other specialists as needed. Document all referrals in the member’s medical record.
- Schedule preventive care appointments for members under the age of 21 following the American Academy of Pediatrics (AAP) periodicity schedule. For more information, go to the AAP website: [www.healthychildren.org](http://www.healthychildren.org).
- Provide immunizations as needed and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP) and the AAP. An instant childhood immunization schedule is available on the CDC website: [www.cdc.gov](http://www.cdc.gov).
- Refer members to the county health department and maintain a record of the child’s immunization status if the provider does not routinely administer immunizations as part of his or her practice.

If the parent or guardian of a BadgerCare Plus or Medicaid SSI member requests a comprehensive HealthCheck examination, the examination must be provided within the following time frames:

- Within 30 days: If the member is under 1 year of age and the screening is due within 30 days. If the screening is not due within 30 days, the provider must schedule the appointment in accordance with the periodicity schedule.
- Within 60 days: If the member is over 1 year of age and the screening is due within 60 days. If the screening is not due within 60 days, the provider must schedule the appointment in accordance with the periodicity schedule.
Please note: As a condition of certification as a provider for BadgerCare Plus and Medicaid SSI members, Anthem must share member immunization status with local health departments and other nonprofit HealthCheck providers upon request and without member authorization. The Wisconsin Department of Health Services (DHS) also requires that local health departments and other nonprofit HealthCheck providers share the same information with Anthem upon request. This provision ensures proper coordination of immunizations and prevents duplication of services. In addition, Anthem requires that the majority of network providers have a signed user agreement with the Wisconsin Immunization Registry (WIR).

HealthCheck: Anthem Reminders
Anthem has developed intervention strategies to keep members up-to-date with the HealthCheck program. These intervention strategies include the following reminders:

- Immunization reminder calls at 3, 6, 9, 12, 15 and 18 months of age
- Preventive care calls to members ages 2 to 20 during their birth months

Please note: For ForwardHealth and Anthem to recognize and reimburse the visit as a complete HealthCheck screening or exam, providers must assess and document all age-specific components.

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

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

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

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

As part of the New Baby, New Life program, members are offered the My Advocate™ program. This program provides pregnant women proactive, culturally appropriate outreach and education through interactive voice response (IVR), text or smartphone application. This program does not replace the high-touch case management approach for high-risk pregnant women; however, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers, and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate, visit www.myadvocatehelps.com. Our case managers are here to help you. If you have a member in your care that would benefit from case management, call us at 1-855-558-1443. Members can also call our 24/7 NurseLine at 1-800-690-7800, 24 hours a day, 7 days a week.
You and Your Baby in the NICU program

For parents with infants admitted to the Neonatal Intensive Care Unit (NICU), we offer the You and Your Baby in the NICU program. Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. Parents are provided with an education resource outlining successful strategies they may deploy to collaborate with the care team.

Disease Management

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

- Asthma
- Chronic obstructive pulmonary disorder
- Congestive heart failure
- Coronary artery disease
- Diabetes
- HIV/AIDS
- Child/adolescent major depressive disorder
- Major depressive disorder
- Schizophrenia

In addition to these nine condition-specific Disease Management programs, our approach allows us to manage members with multiple conditions like substance use disorders, bipolar disorder and hypertension.

The Disease Management Centralized Care Unit (DMCCU) also offers weight management and smoking cessation services.

Program Features

- Proactive identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education including primary prevention, behavior modification programs, compliance/surveillance
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

Anthem Disease Management clinical practice guidelines are located at https://mediproviders.anthem.com/wi. A copy of the guidelines can be printed from the website or you can contact Provider Services at 1-855-558-1443 to receive a copy.

Who is Eligible?

All members with the above listed conditions/diagnoses are eligible for Disease Management services. Members are identified through continuous case finding efforts that include but are not limited to welcome calls, claims mining and referrals.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and case management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their disease. They are provided with continuous education on self-management concepts, which include primary prevention, coaching related to healthy behaviors and compliance/surveillance as well as case/care management for high-risk members. Program evaluation,
outcome measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

Disease Management Provider Rights and Responsibilities
The provider has the right to:

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

Hours of Operation
Anthem case managers are licensed nurses and are available Monday through Friday from 8:30 a.m. to 5:30 p.m. local time. Confidential voicemail is available 24 hours a day.

Contact Information
Call 1-888-830-4300 to reach a case manager. Additional information about disease management can be obtained by visiting https://mediproviders.anthem.com/wi and selecting Medical > Disease Management Centralized Care Unit. Members can obtain information about our DMCCU program by calling 1-888-830-4300 TTY (711).

Women, Infants and Children Program
The special supplemental nutrition program for Women, Infants and Children (WIC) serves to safeguard the health of low-income women, infants and children up to age 5 who are at nutritional risk. WIC provides nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

Providers are responsible for:

- Identifying if a member is eligible for WIC and referring that member to the WIC program.
- Informing and educating eligible members of the availability of WIC services, including availability of food vouchers, nutrition education classes and community referrals.
- Providing written materials about WIC services in the provider’s office.

Member eligibility is contingent upon meeting WIC's nutritional risk requirement, as well as the following:

- A woman who is pregnant, up to six weeks after the birth
- A woman who is breastfeeding, up to the infant's 1st birthday
- An infant, up to the infant's 1st birthday
- A child at nutritional risk, up to the child's 5th birthday

The nutritional risk requirement means that an individual has medically-based or dietary-based conditions. Examples are as follows:

- Medically based conditions include anemia, underweight or a history of poor pregnancy outcomes
• Dietary-based conditions include a failure to meet dietary guidelines or inappropriate nutrition practices.

For more information about the WIC program, go to the WIC website: www.dhs.wisconsin.gov/wic.

24/7 NurseLine
We recognize that questions about health care prevention and management do not always come up during office hours. The 24/7 NurseLine, a phone line staffed by registered nurses, provides a powerful provider support system and is a component of after-hours care. The 24/7 NurseLine allows members to closely monitor and manage their own health by giving members the ability to ask questions whenever the need arises. The 24/7 NurseLine is available 24 hours a day, 7 days a week.
Phone: 1-855-690-7800
TTY: 711

Members may contact the 24/7 NurseLine for:
• Self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments.
• Access to specialized nurses trained to discuss health issues specific to our teenage members.
• Information on more than 300 health care topics through the 24/7 NurseLine audio tape library.

Nurses on 24/7 NurseLine have access to telephone interpreter services for callers who do not speak English. All calls are confidential.

Pharmacy Lock-In Initiative
In conjunction with our initiative to reduce inappropriate use of the emergency room (ER), a lock-in program has been developed to decrease inappropriate use of the ER for pain management and drug-seeking behavior. Members may choose a primary prescriber and a pharmacy; Anthem will assist the member in finding a prescriber if needed. If the member does not do this, they’re assigned a prescriber and pharmacy by the state. Providers assigned to the member receive information on members who are assigned to the lock-in program.

Smoking Cessation
Anthem supports the National Cancer Institute's health education program for members who want to quit smoking. The Smoking Cessation program's goals are to:
• Assist members in improving their health status and quality of life by becoming more actively involved in their own care.
• Encourage members to quit smoking.
• Offer members resources and education as a means of supporting tobacco cessation efforts.

The National Cancer Institute has developed a booklet called Clearing the Air. The booklet provides tips to support tobacco cessation by identifying available resources and offering tools for quitting such as:
• Winning strategies of successful quitters.
• Coping skills for fighting the urge to smoke.
• Strategies for success after a relapse.
• National Quit Line contact information.

National Cancer Society Smoking Quit Line: 1-877-44U-QUIT (1-877-448-7848)
After enrollment, a member may request the Clearing the Air booklet by using the contact information provided in the plan’s welcome packet, contacting our 24/7 NurseLine, or talking to Medical Management nurses or social workers. The booklet is also available to download from the following websites:
National Cancer Institute: https://pubs.cancer.gov
Smokefree.gov: smokefree.gov

Provider Assessment of Tobacco Use
The following are guidelines providers should use to help members quit smoking:
- Assess members’ smoking status and offer advice about quitting.
- Use the state’s online Notification of Pregnancy form as a way to notify us, through the state, of pregnant women who smoke. Women are more likely to quit smoking during pregnancy.
- Offer members resources to stop smoking, including the Clearing the Air program information from the National Cancer Institute.
- Refer members to Wisconsin's help line to stop smoking: 1-800-QUIT-NOW (1-800-784-8669).

Tobacco use disorder is one of the key initiatives the state of Wisconsin is focusing on for HMO patients. The state is measuring the percentage of BadgerCare Plus members who are 12 years of age and older and identified as tobacco users receiving tobacco counseling.

The goals are for patients with tobacco use disorder to receive tobacco counseling and be identified through the claims submission process. Behavioral health and medical services providers should use the appropriate CPT and diagnosis code for their provider type.

SSI Enhanced Care Program
To serve the special health care needs of the Medicaid SSI population, Anthem has developed a team-based, member-centric care management program that coordinates and integrates all aspects of these members’ health care. Anthem’s Care Management team conducts a health needs assessment of each member to assist in developing a comprehensive care plan, using a member-centric, culturally competent and collaborative approach to care. Team members include licensed health care professionals with expertise across medical, mental and behavioral health, and social determinants of health. The team coordinates with the member’s PCP, medical and behavioral health specialists, dentists, and other community resources as driven by the member’s care plan.
CHAPTER 8: CLAIMS AND BILLING

Provider Services:  1-855-558-1443
Provider Services fax:  1-800-964-3627
Hours of operation:  Monday to Friday, 8 a.m. to 5 p.m.

Overview
Having a fast and accurate system for processing claims allows providers to manage their practices and our members’ care more efficiently. With that in mind, we’ve made claims processing as streamlined as possible. Share the following guidelines with your staff, billing service and electronic data processing agents:

- Submit clean claims, making sure the right information is on the right form.
- Submit claims as soon as possible after providing service.
- Submit claims within the contracted filing time limit.

Providers can check claim status through Availity at www.availity.com. Providers will need to be registered with Availity to access the secure portion of the website. Once signed up, you can log in to a single account and perform numerous administrative tasks for patients covered by us or other selected payers. Providers may also access Availity from our website at https://mediproviders.anthem.com/wi by selecting Login or Register. Detailed information on accessing Availity is available at www.availity.com or on our website.

In this chapter, we also provide a detailed list of the following:

- Covered services
- Clinical submission categories
- Common reasons for rejected and returned claims
- Reimbursement policies

Submitting Clean Claims
Claims submitted correctly the first time are called clean, meaning that all required fields have been filled in and that the correct form was used for the specific type of service provided.

A claim submitted with incomplete or invalid information may be returned. If you use Electronic Data Interchange (EDI), claims will be returned for incomplete or invalid information. Claims also may be returned if they are not submitted with the proper HIPAA-compliant code set. In each case, an error report will be sent to you and the claim will not be sent through for payment. You and your staff are responsible for working with your EDI vendor to ensure that errored out claims are corrected and resubmitted.

Generally, there are two types of forms you’ll need for reimbursement:

- CMS-1500 for professional services: www.cms.gov/Medicare/CMS-Forms
- CMS-1450 (UB-04) for institutional services: www.cms.gov/Regulations-and-Guidance

CMS forms are located at www.cms.gov. These forms are available in both electronic and hard copy/paper formats.

Please note: Using the wrong form or not filling out the form correctly or completely causes the claim to be returned, resulting in processing and payment delays.

International Classification of Diseases, 10th Revision (ICD-10)
As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U. S. Department of Health and Human Services (HHS).
What is ICD-10?
International Classification of Diseases, 10th Revision (ICD-10) is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes; and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:
- ICD-10-CM (Clinical Modification) used for diagnosis coding
- ICD-10-PCS (Procedure Coding System) used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States

ICD-10-CM replaced the code sets, ICD-9-CM, Volumes 1 and 2 for diagnosis coding, and ICD-10-PCS replaced ICD-9-CM, Volume 3, for inpatient hospital procedure coding.

Claims Submission Methods
There are two methods for submitting a claim:
- Electronically (preferred)
- Paper or hard copy

The Availity web portal offers a variety of online functions to help you reduce administrative costs and gain extra time for patient care by eliminating paperwork and phone calls. You will need to sign up to access this new portal. Once signed up, you can log in to a single account and perform numerous administrative tasks for patients covered by Anthem BadgerCare Plus or Medicaid SSI or by other payers. Claims can be submitted electronically through Availity web portal. For more information about Availity such as how to register, training opportunities and more, visit www.availity.com.

Electronic Claims
Electronic filing methods are preferred for accuracy, convenience and speed. EDI allows providers and facilities to submit and receive electronic transactions from their computer systems. For questions about EDI, contact the EDI Solutions Helpdesk: 1-800-470-9630.

Anthem’s payer identification number:
- Professional: 00950
- Institutional: 00450

The EDI Solutions Helpdesk can assist with any of the following:
- Learn more about EDI and how to get connected
- Submit claims electronically to Anthem, if your system is compatible
- Get technical assistance and support

Wisconsin providers have access to use any EDI clearinghouse connected to the Anthem Enterprise EDI Gateway. If you use EDI, submit the following provider information:
- Provider name
- Individual or group national provider identifier (NPI), if applicable
- Federal provider tax identification number (TIN)
- Anthem’s payer identification number: (being verified)
After submitting electronic claims, monitor claim status by doing the following:

- Access Availity, the secure provider portal on our website: https://mediproviders.anthem.com/wi. Select Login or Register to access the secure site.
- Watch for and confirm Plan Batch Status Reports from your vendor/clearinghouse to ensure your claims have been accepted by Anthem.
- Correct and resubmit Plan Batch Status Reports and error reports electronically.
- Correct errors and electronically resubmit immediately to prevent denials due to late filing.

Please note: A front-end editing process may occur with your contracted EDI vendor or clearinghouse to catch mistakes. If claims are not in a HIPAA-compliant transaction code set, your claim may be errored out by your EDI vendor. An error report will be sent to you and your claim will not be sent through for payment. Review the error report, make the necessary changes and file again. Claims from providers who are not Wisconsin Medicaid-certified will be rejected during the front-end editing.

Paper Claims

Paper claims are scanned for clean and clear data recording. To get the best results, paper claims must be legible and submitted in the proper format. Anthem accepts black and white paper claim forms as well as original red and white paper claim forms.

Follow these requirements to speed processing and prevent delays:

- Use the correct form.
- Use black or blue ink. Do not use red ink because the scanner may not be able to read red ink.
- Use the Remarks field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to Anthem and retain a copy for your records.
- Do not staple original claims together; Anthem will consider the second claim as an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form. To help our equipment scan accurately, leave a quarter-inch border on the left and right sides of the form after removing perforated sides.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Do not highlight any fields on the claim forms or attachments. Highlighting makes it more difficult to create a clear electronic copy when the document is scanned.
- If using a dot matrix printer, do not use “draft mode” because the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.

If you submit paper claims, you must include the following provider information:

- Provider name
- Provider billing address, including street, city and ZIP+4 (P.O. Box is not accepted.)
- Group and rendering provider NPI
  - Note: Personal care agencies must submit their Medicaid ID.
- Federal provider tax identification number (TIN)
- Anthem’s payer identification number (Professional: 00950; Institutional: 00450)

The group/rendering provider taxonomy code is required on all claims.
Please note: Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim. Claims with attachments should be submitted on paper. Mail paper claims to:

Anthem Blue Cross and Blue Shield - Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

After filing a paper claim, you should receive a response from Anthem within 30 business days after we receive the paper claim. If the claim contains all required information, Anthem enters the claim into the claims system for processing and sends you either a remittance advice (RA) or a claims disposition notice (CDN) when the claim is finalized.

National Provider Identifier
The national provider identifier (NPI) is a 10-digit, all numeric identifier. NPIs are issued only to providers of health services and supplies. As a provision of HIPAA, the NPI has been established to improve efficiency and reduce fraud and abuse.

NPIs are divided into two types:
• Type 1: individual providers
• Type 2: institutional providers

Providers may apply for an NPI online at the National Plan and Provider Enumeration System (NPPES) website: https://nppes.cms.hhs.gov.

The following websites offer additional NPI information:
• CMS: www.cms.gov
• NPPES: https://nppes.cms.hhs.gov
• Workgroup for Electronic Data Interchange: www.wedi.org
• National Uniform Claims Committee: www.nucc.org

Enrollment in Wisconsin Medicaid
To be reimbursed for services by Anthem, providers must complete Wisconsin Medicaid’s provider enrollment process. Providers enroll by completing an online enrollment application using the ForwardHealth website at:

Filing Limits
Claims Filing Limits
Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied.

Please note: Anthem is not responsible for a claim never received. If a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. Claims must pass basic edits to be considered received. To avoid missing deadlines, submit clean claims as soon as possible after delivery of service.
Filing limits are determined as follows: If Anthem is the primary payer, the time period is 180 days from the last date of service on the claim. If the member has other health insurance that is primary, timely filing is counted from the date of the explanation of payment of the other carrier.

**Claim Forms and Filing Limits**
Refer to your Anthem provider contract to confirm timely filing limits, which may be different from what is stated below.

<table>
<thead>
<tr>
<th>Form</th>
<th>Type to be Billed</th>
<th>Time Limit to File</th>
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<tbody>
<tr>
<td><strong>CMS-1500 Claim Form</strong></td>
<td>- Physician, physician groups and other professional services</td>
<td>Submit within 180 days of service date.</td>
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<td>- Specific ancillary services, including:</td>
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<td>o Audiologists</td>
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<td></td>
<td>o Ambulance</td>
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<td>o Ambulatory surgical center</td>
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<td>o Dialysis</td>
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<td>o Durable medical equipment (DME)</td>
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<td>o Diagnostic imaging centers</td>
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<td>o Hearing aid dispensers</td>
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<td>o Laboratories</td>
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<td>o Mental health and substance abuse clinics</td>
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<td>o Occupational therapy</td>
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<td>o Orthotics</td>
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<td>o Physical therapy</td>
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<td>o Speech therapy</td>
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<td>Some ancillary providers may use a CMS-1450 form if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.</td>
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</table>

| CMS-1450 Claim Form      | - Skilled nursing facility (SNF)                                                 | Submit within 180 days of service date or date of discharge if the services are related to an inpatient stay. |
|                          | - Hospitals, hospices, institutions and home health services                    |                                                                                   |

**Other Filing Limits**

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<tr>
<th>Action</th>
<th>Details</th>
<th>Time Frame</th>
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<tbody>
<tr>
<td>Third-Party Liability or Coordination of Benefits (COB)</td>
<td>If the claim has third-party liability, COB or requires submission to a third party before submitting to Anthem, timely filing is counted from the date of the explanation of payment of the other carrier.</td>
<td>Submit within 180 days from the date of the explanation of payment of the other carrier.</td>
</tr>
<tr>
<td>Checking Claim Status</td>
<td>Check claim status at any time by calling Provider Services or accessing our secure provider portal at <a href="http://www.availity.com">www.availity.com</a>. Refer to the Monitoring Submitted Claims section of this chapter for details.</td>
<td></td>
</tr>
<tr>
<td>Claim Correspondence or Corrected Claim</td>
<td>If we request additional information or a correction to a claim, a claim follow-up is needed and you must submit a corrected claim.</td>
<td>Return the requested information within 180 days of the date of service or per your contract.</td>
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<tr>
<td>Action</td>
<td>Details</td>
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| Claim Appeal| Formal claim payment appeals can be submitted:  
   - Verbally by calling Provider Services at **1-855-558-1443** (Monday to Friday, 8 a.m. to 5 p.m.).  
   - In writing to:  
     Anthem Blue Cross and Blue Shield  
     Claim Appeals  
     P.O. Box 61599  
     Virginia Beach, VA 23466-1599  
   - Online at **https://www.availity.com**.                                                                                                                                                                     | Submit within 180 days from the date of the explanation of payment, or per your contract. |
| Provider Dispute | We may request additional information on the dispute filed.                                                                                                                                                 | Return the requested information within 60 days of the date of the request.                   |

**Claims from Noncontracted Providers**

Anthem accepts the following claims from noncontracted providers under certain conditions and within certain time frames:

- Emergency services: 365 days from date of service or discharge date
- Medicaid enrolled: 365 days with precertification if services are not available in Wisconsin
- Newly Medicaid-enrolled: Within 365 days of the date the new provider identifier is issued and within 365 days of the date of service

**Member Copayments and Balance Billing**

Providers contracted with Anthem may not balance bill our members, meaning that providers may not collect payment from a member for covered services above the amount Anthem pays to the provider.

A member may request a noncovered service or a covered service for which prior authorization was denied. When precertification of a covered service is denied, the provider must establish and demonstrate compliance with the following before collecting payment from the member:

- Establish that precertification was requested and denied before rendering service.
- Request a review of Anthem’s authorization decision.
- Notify the member that the service requires precertification and Anthem has denied authorization. If out-of-network, the provider also must explain to the member that covered services may be available without cost when provided by an in-network provider. Precertification for out-of-network services is required.
- Inform the member of his or her right to file a grievance if the member disagrees with the decision to deny authorization.

The charge for a service may be collected from the member if the following conditions are met prior to the delivery of that service:

- The member accepts responsibility for payment and the provider and member make payment arrangements for the service.
- If the provider uses a waiver to establish member responsibility for payment, the waiver must meet the following requirements:
  - The waiver is signed only after the member receives appropriate notification and before services are rendered.
o The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.

o A waiver must be obtained for each encounter or member visit that falls under the scenario of the noncovered services. Providers may not use nonspecific patient waivers.

o The waiver must specify the date services were provided and which services fall under the waiver’s application.

o The waiver must show the cost of the services and have a payment plan established.

The provider has the right to appeal a denial of Anthem payment resulting from a denial of authorization.

**Coordination of Benefits (COB)**

If a member carries insurance through multiple insurers, Anthem will coordinate the benefits to ensure maximum coverage without duplication of payments. Providers must submit COB claims to the primary carrier before submitting to Anthem. After submitting the claim to the primary carrier, submit a claim for the total billed charges to Anthem along with a copy of the primary carrier’s remittance advice (RA). Indicate the other coverage information on the appropriate claim form. If you need to coordinate benefits, include at least one of the following items from the other health care program:

- Third-party RA
- Third-party letter explaining either the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other health care program first. Make sure the information you submit explains all coding listed on the other carrier’s RA or letter. We cannot process the claim without this information. Timely filing is counted from the date of the explanation of payment of the other carrier.

**Subrogation**

Anthem follows the state of Wisconsin's subrogation laws as cited in the Administrative Code DHS 106.03(8) – personal injury and workers’ compensation claims: If a provider treats a recipient for injuries or illness sustained in an event for which liability may be contested or during the course of employment, the provider may elect to bill Medicaid for services provided without regard to the possible liability of another party or the employer. Alternatively, the provider may elect to seek payment by joining in the recipient’s personal injury claim or workers’ compensation claim, but in no event may the provider seek payment from both Medicaid and a personal injury or workers’ compensation claim. After the provider accepts the Medicaid payment for services provided to the recipient, the provider shall not seek or accept payment from the recipient’s personal injury or workers’ compensation claim.

Providers must choose which method of payment they will pursue at the time of treatment and submit claims either to Anthem or to the member’s personal injury/workers’ compensation carrier. The law does not allow providers to submit claims to both carriers. If a provider submits to both carriers, receives payment from both carriers, and subsequently sends a refund to Anthem, submission of the refund still could be considered a fraudulent action. Seeking or accepting payment from both carriers is prohibited by law.

**Claims Filed With the Wrong Plan**

If you file a claim with the wrong insurance carrier, Anthem will process your claim within 180 days from the date of service.
Payment of Claims
After receiving a claim, Anthem:
- Analyzes the claim for covered services.
- Generates a remittance advice statement, summarizing the services rendered and the action taken.
- Sends the appropriate payment to the provider.
- Sends a CDN to the provider with the specific claims processing information.

Anthem will finalize a clean electronic or paper claim within 30 days from the date the claim is received.

Monitoring Submitted Claims
After submitting paper or electronic claims, you can monitor and make changes to the claim by:
- Checking claim status on the secure provider portal of our website: [https://mediproviders.anthem.com/wi](https://mediproviders.anthem.com/wi). Select Login or Register to access the secure site.
- Calling Provider Services: 1-855-558-1443.
- Confirming receipt of Plan Batch Status Reports from your vendor/clearinghouse to ensure claims have been accepted by Anthem.
- Correcting and resubmitting Plan Batch Status Reports and error reports electronically.
- Correcting errors and immediately resubmitting to prevent denials due to late filing.

Electronic Funds Transfers and Electronic Remittance Advices
Anthem allows electronic funds transfer (EFT) for claims payment transactions, meaning that claims payments are deposited directly into a previously selected bank account. Enroll in this service by calling Provider Services: 1-855-558-1443.

Anthem providers can choose to receive electronic remittance advices (ERAs). ERAs are received through an electronic mailbox that has been set up between Anthem, the provider and/or the provider's clearinghouse. In support of HIPAA administrative simplification requirements, Anthem discontinued mailing paper remittances to all providers registered for ERA effective October 1, 2015. In-network providers can continue to access copies of paper remits online via the Availity web portal. For more information, call Provider services: 1-855-558-1443.

Claims Overpayment Recovery and Refund Procedure
Anthem seeks recovery of all excess claims payments from the person or entity to whom the benefit check was made payable. When an overpayment is discovered, Anthem initiates the overpayment recovery process by sending written notification. If you are notified by Anthem of an overpayment or discover that you have been overpaid, mail the refund check, along with a copy of the notification or other supporting documentation, to the following address:

Anthem Blue Cross and Blue Shield in Wisconsin  
P.O. Box 933657  
Atlanta, GA 31193-3657

Log in to our secure provider website at [https://mediproviders.anthem.com/wi](https://mediproviders.anthem.com/wi) for the Recoupment Notification Form and Overpayment Refund Notification Form, located under Claims Forms.

If you believe the overpayment notification was created in error, contact Provider Services: 1-855-558-1443.
For claims re-evaluation, send your correspondence to the address indicated on the overpayment notice. If Anthem does not hear from you or receive payment within 30 days, the overpayment amount is deducted from your future claims payments.
Inpatient Clean Claims Review Process: Equian
Anthem partners with Equian, a claims review service provider. Equian applies condition-specific medical and financial expertise to review high-dollar hospital bills for clinical appropriateness, billing errors and variances from industry billing practices. If Equian identifies any discrepancies during its claim review, they work directly with the provider to resolve the adjustments identified.

An itemized bill will be required for all diagnosis-related group (DRG) outliers paying $25,000 or above with a $2,500 outlier payable and above. If an itemized bill is not received with the initial claim, Anthem will request the documentation; however, submitting with the initial claim will avoid unnecessary delay.

Third-Party Recovery
Providers may not interfere with or place any liens upon Wisconsin’s or Anthem’s right, acting as Wisconsin’s agent, to recovery from third-party billing.

Claim Resubmissions
If you have not heard from Anthem regarding a submitted claim after 30 business days from the submission of the claim, contact us to determine the status. To determine whether you need to resubmit a claim:
• Check on our secure provider website: https://mediproviders.anthem.com/wi. Select Login or Register to access the secure site.
• Contact Provider Services: 1-855-558-1443.

Returned Claims
Claims Returned for Additional Information
Anthem will send you a request for additional or corrected information when the claim cannot be processed due to incomplete, missing or incorrect information. Anthem also may request additional information retroactively for a claim already paid. If you receive a request from Anthem for additional information, you must provide that information within 180 days of the date of service, or your claim may be denied.

To submit additional or corrected information, you should send:
• All supporting documentation you believe to be important or that is specifically requested by Anthem.
• A copy of the original, corrected CMS-1500 or CMS-1450 claim form.

Please note: Many of the claims returned for further information are returned for common billing errors.

Common Reasons for Rejected and Returned Claims
Many of the claims returned for further information are returned for common billing errors.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Explanation</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s ID number is incomplete</td>
<td></td>
<td>Use the member’s ID number on the ForwardHealth card.</td>
</tr>
<tr>
<td>Problem</td>
<td>Explanation</td>
<td>Resolution</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Duplicate claim submission</td>
<td>Overlapping service dates for the same service create a question about duplication. Claim was submitted to Anthem Blue Cross and Blue Shield twice without additional information for consideration.</td>
<td>List each date of service, line by line, on the claim form. Avoid spanning dates, except for inpatient billing. Read remittance advices (RAs) and claim disposition notices (CDNs) for important claim determination information before resubmitting a claim. Additional information may be necessary.</td>
</tr>
<tr>
<td>Missing codes for required service categories</td>
<td>Current HCPCS and CPT manuals must be used because changes are made to the codes quarterly or annually. Manuals may be purchased at any technical bookstore, or through the American Medical Association (AMA) or the Practice Management Information Corporation.</td>
<td>Verify all services are coded with the correct codes (see lists provided). Check the codebooks or ask someone in your office who is familiar with coding.</td>
</tr>
<tr>
<td>Unlisted code for service</td>
<td>Some procedures or services do not have an associated code; use an unlisted procedure code.</td>
<td>Anthem needs a description of the procedure and medical records to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer’s invoice.</td>
</tr>
<tr>
<td>By report code for service</td>
<td>Some procedures or services require additional information.</td>
<td>Anthem needs a description of the procedure and medical records to calculate reimbursement. DME, prosthetic devices, hearing aids and blood products require a manufacturer’s invoice.</td>
</tr>
<tr>
<td>Unreasonable numbers submitted</td>
<td>Unreasonable numbers, such as “9999”, may appear in the Service Units fields.</td>
<td>Check your claim for accuracy before submission.</td>
</tr>
<tr>
<td>Submitting batches of claims</td>
<td>Stapling claims together may make the subsequent claims appear to be attachments, rather than individual claims.</td>
<td>Clearly identify each individual claim and do not staple it to another claim.</td>
</tr>
</tbody>
</table>

**Common Claim Issues vs. Payment Appeal**

The following table provides examples of claim-related issues that should not go through the payment reconsideration or appeal process. We’d like to provide guidance on the most efficient way to resolve these common claim issues.
Note: To download a copy of the Claim Correspondence form, go to our provider website at https://mediproviders.anthem.com/wi.

<table>
<thead>
<tr>
<th>Type of Issue</th>
<th>What Do I need to Do?</th>
<th></th>
</tr>
</thead>
</table>
| **EOP requests for supporting documentation** (sterilization/hysterectomy/abortion consent forms, itemized bills and invoices) | Submit a Claim Correspondence form, a copy of your EOP and the supporting documentation to:                                                                                                                        | Claims Correspondence  
Anthem Blue Cross and Blue Shield  
P.O. Box 61599  
Virginia Beach, VA 23466-1599  

EOP requests for medical records                                                                                                                                                                                                                                                                                                                                 |
| Submit a Claim Correspondence form, a copy of your EOP and the medical records to:                                                                                                 | Claims Correspondence  
Anthem Blue Cross and Blue Shield  
P.O. Box 61599  
Virginia Beach, VA 23466-1599  

Need to submit a corrected claim due to errors or changes on original submission                                                                                                                                                                                                                                                                                                                                                           |
| Provided the claim was originally received timely, a corrected claim must be received within 180 day from the date of service. Submit a Claim Correspondence form and your corrected claim to:                                                                 | Claims Correspondence  
Anthem Blue Cross and Blue Shield  
P.O. Box 61599  
Virginia Beach, VA 23466-1599  

Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We’ll return claims that have been altered with an explanation of the reason for return.                                                                                                                                                                                                 |                                                                                                                                                                                                 |
| Submission of coordination of benefits (COB)/third-party liability (TPL) information | Submit a Claim Correspondence form, a copy of your EOP and the COB/TPL information to:                                                                                                                                  | Claims Correspondence  
Anthem Blue Cross and Blue Shield  
P.O. Box 61599  
Virginia Beach, VA 23466-1599  

Claims Payment Appeals  
If a provider disagrees with the outcome of a claim decision, the provider may use the claims payment appeals process to challenge the decision. Submit a verbal or written request to the plan for
reconsideration. Due to the nature of appeals, some cannot be accepted verbally and therefore must be submitted in writing. The guidance below will be used in determining the appropriate submission method. To file a verbal appeal, call Provider Services at 1-855-558-1443. If the appeal must be submitted in writing, or if the provider wishes to use the written process instead of the verbal process, the appeal should be submitted to:

Anthem Blue Cross and Blue Shield - Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

For participating and nonparticipating providers, the payment appeal for reconsideration, whether verbal or written, must be received by the plan within 180 calendar days of the explanation of payment (EOP) paid date or recoupment date, or the time limit set forth in the provider’s contract.

When submitting the appeal verbally or in writing, you must provide:

1. A listing of disputed claims.
2. A detailed explanation of the reason for the appeal.
3. Supporting statements for verbal appeals and supporting documentation for written.

The following guidance will be used in determining the appropriate reconsideration submission method.

<table>
<thead>
<tr>
<th>Issue type</th>
<th>Submission method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denied for timely filing</td>
<td>• If plan system error, then verbal</td>
</tr>
<tr>
<td></td>
<td>• If provider needs to submit paper proof, then written</td>
</tr>
<tr>
<td>Denied for no authorization</td>
<td>• If authorization on file and plan system error, then verbal</td>
</tr>
<tr>
<td></td>
<td>• If provider needs to submit paper proof, then written</td>
</tr>
<tr>
<td>Authorization issue</td>
<td>• If authorization is on file and clear plan system error, then verbal</td>
</tr>
<tr>
<td></td>
<td>• If provider needs to submit paper proof or requesting retro review, then written</td>
</tr>
<tr>
<td>Denied for needing medical records*</td>
<td>• If records have not been received prior to call, then written</td>
</tr>
<tr>
<td></td>
<td>• If records received and on file, then verbal</td>
</tr>
<tr>
<td></td>
<td>* Denials issued for this reason are considered nonclean claims and should not be logged as appeals. These will be treated as inquiries/correspondence.</td>
</tr>
<tr>
<td>Provider says not paid according to their contract, at appropriate DRG or per diem rate, fee schedule, Service Case Agreement or appropriate bed type, etc.</td>
<td>Verbal, written or via the Availity Portal</td>
</tr>
<tr>
<td>Provider indicates member doesn't have other health insurance (OHI), but claim denied for OHI</td>
<td>Verbal, written or via the Availity Portal</td>
</tr>
<tr>
<td>Claim check denial</td>
<td>Verbal, written or via the Availity Portal</td>
</tr>
<tr>
<td>Denied as duplicate</td>
<td>Verbal, written or via the Availity Portal</td>
</tr>
<tr>
<td>Claim denied related to provider data issue</td>
<td>Verbal</td>
</tr>
<tr>
<td>Retro-eligibility issue</td>
<td>Verbal</td>
</tr>
<tr>
<td>Issue type</td>
<td>Submission method</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Experimental/investigational procedure denial</td>
<td>Verbal, written or via the Availity Portal</td>
</tr>
<tr>
<td>Wrong provider or member selected</td>
<td>Verbal</td>
</tr>
<tr>
<td>Claims data entry error</td>
<td>Verbal</td>
</tr>
<tr>
<td><strong>Second level appeal</strong></td>
<td>Second-level appeals must be submitted in writing to:</td>
</tr>
<tr>
<td></td>
<td>Anthem Blue Cross and Blue Shield</td>
</tr>
<tr>
<td></td>
<td>Claim Appeals</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 61599</td>
</tr>
<tr>
<td></td>
<td>Virginia Beach, VA 23466-1599</td>
</tr>
<tr>
<td></td>
<td>They will not be accepted verbally or via the Availity Portal.</td>
</tr>
<tr>
<td></td>
<td>Second-level written appeals must be received within 30 days from</td>
</tr>
<tr>
<td></td>
<td>the date listed on the first-level resolution letter.</td>
</tr>
</tbody>
</table>

**Claims Payment Appeals Response Timeline**

Claims payment appeals are resolved by Anthem within 45 days of receipt of the verbal or written request. When we uphold or overturn a previous claim disposition, a resolution letter with the details of our decision is sent to the provider.

**State Appeals Process**

If a provider is not satisfied with the outcome of the review process or if we do not respond to an appeal within 45 days, additional steps may be taken:

- Providers may appeal to the Wisconsin DHS in writing within 60 days of the final decision by Anthem or within 60 days from the 45 day timeline allotted to Anthem to respond.
- Providers must use the DHS form when submitting the appeal for DHS review. All elements of the form must be completed when submitting the form, including medical records for an appeal regarding medical necessity.

The DHS form is available at [www.dhs.wisconsin.gov](http://www.dhs.wisconsin.gov). On the DHS home page, scroll to the **Favorite Searches** section and select the **Forms** option. In the Search DHS Forms Library field, enter search criteria (for example, payment appeal) and select the **Search** button. Mail or fax the completed form to:

- BadgerCare Plus and Medicaid Social Security Income (SSI)
  - Managed Care Unit
  - P.O. Box 6470
  - Madison, WI 53716-0470
  - Fax: **1-608-224-6318**.

**Covered Services**

For billing purposes, covered services include but are not limited to:

- Ambulance services
- Audiology services, including hearing aids for adults
- Behavioral health services, including:
  - Inpatient and outpatient behavioral/mental health services
  - Outpatient substance abuse services
  - Detoxification services
  - Psychiatry services
  - Behavioral health and substance abuse counseling services
• Dialysis
• Durable medical equipment and supplies
• Emergency services
• Family planning services
• Home health care services
• Hospital services, including inpatient and outpatient
• Laboratory
• Optometry (glasses and contact lenses, if medically necessary)
• Podiatry
• Prenatal care
• Primary care services
• Radiology, imaging and X-rays
• Specialist services
• Therapies (physical, occupational and speech)
• Transplantation of certain organs and tissues
• Vision, including optometry and glasses

Clinical Submissions Categories
The following is a list of claims categories for which we routinely may require submission of clinical information before or after payment of a claim. If the claim:
• Involves precertification, predetermination or some other form of utilization review including but not limited to claims that are:
  o Pending for lack of precertification.
  o Involving medical necessity or experimental/investigative determinations.
• Requires certain modifiers.
• Includes unlisted codes.
• Is under review to determine if the service is covered; benefit determination cannot be made without reviewing medical records. This category includes but is not limited to specific benefit exclusions.
• Involves termination of pregnancy; all termination of pregnancy claims require review of medical records to determine if: 1) the pregnancy is the result of an act of rape or incest or 2) the woman suffers from a physical disorder, physical injury or physical illness, including a physical condition that endangers the woman’s life and is caused by or arising from the pregnancy itself. In these cases, this condition would, as certified by a provider, place the woman in danger of death unless a termination of pregnancy is performed.
• Involves possible inappropriate or fraudulent billing.
• Is the subject of an internal or external audit, including high-dollar claims.
• Involves individuals under case management or disease management.
• Is under appeal or is otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated.

Other situations in which clinical information might be requested:
• Coordination of benefits
• Quality improvement/assurance efforts
• Recovery/subrogation
• Requests relating to underwriting, including, but not limited to, member or provider misrepresentation/fraud reviews and stop-loss coverage issues

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.
Reimbursement Policies

Reimbursement policies serve as a guide to assist you with accurate claims submissions and outline the basis for reimbursements when services are covered by the member’s Anthem plan. These policies can be accessed at https://mediproviders.anthem.com/wi. The determination that a service, procedure, item, etc. is covered under a member’s benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as the member’s state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claims submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedures Coding Systems (HCPCS) codes and/or revenue codes. The codes denote the service and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

The Anthem reimbursement policies are based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or state contracts, or state, federal, or CMS requirements. System logic or set-up may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

We reserve the right to review and revise our policies periodically when necessary. When there is an update we will publish the most current policies to our provider website under Claims on the Quick Tools menu.

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Reviews and Updates to Reimbursement Policies

Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements, and Anthem business decisions. Updated policies are posted to the Anthem provider website under Claims on the Quick Tools menu.

Reimbursement by Code Definition

Anthem allows reimbursement for covered services based on their procedure code definitions or descriptors unless otherwise noted by state or provider contracts, or state, federal, or CMS requirements. There are eight CPT sections:
1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures
Overview
Providers can depend on efficient claims handling and faster reimbursement when they follow the Anthem professional and ancillary billing requirements. These requirements include reporting standard CPT and HCPCS codes. This chapter is broken down into health service categories to help you find the specific billing requirements and codes you will need for each.

For the most efficient claims processing, accurately completed claims are essential. Follow these general guidelines for claims filing:

- Indicate the billing provider name, address (including ZIP+4) and taxonomy code, as certified with Wisconsin Medicaid in Box 33. Claims submitted with a P.O. Box entered in the address field will be rejected.
- Indicate the rendering provider’s national provider identifier (NPI) number and taxonomy code, as certified with Wisconsin Medicaid in Box 24J of the CMS-1500 form, when appropriate. Missing or invalid numbers may result in nonpayment.
- Use the member’s ID number from the ForwardHealth ID card.
- All providers must be certified by Wisconsin Medicaid in order to bill Anthem.

Preventive Medicine Services for New Patients
Preventive medicine services for a new patient include an initial, comprehensive preventive medical evaluation. This evaluation includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures. For members under age 21, preventive medicine visits are considered HealthCheck visits. CPT codes 99381-99385 and 99391-99395 should only be used to report a comprehensive HealthCheck screen. Other preventive visits should be billed using the appropriate office visit code.

Preventive Medicine Services for Established Patients
Preventive medicine services for an established patient involve re-evaluation and management of existing conditions, if any. This exam includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures.

Behavioral Health
See the Covered and Noncovered Services chapter for more detailed information about behavioral health benefits. Anthem behavioral health has contracted with a network of hospitals and behavioral health practitioners to offer behavioral health services to our members. When rendering medically necessary behavioral health services, bill Anthem using behavioral health CPT and HCPCS codes.

Physical, Speech and Occupational Therapies
All physical, occupational and speech therapy services must be reported on the CMS-1500 claim form, regardless of whether services are rendered in a facility or clinic setting.

Please note: The treatment is limited to 20 visits per therapy discipline per enrollment year. All physical, speech and occupational therapy services require precertification.
Emergency and Related Professional Services
Emergency services, as defined by state and local law, the Provider Agreement, and our member handbook, are reimbursed in accordance with the Anthem Provider Agreement.

Emergency services do not require precertification, so the above statement should not be deleted.

An emergency is any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could:

- Place the member’s health in serious jeopardy. Or, with respect to a pregnant woman, the health of the woman and her unborn child.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction to any bodily organ or part.

Covered emergency services include:

- Hospital-based emergency department services (room and ancillary) needed to evaluate or stabilize the emergency medical or behavioral health condition.
- Professional services by emergency medicine providers.

All members should be referred back to their PCP for follow-up care. Unless clinically required, follow-up care should never occur in a hospital emergency room.

Immunizations Covered By Vaccines for Children (VFC)
Anthem providers who administer vaccines to children through 18 years of age should enroll in the VFC program. Anthem will reimburse only the administration fee for any vaccine available through the VFC program. When billing immunizations, report the appropriate vaccine CPT code.

Maternity Services
Providers may elect to bill maternity services on either a global basis or as individual services. Anthem will only reimburse the global obstetric codes when all antepartum visits, delivery and postpartum care are provided. When a global OB package is not performed, providers may bill only the individual services that were actually provided. Refer to the Maternity Services Reimbursement Policy for a list of services that are not separately reimbursable when a global OB CPT code is billed.

Maternity Services: Newborns
Providers must bill for newborn services with the newborn’s Medicaid ID number; providers may not submit claims with the mother’s Medicaid ID number. Hospitals should submit a newborn report as soon as possible after a baby is born to avoid a delay in establishing the baby’s enrollment in BadgerCare Plus and ensure timely reimbursement for the provider.

Testing for Drugs of Abuse
Providers should follow the CPT coding and coverage requirements published in the ForwardHealth provider manuals when submitting claims for drug abuse testing.

Urgent Care Visits
Urgent care means nonscheduled, nonemergency services required to prevent serious deterioration of a patient’s health as a result of an unforeseen illness or injury. Urgent care visits are reported using the CPT codes for “Office or Other Outpatient Services” and “Place of Service 20 – Urgent Care Facility” (location,
distinct from a hospital emergency room, office or clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention).

**Sterilization**

Sterilization is any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilization does not include medical procedures that may have the effect of producing sterility but were performed for an entirely different purpose, such as removal of a cancerous uterus or prostate gland. To qualify for reimbursement, the following conditions must be met:

- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the surgery date.
- Prior to sterilization, the provider must complete the Consent for Sterilization form, which must be signed by: 1) the member, 2) the interpreter (if one was used), 3) the person who obtained consent, and 4) the physician who performed the sterilization procedure. The form is on the ForwardHealth website at: [https://www.forwardhealth.wi.gov/kw/html/SterilizationInformedConsent.html](https://www.forwardhealth.wi.gov/kw/html/SterilizationInformedConsent.html).

**Please note:** Payment cannot be made to providers of associated services, including hospitals, anesthesiologists, pathologists and radiologists, unless the consent form is completed in an accurate and timely manner. The state of Wisconsin DHS will ask for recoupment of fees from Anthem, which will subsequently be recouped from the provider.

The following are required before performing sterilization:
- Patient has voluntarily given his or her consent to be sterilized.
- Patient was at least 21 years of age on the date informed written consent is obtained.
- Patient is not mentally incompetent.
- Patient is not institutionalized.
- At least 30 days, but no more than 180 days, have elapsed between the date of consent and the sterilization.
- Consent form used is the DHS-mandated form; no other form may be substituted.
- Dates on the consent form cannot be altered.

The following are the exceptions to the 30-day waiting period:
- The sterilization is performed during emergency abdominal surgery and at least 72 hours have passed since the member gave written informed consent for sterilization.
- In the case of premature delivery, the sterilization is performed at the time of premature delivery and written informed consent was given at least 30 days prior to the expected date of delivery and at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.

The provider must follow these sterilization procedures for Anthem to pay the claim:
- At the time of the sterilization consult, the nurse verifies the patient is a member of Anthem. The nurse then attaches the appropriate consent form to the front of the patient's chart.
- The patient completes, signs, and dates the Consent for Sterilization section.
- If an interpreter is necessary, the interpreter signs the consent form.
- The provider completes, signs and dates the Statement of Person Obtaining Consent section, including the name and address of the facility where the procedure will be performed.
- The scheduling nurse schedules surgery. If anything is not in order, the procedure is postponed until the issue is resolved.
- At the post-operative visit, the provider follows the instructions for use of alternative final paragraphs, signs and dates the Physician Statement on the Sterilization Consent Form.
• The provider forwards a copy of the signed Sterilization Consent Form to the facility where the procedure was performed.
• The provider files the original, signed Sterilization Consent Form in the member’s chart.
• The provider sends a signed copy of the Sterilization Consent Form to Anthem, either submitted with the claim or sent separately to the claims department.

Hysterectomy
An Acknowledgment of Receipt of Hysterectomy Information form must be completed prior to a covered, nonemergency hysterectomy, except in the following circumstances:
• The member was already sterile.
• The hysterectomy was required as the result of a life-threatening emergency situation in which the physician determined that prior acknowledgment of receipt of hysterectomy information was not possible.
• The hysterectomy was performed during a period of retroactive member eligibility and one of the following circumstances applied:
  o The member was informed before the surgery that the procedure would make her permanently incapable of reproducing.
  o The member was already sterile.
  o The member was in a life-threatening emergency situation that required a hysterectomy.

A hysterectomy may not be performed solely for the purpose of rendering the member permanently incapable of reproduction. In addition, a hysterectomy may not be performed to correct the following medical conditions:
• Fallen uterus
• Fibroids
• Retroverted uterus

Please note: Payment cannot be made to providers of associated services, including hospitals, anesthesiologists, pathologists and radiologists, unless the Acknowledgment of Receipt of Hysterectomy Information form is completed accurately and in a timely manner. The state of Wisconsin DHS will ask for recoupment of fees from Anthem, which will subsequently be recouped from the provider.

Locate the Acknowledgment of Receipt of Hysterectomy Information form in the ForwardHealth provider online manual under the “Covered and Noncovered Services” section “Surgery Services.”

Providers must follow these hysterectomy procedures for Anthem to pay the claim:
• At the time of the hysterectomy consultation, the nurse verifies that the patient is a member of Anthem. The nurse then attaches the Acknowledgment of Receipt of Hysterectomy Information form to the front of the patient’s chart.
• The member signs the form.
• If an interpreter is necessary, the interpreter signs the form.
• The provider schedules the surgery. If everything is not in order, the procedure is postponed until the issue is resolved.
• The provider returns the signed form to medical records.
• The provider sends a signed copy of the form to Anthem.
• The provider sends a copy of the signed form to the facility where the procedure was performed.
• The provider files the original, signed form in the member’s chart.
**Termination of Pregnancy**

For termination of pregnancy procedures to be covered by the BadgerCare Plus and Medicaid SSI program, the member must meet a requirement listed below:

- The abortion is directly and medically necessary to save the life of the woman. Prior to the termination of the pregnancy, the provider attests in a signed, written statement that, based on his or her best clinical judgment, the termination of pregnancy meets this condition.
- The abortion is due to sexual assault or incest. Prior to the termination of pregnancy, the provider attests in a signed, written statement, in his or her opinion, sexual assault or incest has occurred. The crime must be reported to law enforcement authorities.
- Due to a medical condition that existed prior to the abortion, the provider determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman. Prior to the termination of pregnancy, the provider attests in a signed, written statement that, based on his or her best clinical judgment, the termination of pregnancy meets this condition.

The provider must complete an Abortion Certification Statement attesting to one of the circumstances listed above. In the case of rape or incest, the provider must include evidence that the crime was reported to law enforcement authorities. The Abortion Certification Statement form must be faxed to Anthem’s claims department, along with progress notes and any law enforcement documentation.

Locate the **Abortion Certification Statement** form in the provider online manual under the “Covered and Noncovered Services” section “Surgery Services.”

Anthem reimburses for Mifeprex under the same coverage policy that it reimburses other surgical or medical abortion procedures.

When a termination of pregnancy meets criteria for coverage, office visits and all other medically necessary related services are covered. Treatment for complications arising from a termination of pregnancy are covered, regardless of whether or not the procedure to terminate the pregnancy itself is covered, because the complications represent new conditions, and thus the services are not directly related to the performance of the procedure to terminate the pregnancy.

**Billing Members for Services Not Medically Necessary**

Providers are prohibited from collecting payment from Anthem members for Anthem covered benefits. Members may be billed for noncovered services if they accept financial responsibility and the provider makes payment arrangements with them prior to delivery of the service. The following conditions must be met prior to delivery of the service:

- The member requests a noncovered service or a specific service or item that, in the provider’s opinion, may not be reasonable or medically necessary.
- The provider obtains a written acknowledgement, prior to rendering services, verifying that the Anthem member was notified of financial responsibility for services rendered.
- The member signs and dates the acknowledgement, indicating that the member has been notified of their responsibility to pay for the requested service prior to services being rendered.

**Recommended Fields for CMS-1500**

All professional providers and vendors should bill Anthem using the most current version of the CMS-1500 claim form. The following guidelines will assist you in completing the CMS-1500 form. An M indicates a mandatory field.
<table>
<thead>
<tr>
<th>Field</th>
<th>Title</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| Field 1    | Medicare
Medicaid
TRICARE CHAMPUS
CHAMPVA
Group Health Plan W
FECA Blk Lung
Other ID | If the claim is for Medicaid, put an X in the Medicaid box. If the member has both Medicaid and Medicare, put an X in both boxes. Attach a copy of the form submitted to Medicare to the claim. |
<p>| Field 1a   | Member’s ID Number                               | Field intentionally left blank. Use the 10-digit member ID. Please note: The member ID has no prefix.                                    |
| Field 2    | Member’s Name                                    | Enter the last name, the first name, and middle initial (if known). Do not use nicknames or full middle names.                             |
| Field 3    | Member’s Birth Date/Sex                          | Date of birth format: MM/DD/YYYY. For example, write September 1, 1963, as 09/01/1963. Check the appropriate box for the patient’s sex. |
| Field 4    | Insured’s Name                                   | “Same” is acceptable if the insured is the patient.                                                                                    |
| Field 5    | Member’s Address/Phone                           | Enter the member’s complete address and phone number, including any unit or apartment number. Abbreviations for road, street, avenue, boulevard, place or other common endings to the street name are acceptable. |
| Field 6    | Patient Relationship to Insured                  | The relationship to the member or subscriber.                                                                                           |
| Field 7    | Insured’s Address                                | “Same” is acceptable if the insured is the patient.                                                                                     |
| Field 8    | Reserved for NUCC Use                            | None                                                                                                                                     |
| Field 9    | Other Insured’s Name                             | If there is insurance coverage in addition to the member’s plan coverage, enter the name of the insured.                                 |
| Field 9a   | Other Insured’s Policy or Group Number           | Enter the policy or group number of the other insured.                                                                                  |
| Field 9b   | Reserved for NUCC Use                            | None                                                                                                                                     |
| Field 9c   | Reserved for NUCC use                            | None                                                                                                                                     |
| Field 9d   | Insurance Plan Name or Program Name              | Name of plan carrier.                                                                                                                  |
| Field 10   | Patient’s Condition Related To                   | Include any description of injury or accident and whether or not it occurred at work.                                                  |
| Field 10a  | Related to Employment?                           | Y or N. If insurance is related to workers’ compensation, enter Y.                                                                      |
| Field 10b  | Related to Auto Accident/Place?                  | Y or N; enter the state in which the accident occurred.                                                                               |
| Field 10c  | Related to Other Accident?                       | Y or N                                                                                                                                    |
| Field 10d  | Claim Codes                                     | Identify additional information about the patient’s condition or the claim.                                                             |
| Field 11   | Insured’s Policy, Group or FECA Number           | Insured’s policy or group number. Complete information about insured, even if the insured is the same as patient.                        |</p>
<table>
<thead>
<tr>
<th>Field</th>
<th>Title</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 11a</td>
<td>Insured’s Date of Birth/Sex</td>
<td>Date of birth format: MM/DD/YYYY. Sex: M or F</td>
</tr>
<tr>
<td>Field 11b</td>
<td>Other Claim ID</td>
<td>This is another identifier applicable to the claim.</td>
</tr>
<tr>
<td>Field 11c</td>
<td>Insurance Plan Name or Program Name</td>
<td>Plan carrier/EP1 benefit code for paper claims.</td>
</tr>
<tr>
<td>Field 11d</td>
<td>Is There Another Health Benefit Plan?</td>
<td>Y or N; if yes, items 9A-9D must be completed.</td>
</tr>
<tr>
<td>Field 12</td>
<td>Patient’s or Authorized Person’s Signature</td>
<td>Signature and date; “Signature on file,” indicating that the appropriate signature was obtained by the provider, is acceptable for this field.</td>
</tr>
<tr>
<td>Field 13</td>
<td>Member’s or Authorized Person’s Signature</td>
<td>Signature; “Signature on file” is acceptable for this field.</td>
</tr>
<tr>
<td>Field 14</td>
<td>Date of Current Illness, Injury, Pregnancy (LMP)</td>
<td>This identifies the first date of onset of illness, the actual date of injury or the LMP for pregnancy</td>
</tr>
<tr>
<td>Field 15</td>
<td>Other Date</td>
<td>This is another date related to the patient’s condition or treatment. Date format: MM/DD/YYYY</td>
</tr>
<tr>
<td>Field 16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
<td>This is the time span the patient is or was unable to work.</td>
</tr>
<tr>
<td>Field 17</td>
<td>Name of Referring Physician or Other Source</td>
<td>Name of physician, clinic or facility referring the patient to the provider.</td>
</tr>
<tr>
<td>Field 17a</td>
<td>Other ID#</td>
<td>The non-NPI ID number of the referring, ordering or supervising provider is the unique identifier of the professional or the provider designated taxonomy code.</td>
</tr>
<tr>
<td>Field 17b (M)</td>
<td>NPI</td>
<td>The NPI number refers to the HIPAA national provider identifier number.</td>
</tr>
<tr>
<td>Field 18</td>
<td>Hospitalization Dates Related to Current Services (From - To)</td>
<td>Date format: MM/DD/YYYY</td>
</tr>
<tr>
<td>Field 19 (M)</td>
<td>Additional Claim Information (Designated by NUCC)</td>
<td>This identifies additional information about the patient’s condition or the claim.</td>
</tr>
<tr>
<td>Field 20</td>
<td>Outside Lab? $ Charge</td>
<td>Include information here if lab services were sent to an outside lab.</td>
</tr>
<tr>
<td>Field 21 (M)</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</td>
</tr>
<tr>
<td>Field 22</td>
<td>Resubmission and/or Original Reference Number</td>
<td>This is the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.</td>
</tr>
<tr>
<td>Field 23</td>
<td>Prior Authorization Number</td>
<td>This is the payer assigned number authorizing the service(s).</td>
</tr>
<tr>
<td>Field 24A (M)</td>
<td>Date(s) of Service</td>
<td>If dates of service cross over from one year to another, submit two separate claims. Example: One claim for services in 2012 and one claim for services in 2013; itemize each date of service on the claim and avoid spanning dates.</td>
</tr>
<tr>
<td>Field 24B (M)</td>
<td>Place of Service</td>
<td>Enter a two-digit code using current Wisconsin Medicaid-specified codes.</td>
</tr>
<tr>
<td>Field</td>
<td>Title</td>
<td>Explanation</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Field 24C</td>
<td>EMG</td>
<td>Enter the appropriate condition indicator for medical checkups if applicable.</td>
</tr>
<tr>
<td>Field 24D (M)</td>
<td>Procedure, Services or Supplies</td>
<td>Enter the appropriate CPT codes. Indicate appropriate modifier when applicable. Do not use not otherwise classified (NOC) codes unless there is no specific CPT code available. If you use an NOC code, include a narrative description.</td>
</tr>
<tr>
<td>Field 24E (M)</td>
<td>Diagnosis Pointer</td>
<td>Use the most specific ICD code available.</td>
</tr>
<tr>
<td>Field 24F (M)</td>
<td>Dollar Charges</td>
<td>Enter the charge for each single line item.</td>
</tr>
<tr>
<td>Field 24G</td>
<td>Days or Units</td>
<td>The quantity of services for each itemized line. For anesthesia, enter the actual time of the service rendered, in minutes.</td>
</tr>
<tr>
<td>Field 24H</td>
<td>EPSDT Family Plan</td>
<td>Indicate if the services were the result of a checkup or a family planning referral.</td>
</tr>
<tr>
<td>Field 24I (M)</td>
<td>ID. Qual./NPI</td>
<td>Enter your NPI if available. An NPI is required for electronic claims, and we strongly encourage you to use your NPI number for paper claims.</td>
</tr>
<tr>
<td>Field 24J (M)</td>
<td>Rendering Provider ID. #</td>
<td>Enter the rendering provider’s NPI number in the unshaded portion. Enter the rendering taxonomy code in the shaded portion.</td>
</tr>
<tr>
<td>Field 25</td>
<td>Federal Tax ID Number</td>
<td>Enter the nine-digit number from your W-9.</td>
</tr>
<tr>
<td>Field 26</td>
<td>Patient’s Account Number</td>
<td>This is for the provider’s use in identifying patients and allows up to nine numbers or letters (no other characters are allowed).</td>
</tr>
<tr>
<td>Field 27 (M)</td>
<td>Accept Assignment?</td>
<td>All providers of Medicaid services must check YES.</td>
</tr>
<tr>
<td>Field 28 (M)</td>
<td>Total Charge</td>
<td>Total charge for each single line item.</td>
</tr>
<tr>
<td>Field 29 (M)</td>
<td>Amount Paid</td>
<td>Enter any payment that has been received for this claim.</td>
</tr>
<tr>
<td>Field 30</td>
<td>Balance Due</td>
<td>Must equal the amount in box 28 less the amount in box 29.</td>
</tr>
<tr>
<td>Field 31 (M)</td>
<td>Signature of Physician or Supplier Including Degrees or Credentials</td>
<td>This refers to the authorized or accountable person and the degree, credentials or title.</td>
</tr>
<tr>
<td>Field 32</td>
<td>Service Facility Location Information</td>
<td>The name and address of the facility where services were rendered identifies the site where service(s) were provided.</td>
</tr>
<tr>
<td>Field 32A</td>
<td>NPI#</td>
<td>The NPI number refers to the HIPAA national provider identifier number.</td>
</tr>
<tr>
<td>Field 33 (M)</td>
<td>Billing Provider Info and Phone #</td>
<td>The billing provider’s or supplier’s billing name, address, ZIP code and phone number is the billing office location and telephone number of the provider or supplier.</td>
</tr>
<tr>
<td>Field 33A (M)</td>
<td>Billing Provider NPI</td>
<td>The NPI number refers to the HIPAA national provider identifier number.</td>
</tr>
<tr>
<td>Field 33B (M)</td>
<td>Other ID#</td>
<td>Enter the taxonomy code of the billing provider.</td>
</tr>
</tbody>
</table>
CHAPTER 10: BILLING INSTITUTIONAL CLAIMS

Overview

Hospital and other facility billing can require special attention because billing requirements vary according to the provider and service type. Throughout this chapter, specific billing requirements are broken down into the following service areas:

- Emergency room visits
- Maternity
- Termination of pregnancy
- Inpatient acute care
- Inpatient sub-acute care
- Outpatient laboratory, radiology and diagnostic services
- Outpatient surgical services
- Outpatient infusion therapy visits and pharmaceuticals

Inpatient hospital reimbursement is based on DRGs, which applies to the following:

- Acute care general hospitals
- Institutions for Mental Disease (IMD) hospitals, except state-operated IMD hospitals

The following are excluded from the DRG system and are paid under a hospital-specific daily rate:

- Rehabilitation hospitals
- State-operated IMD hospitals
- State-operated veterans hospitals

Payment for the following specialized inpatient services are exempt from the DRG-based payment system:

- Services provided at rehabilitation hospitals
- Services related to ventilator care, brain injury cases and certain other unusual cases
- Services provided to Department of Corrections inmates

We also have included helpful billing guidelines for the ancillary services used most often by providers, including diagnostic imaging. These ancillary services include the following:

- Ambulance services
- Ambulatory surgical centers
- Durable medical equipment
- Dialysis
- Laboratory and diagnostic imaging
- Skilled nursing facilities
- Home health care
- Hospice

Please note: A member’s benefits may not cover some of these services; confirm coverage before providing service.

And finally, this chapter will take a look at specific coding guidelines for the CMS-1450 (UB-04) claim form for hospitals and health care facilities.
Basic Billing Guidelines
In general, these are the basic billing guidelines for institutional claims submitted to Anthem:

- Use Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) codes or revenue codes. Valid HCPCS, CPT or revenue codes are required for all line items billed, whether sent on paper or electronically.
- Provide medical records. Medical records for certain procedures may be requested for determination of medical necessity.
- Use modifiers in accordance with your specific billing instructions.
- Use codes for unlisted procedures. Because some provider services or procedures are not found in CPT, specific code numbers for reporting unlisted procedures have been designated. When using an unlisted procedure code, include a description of the service to help us calculate the appropriate reimbursement. We may request the member’s medical records.
- Complete the appropriate billing for supplies and materials. Do not use CPT code 99070, which is for supplies and materials provided over and above those usually included with an office visit or other services. Anthem does not accept CPT code 99070. Health care providers must use HCPCS Level II codes, which provide a detailed description of the service.

Please note: System edits are in place for both electronic and paper claims. Claims submitted improperly cannot be processed easily and most likely will be returned.

Emergency Room Visits
Emergency room services are considered to be one continuous outpatient visit unless the member is admitted to the hospital and counted in the midnight census. If the emergency room visit results in an inpatient admission, all services provided in the emergency room must be billed in conformity with the guidelines and requirements for inpatient acute care.

The billing requirements for emergency room treatment cover all diagnostic and therapeutic services including but not limited to:

- Equipment
- Facility use (including nursing care)
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the emergency room visit

Precertification is not required for medically necessary emergency services, but specific coding is required for emergency room billing. Use the following guidelines:

- Bill each service date as a separate line item.
- Perform a screening examination on the member, regardless of copay.
- Use CPT codes 99281-99285 for emergency room billing.
- Use ICD principal diagnosis codes as required for all services provided in an emergency room setting.
- Use revenue codes 0450-0452 and 0459 as required.

Please note: Unless clinically required, follow-up care should never occur in the emergency department. Members should be referred back to their PCP and correct billing should follow standard, nonemergency guidelines.
Maternity Services
The billing requirements for maternity care apply to all live and stillbirth deliveries. Payment for services includes but is not limited to:

- Room and board for mother (including nursing care)
- Nursery for baby (including nursing care)
- Delivery room/surgical suites
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Other services incidental to admission

The maternity care rate covers the entire admission. If an admission is approved for extension beyond the contracted time limit for continuous inpatient days, the billing requirement for the entire admission shifts to inpatient acute care. This applies to each approved and medically necessary service day. Therapeutic termination of pregnancy, treatment for ectopic and molar pregnancies and similar conditions are excluded from payment under this rate.

Inpatient Acute Care
All hospital services are considered to be part of a single, continuous inpatient stay when the services occur contiguously and the member is eventually granted inpatient status. On an inpatient claim, providers are required to include all services provided during an outpatient visit that are contiguous with an inpatient stay for the member. Most covered services provided during an inpatient stay are hospital inpatient services that are included in the DRG-based payment system. The following hospital services also are considered part of the DRG-based payment system:

- Drugs, except take-home drugs on the date of discharge
- Services by independent therapists, (PT, OT, SLP, etc.)
- Services of residents and interns
- Services provided by another hospital (except on the date of admission and discharge)
- Services provided by social workers and substance use counselors
- Technical services by independent imaging groups (X-ray, MRI, etc.)
- Technical services provided by a nonhospital laboratory

Please note: Precertification is required for all admissions except standard vaginal delivery and Cesarean sections.

Inpatient Clean Claims Review Process: Equian
The health plan partners with Equian, a claims review service provider. Equian applies condition-specific medical and financial expertise to review high-dollar hospital bills for clinical appropriateness, billing errors and variances from industry billing practices. If Equian identifies any discrepancies during its claim review, they work directly with the provider to resolve the adjustments identified.

An itemized bill will be required for all diagnosis-related group (DRG) outliers paying $25,000 or above with a $2,500 outlier payable and above. If an itemized bill is not received with the initial claim, Anthem will request the documentation; however, submitting with the initial claim will avoid unnecessary delay.
**Inpatient Sub-Acute Care**

The billing requirements for inpatient sub-acute care include each approved and medically necessary service day in a licensed and accredited facility at the appropriate level of care.

Sub-acute care includes levels of inpatient care less intensive than those required in an inpatient acute care setting.

Covered services include but are not limited to:
- Room and board (including nursing care)
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the admission

**Please note:** All sub-acute admissions require precertification and a treatment plan. The treatment plan must accompany the admission and include:
- Functional, reasonable, objective and measurable goals within a predictable time frame for each skilled discipline.
- A discharge plan and customized options identified and implemented from the admission date.
- Weekly summaries for each discipline.
- Biweekly conference reports.

**Outpatient Hospital Diagnostic Testing, Laboratory and Therapeutic Services**

Diagnostic testing, laboratory and therapeutic services are considered outpatient hospital services when provided by a licensed hospital and ordered by a physician as a result of a member’s visit to the outpatient hospital. The member may not be a hospital inpatient.

Anthem adopted Wisconsin Medicaid’s Enhanced Ambulatory Patient Grouping (EAPG) reimbursement methodology. Detailed information on EAPG may be found in the ForwardHealth provider manual under “Topic #15217.”

Some laboratory services are not processed through the EAPG system and are reimbursed at the lower of the usual and customary charge or the maximum allowable fee. Outpatient hospitals may receive reimbursement for laboratory services resulting from specimens transferred from a source outside the hospital when the hospital laboratory is separately enrolled as an independent laboratory.

The following sections provide special billing requirements for each.

**Note:** Because the member’s benefits may not cover all of the services listed, confirm benefit coverage first.

**Ambulance Services**

Ambulance providers, including municipalities, should use the CMS-1500 form to bill for ambulance services. Ambulance providers are required to report pick-up and drop-off addresses on the claim form. Addresses must include street number, street name, city, state and ZIP code.
**Ambulatory Surgical Centers**
Most outpatient surgery delivered in an ambulatory surgery center requires precertification. Ambulatory surgical centers use the CMS-1500 form.

**Durable Medical Equipment**
Durable medical equipment (DME) providers must use the CMS-1500 form. Billing for custom-made DME, prescribed to preserve bodily functions or prevent disability, requires pre-service review. Without such review, claims for DME will be denied. Prior to dispensing, please contact Anthem’s Medical Management department: 1-855-558-1443.

**Please note:** The presence of an HCPCS code does not necessarily mean that the benefit is covered or that payment will be made. Some DME codes may be by report (customized) and require additional information for pre-service review and processing.
DME billing requires a differentiation between rentals and purchased equipment as well as specific codes and modifiers. Special guidelines for DME billing include:
- Use HCPCS codes for DME or supplies.
- Use an unlisted or miscellaneous code, such as E1399, when an HCPCS code does not exist for a particular item of equipment.
- Use valid codes for DME and supplies. If valid HCPCS codes exist, unlisted codes will not be accepted.
- Attach the manufacturer’s invoice to the claim if using a miscellaneous or unlisted code. The invoice must be from the manufacturer, not the office making the purchase.

**Please note:** Catalogue pages are not acceptable as a manufacturer’s invoice.

**Durable Medical Equipment Rentals**
Some DME is dispensed on a rental basis and requires medical documentation from the prescribing provider. Rented items remain the property of the DME provider until the purchase price is reached. Charges for rentals exceeding the reasonable charge for a purchase are not accepted. Rental extensions may be obtained only on approved items.

**Please note:** DME providers should use normal equipment collection guidelines. Anthem is not responsible for equipment not returned by members.

**Durable Medical Equipment Purchase**
Most DME may be purchased unless otherwise specified at the time of review by our Medical Management department.

**Dialysis**
With the exception of a limited number of emergency dialysis treatments, hospital providers are required to be separately enrolled as a Medicaid end-stage renal disease (ESRD) provider with a specialty of “Hospital Affiliated” to receive reimbursement for renal disease-related services. Hospitals submitting claims under their hospital enrollment (not their ESRD enrollment) may receive reimbursement for providing up to three emergency dialysis treatments for a member per calendar year. These dialysis treatments are meant for emergency services only and not for a member with chronic renal failure. Precertification must be obtained for all dialysis care except where Medicare is the primary payer. Contact Anthem’s Medical Management department for precertification: 1-855-558-1443.

**Home Infusion Therapy**
Supplies and equipment, such as infusion pumps associated with the IV, may be separately reimbursed by Anthem. Infused solutions are covered under the pharmacy benefit, which is a carve-out to the state.
**Skilled Nursing Facilities**
All skilled nursing facility care requires precertification. Contact Anthem’s Medical Management department for precertification and bill using the CMS-1450 form. Anthem’s Medical Management department phone: **1-855-558-1443**.

**Home Health Care**
All home health care requires precertification from Anthem’s Medical Management department before delivery of service. When billing for a home health care visit, use the CMS-1450 form.

*Please note:* When billing for supplies and equipment used in a home health care visit, refer to the **Durable Medical Equipment** section of this chapter for billing requirements. Anthem’s Medical Management department phone: **1-855-558-1443**.

**Hospice**
Hospice services require precertification. Contact Anthem’s Medical Management department for precertification before hospice admission. When billing for hospice services, use the CMS-1450 form. Anthem’s Medical Management department phone: **1-855-558-1443**.

**Additional Billing Resources**
The following reference books provide detailed instructions on uniform billing requirements:

- Current Procedural Terminology published by the American Medical Association (AMA)
- Healthcare Common Procedure Coding System, National Level II (current year) published by the Centers for Medicare and Medicaid Services (CMS)
- ICD (current edition) Volumes 1, 2 and 3 (current year) published by the Practice Management Information Corporation

**CMS-1450 Claim Form**
All Medicare-approved facilities should bill Anthem using the most up-to-date version of the CMS-1450 claim form. All fields must be completed using standardized code sets. These code sets are used to ensure that claims are processed in an orderly and consistent manner. HCPCS provides codes for a variety of services and consists of Level I and Level II codes:

- Level I: CPT codes determined by the AMA and represented by five numeric digits.
- Level II: Other codes identifying products, supplies and services not included in the CPT codes such as ambulance services and DME. Sometimes referred to as the alphanumeric codes, because they consist of a single alphabetical letter followed by four numeric digits.

In some cases, two-digit/character modifier codes should accompany the Level I or Level II coding.

**CMS-1450 Revenue Codes**
CMS-1450 revenue codes are required for all institutional claims.

**Institutional Inpatient Coding**
For institutional inpatient coding, use these guidelines:

- Use current applicable ICD and procedure codes in Boxes 74-74e of the CMS-1450 claim form when the claim indicates that a procedure was performed.
- Use modifier codes when appropriate; refer to the current edition of the provider’s CPT manual published by the AMA.
- Refer to your Provider Agreement for diagnosis-related group (DRG) information.
Institutional Outpatient Coding

For institutional outpatient coding, use the guidelines in the following code manuals:

- The Healthcare Common Procedure Coding System published by the Centers for Medicare and Medicaid Services (CMS).

Please note: When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

Recommended Fields for CMS-1450

The following guidelines will assist in completing the CMS-1450 form. An R indicates a mandatory field.

<table>
<thead>
<tr>
<th>Field #</th>
<th>Box Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (R)</td>
<td>Blank</td>
<td>Field intentionally left blank. Facility name, address and phone number.</td>
</tr>
<tr>
<td>2</td>
<td>Blank</td>
<td>Field is intentionally left blank, but is required when the address for payment is different than that of the billing provider information located in Box 1.</td>
</tr>
<tr>
<td>3a</td>
<td>PAT. CNTL #</td>
<td>Member’s account number</td>
</tr>
<tr>
<td>3b</td>
<td>MED. REC #</td>
<td>Member’s record number, which can be up to 20 characters long</td>
</tr>
<tr>
<td>4 (R)</td>
<td>TYPE OF BILL</td>
<td>Enter the type of bill (TOB) code.</td>
</tr>
<tr>
<td>5 (R)</td>
<td>FED. TAX NO.</td>
<td>Enter the provider’s federal tax identification (ID) number.</td>
</tr>
<tr>
<td>6 (R)</td>
<td>STATEMENT COVERS PERIOD</td>
<td>From and through date(s) covered by the claim being submitted</td>
</tr>
<tr>
<td>8a–b (R)</td>
<td>PATIENT NAME</td>
<td>Member’s name</td>
</tr>
<tr>
<td>9a–e (R)</td>
<td>PATIENT ADDRESS</td>
<td>Complete address (number, street, city, state, ZIP code and phone number)</td>
</tr>
<tr>
<td>10 (R)</td>
<td>BIRTHDATE</td>
<td>Member’s date of birth in MM/DD/YY format</td>
</tr>
<tr>
<td>11 (R)</td>
<td>SEX</td>
<td>Member’s gender</td>
</tr>
<tr>
<td>12 (R)</td>
<td>ADMISSION DATE</td>
<td>Member’s admission date to the facility in MM/DD/YY format</td>
</tr>
<tr>
<td>13 (R)</td>
<td>ADMISSION HR</td>
<td>Member’s admission hour to the facility in military time (00 to 23) format</td>
</tr>
<tr>
<td>14 (R)</td>
<td>ADMISSION TYPE</td>
<td>Type of admission</td>
</tr>
<tr>
<td>15 (R)</td>
<td>ADMISSION SRC</td>
<td>Source of admission</td>
</tr>
<tr>
<td>16 (R)</td>
<td>DHR</td>
<td>Member’s discharge hour from the facility in military time (00 to 23) format</td>
</tr>
<tr>
<td>17 (R)</td>
<td>STAT</td>
<td>Patient status</td>
</tr>
<tr>
<td>18–28</td>
<td>CONDITION CODES</td>
<td>Enter condition code (81) X0 – X9</td>
</tr>
<tr>
<td>29</td>
<td>ACDT STATE</td>
<td>Accident state</td>
</tr>
<tr>
<td>31–34 (R)</td>
<td>OCCURRENCE CODE OCCURRENCE DATE</td>
<td>Occurrence code (42) and date, if applicable</td>
</tr>
<tr>
<td>35–36</td>
<td>OCCURRENCE SPAN (CODE, FROM and THROUGH)</td>
<td>Enter dates in MM/DD/YY format.</td>
</tr>
<tr>
<td>38</td>
<td>Blank</td>
<td>Field is intentionally left blank, but enter the responsible party name and address if applicable.</td>
</tr>
<tr>
<td>39–41</td>
<td>VALUE CODES (CODE and AMOUNT)</td>
<td>Enter value codes, if applicable.</td>
</tr>
<tr>
<td>Field #</td>
<td>Box Title</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
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</tr>
<tr>
<td>42 (R)</td>
<td>REV. CD.</td>
<td>Revenue code (required for all institutional claims)</td>
</tr>
<tr>
<td>43 (R)</td>
<td>DESCRIPTION</td>
<td>Description of services rendered</td>
</tr>
<tr>
<td>44 (R)</td>
<td>HCPCS/RATE/HPICS CODE</td>
<td>Enter the accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient services.</td>
</tr>
<tr>
<td>45 (R)</td>
<td>SERV. DATE</td>
<td>Date of services rendered</td>
</tr>
<tr>
<td>46 (R)</td>
<td>SERV. UNITS</td>
<td>Number/units of occurrence for each line or service being billed</td>
</tr>
<tr>
<td>47 (R)</td>
<td>TOTAL CHARGES</td>
<td>Total charge for each line of service being billed</td>
</tr>
<tr>
<td>48</td>
<td>NONCOVERED CHARGES</td>
<td>Enter any noncovered charges.</td>
</tr>
<tr>
<td>50</td>
<td>PAYER NAME</td>
<td>Payer ID – Enter any third-party payers.</td>
</tr>
<tr>
<td>51 (R)</td>
<td>HEALTH PLAN ID</td>
<td>Leave this blank (assigned by the health care plan).</td>
</tr>
<tr>
<td>52 (R)</td>
<td>REL. INFO</td>
<td>Release of information certification indicator</td>
</tr>
<tr>
<td>53</td>
<td>ASG BEN.</td>
<td>Assignment of benefits certification indicator</td>
</tr>
<tr>
<td>54</td>
<td>PRIOR PAYMENTS</td>
<td>Prior payments</td>
</tr>
<tr>
<td>55</td>
<td>EST. AMOUNT DUE</td>
<td>Estimated amount due</td>
</tr>
<tr>
<td>56 (R)</td>
<td>NPI</td>
<td>Enter the NPI number.</td>
</tr>
<tr>
<td>57 (R)</td>
<td>OTHER PRIV ID</td>
<td>Enter the other provider ID number.</td>
</tr>
<tr>
<td>58 (R)</td>
<td>INSURED’S NAME</td>
<td>Member’s name</td>
</tr>
<tr>
<td>59 (R)</td>
<td>P. REL</td>
<td>Patient’s relationship to insured – Enter N/A if the member is the insured.</td>
</tr>
<tr>
<td>60 (R)</td>
<td>INSURED’S UNIQUE ID</td>
<td>Use the 10-digit member ID. Please note: The member ID has no prefix.</td>
</tr>
<tr>
<td>61</td>
<td>GROUP NAME</td>
<td>Insured group name – Enter the name of any other health plan.</td>
</tr>
<tr>
<td>62</td>
<td>INSURANCE GROUP NO.</td>
<td>Enter the policy number of any other health plan.</td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODES</td>
<td>Enter the authorization number or authorization information.</td>
</tr>
<tr>
<td>64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td>Enter the control number assigned to the original bill.</td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME</td>
<td>Enter the name of the organization from which the insured obtained the other policy.</td>
</tr>
<tr>
<td>66 (R)</td>
<td>DX/PROC qualifier</td>
<td>Enter the diagnosis and procedure code qualifier (ICD version indicator).</td>
</tr>
<tr>
<td>67 (R)</td>
<td>DX</td>
<td>Principal diagnosis codes – Enter the ICD diagnostic codes if applicable.</td>
</tr>
<tr>
<td>67a–q (R)</td>
<td>DX</td>
<td>Other diagnostic codes – Enter the ICD diagnostic codes if applicable and indicate POA.</td>
</tr>
<tr>
<td>69</td>
<td>ADMIT DX</td>
<td>Admission diagnosis code – Enter the ICD code.</td>
</tr>
<tr>
<td>70a–c</td>
<td>PATIENT REASON DX</td>
<td>Enter the member’s reason for this visit if applicable.</td>
</tr>
<tr>
<td>71</td>
<td>PPS CODE</td>
<td>Prospective payment system (PPS) code</td>
</tr>
<tr>
<td>72</td>
<td>ECI</td>
<td>External cause of injury code</td>
</tr>
<tr>
<td>74 (R)</td>
<td>PRINCIPAL PROCEDURE (CODE/DATE)</td>
<td>ICD principal procedure code and date if applicable</td>
</tr>
<tr>
<td>74a–e (R)</td>
<td>OTHER PROCEDURE (CODE/DATE)</td>
<td>Other procedure codes</td>
</tr>
<tr>
<td>76 (R)</td>
<td>ATTENDING</td>
<td>Enter the attending provider’s ID number.</td>
</tr>
<tr>
<td>77 (R)</td>
<td>OPERATING</td>
<td>Enter the provider number if you use a surgical procedure on this form.</td>
</tr>
<tr>
<td>Field #</td>
<td>Box Title</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>78–79</td>
<td>OTHER</td>
<td>Enter any other provider numbers if applicable.</td>
</tr>
<tr>
<td>80</td>
<td>REMARKS</td>
<td>Use this field to explain special situations.</td>
</tr>
<tr>
<td>81a–d (R)</td>
<td>CC</td>
<td>Enter taxonomy code with qualifier B3.</td>
</tr>
</tbody>
</table>
Overview
At Anthem, our members have the freedom to choose their most important link to quality health care: their doctor. After enrollment, we strongly encourage our members to select a PCP and remain with that provider, because we believe in the positive impact of having a medical home. This home establishes a centralized hub from which all health care can be coordinated, no matter how many other caregivers become involved.

Occasionally, members may encounter barriers to effective relationships with their PCP. These obstacles may arise from geographical access, cultural and language differences, or simply personal preferences. Our members may change their PCP at any time, for any reason.

Members also have the right to change health care plans, as long as they follow specific rules and timelines. If a member requests disenrollment, Anthem will provide information and assistance in the disenrollment process.

We are committed to supporting providers’ practices as well. Providers also have the right to request that a member be reassigned to another PCP under certain conditions and following specific guidelines.

Anthem notifies PCPs of changes in member assignments through PCP Assignment Reports. These reports are available on Availity, our secure provider portal on our website: https://mediproviders.anthem.com/wi. Select Login or Register to access the secure site. Providers also may call Provider Services: 1-855-558-1443.

PCP-Initiated Member Transfers
A PCP may request member reassignment to a different PCP by completing and submitting the Provider Request for Member Deletion from PCP Assignment form located at https://mediproviders.anthem.com/wi > Medical > Forms.

Anthem will conduct a thorough review of the request for reassignment to determine whether the cause and documentation are sufficient to approve the request. This review includes monitoring to ensure consistency with our guidelines and policies.

The provider is expected to coordinate service for up to 30 days after the date Anthem receives the change request form. Upon completing the PCP assignment change, we will forward the form and any other information related to the case to the Member Services representative. This representative informs the member of the change within five working days. The change will be effective the day Anthem enters the change into the system.

PCP-Initiated Member Disenrollment
The disenrollment process for abusive behavior and failure to follow a prescribed treatment plan is as follows:
A. Complete the provider request for member deletion from PCP assignment form located at https://mediproviders.anthem.com/wi > Medical > Forms.
B. Mail or fax (preferred) the form to:
C. Continue to manage the member’s care as required until we can reassign the member to another PCP, or not more than 30 days from the day we receive the Provider Request for Member Deletion from PCP Assignment form, whichever comes first.

Following Anthem’s receipt of the Provider Request for Member Deletion from PCP Assignment form, the process is to:

- Scan and log the form into the system for tracking purposes.
- Reassign the member to a new PCP for continuity of care. The effective date is no later than 30 days from the date on the Provider Request for Member Deletion from PCP Assignment form.
- Log the new PCP assignment into the tracking system.
- Send an identification (ID) card and fulfillment material to the member indicating the newly assigned PCP’s name, address and phone number.
- Document any abusive behavior and notify the Anthem Fraud and Abuse department if the abusive behavior continues.
- Send a warning letter to the member stating that if the behavior continues, Anthem will file a disenrollment request with the member advocate. The member advocate gathers the necessary documentation and makes the request to Wisconsin’s Department of Health Services (DHS). If DHS grants approval, Anthem proceeds with the disenrollment process.

Prior to disenrollment, we will make every attempt to resolve issues and keep the member in our health care plan. These efforts include a referral to the member advocate who assists the member with reassignment to another PCP or with initiating the disenrollment request.

**State Agency-Initiated Member Disenrollment**
Contracted state agencies inform Anthem of membership changes by sending daily and monthly enrollment reports. These reports contain all active membership data and incremental changes to eligibility records and Anthem disenrolls members not listed on the report. Reasons for disenrollment may include:

- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month (disenrollment is 30 days for BadgerCare members and 90 days for SSI)
- Change in eligibility status
- County changes
- Death
- Incarceration
- Loss of benefits
- Member has other nongovernment or government sponsored health coverage
- Permanent change of residence out of service area
- Voluntary disenrollment member transfers and disenrollment

Disenrollment requests based on the reasons outlined above require a referral to the member advocate in the health plan.

**Member-Initiated PCP Reassignment**
Members have the right to change their PCP at any time. When a member enrolls in Anthem, he or she may select a PCP or allow their PCP to be assigned. After that, if the member wants to make a change, he or she is instructed to call Member Services at **1-855-690-7800** to request an alternate PCP.
Anthem accommodates member requests for PCP reassignment whenever possible. Our staff will work with the member to make the new selection, focusing on special needs. Our policy is to maintain continued access to care and continuity of care during the transfer process. When a member calls to request a PCP change:

- The Member Services representative checks the availability of the member’s choice. If the member can be assigned to the selected PCP, the Member Services representative will do so. If the PCP is not available, the representative will assist the member in finding an available PCP. If the member advises the representative that he or she is hospitalized, the PCP change will take effect upon discharge.
- Anthem notifies PCPs of member transfers through the PCP assignment report. These reports are available on Availity, our secure provider portal at https://mediproviders.anthem.com/wi. Select Login or Register to access the secure site.
- The effective date of a PCP change will be the same as the date of the member request.

Members also may select a new PCP by completing the Primary Care Reassignment Request form. This form can be accessed from the Find a Doctor link on the provider website. The form includes fillable form fields; completed forms can be faxed to 1-866-840-4993.

**Member-Initiated Disenrollment Process**

When members enroll in our program, we provide instructions on disenrollment procedures. Disenrollments become effective the last day of the calendar month following administrative cut-off or are subject to the Wisconsin DHS cut-off. If a member asks a provider how to disenroll from Anthem, the provider should direct the member to call Member Services: 1-855-690-7800.

**Please note:** Providers may not take retaliatory action against any member for requesting transfer or disenrollment.

When Member Services receives a call from a member who wants to disenroll, we attempt to find out the reason for the request and determine if we can resolve the situation. If Member Services is unable to resolve the issue, a referral is made to the member advocate in the health plan. The member advocate makes the referral to the enrollment contractor for an enrollment change if unable to resolve the situation.

**Member Transfers to Other Plans**

Members may choose a different health care plan on an annual basis during the open enrollment period. Open enrollment is 90 days for all Medicaid members, including SSI. Within the first 90 days of enrollment, all Medicaid members may change to a different HMO if the member is not satisfied with the HMO. After the open enrollment period ends, members remain with their chosen health care plan for the remaining 12-month period.

**Anthem-Initiated Member Disenrollment**

Anthem also may request disenrollment for a member who has moved out of the service area. When a member moves out of our service area, he or she is responsible for notifying DHS of the new permanent address. Wisconsin's DHS will disenroll the member from Anthem.

There are a number of situations where the Anthem member advocate can request disenrollment. They are:

- Just cause
- COP/CIP community based waiver or family care
- Infants with low birth weight (under 1200 grams)
- Inmates of a public institution
- Commercial HMO
- Death
• Medicare
• Out-of-state or out-of-area move
• Loss of BadgerCare Plus eligibility or Medicaid SSI eligibility
• Nine-month pregnancy
Overview
We encourage providers and members to seek resolution of issues through our grievances and appeals process. Verbal complaints and written grievances are tracked and trended, resolved within established time frames, and referred to member advocates when needed. The Anthem grievances and appeals process meets all state of Wisconsin requirements and federal laws. The building blocks of this resolution process are the grievance and the appeal.

Grievance: Any expression of dissatisfaction from a provider or member to Anthem.
Appeal: A formal request for Anthem to change a decision upheld by Anthem through the grievance process.

Provider grievances and appeals are classified into the following categories:
- Grievances relating to the operation of Anthem, including:
  - Benefit interpretation
  - Claim processing
  - Reimbursement
- Provider appeals related to adverse determinations
- Provider appeals of nonmedical necessity claims determinations

If a member has a grievance, we would like to hear about the issue, either by phone or in writing. Members have the right to file a grievance regarding any aspect of Anthem’s services. Member grievances and appeals include but are not limited to:
- Access to health care services.
- Care and treatment by a provider.
- Issues having to do with how we conduct business.

Anthem does not discriminate against providers for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for expressing a complaint or filing a grievance.

Please note: Anthem offers an expedited appeal for decisions involving urgently needed care. Standard and expedited appeals are never reviewed by a person who is subordinate to the initial decision maker.

Provider Grievances and Appeals

Provider Grievances and Appeals Relating to the Operation of the Plan
A provider may be dissatisfied or concerned about another provider, a member or an operational issue, including claims processing and reimbursement. Provider grievances must be submitted in writing and include the following:
- Provider’s name
- Date of the incident
- Description of the incident
Submit the grievance to:

BadgerCare Plus and Medicaid SSI
Medicaid Managed Care Unit
P.O. Box 6470
Madison, WI 53716-0470

Or fax to: 1-866-387-2968

A grievance may be filed up to 60 days from the date the provider became aware of the issue. Appeals may be filed up to 30 days from the date on the Notice of Action letter advising of an adverse determination. Anthem may request medical records or an explanation of the issues raised in the grievance via:

- Phone
- Fax (with a signed and dated letter)
- Mail (with a signed and dated letter)

The timelines for responding to the request for more information are as follows:

- Grievances or appeals: providers must comply with the request for additional information within ten days of the date on the request.
- Expedited appeals: providers must comply with the request for additional information within 24 hours of the date on the request.

Providers are notified in writing of the grievance resolution, including their right of appeal if any. Findings or decisions of peer review or quality of care issues are not disclosed.

**Provider Grievances and Appeals: When to Expect Resolution**

- Provider grievances: Anthem sends a written resolution letter to the provider within 30 days of the receipt of the grievance.
- Provider appeals: Anthem sends a written resolution letter to the provider within 30 days of the receipt of the appeal. The letter also provides details on further rights to appeal.

**Provider Grievances and Appeals: Appeals Related to Adverse Determinations**

When a provider expresses dissatisfaction about an adverse determination involving a clinical issue, the case is handled automatically as an appeal or reconsideration rather than a complaint.

**Adverse determination:** A denial, modification or reduction of services based on eligibility, benefit coverage or medical necessity

Claims denials also are considered adverse determinations. If a provider wants to challenge a claims decision, the provider may begin a claim payment appeal.

**Claim payment appeal:** The process by which a provider may challenge the disposition of a claim that has already been decided.

Requests for claim payment appeals must be made in writing to BadgerCare Plus within 60 days of a claim disposition and must include all pertinent information:

Anthem Blue Cross and Blue Shield
Claim Appeals/Correspondence
P.O. Box 61599
Virginia Beach, VA 23466-1599
Claim payment appeal requests are resolved within 30 days of receipt of the written request in one of the following ways:

- **Anthem changes a previous claim disposition:** The provider will be notified of the final disposition through a Remittance Advice (RA) notice indicating the additional payment due to the provider.
- **Anthem upholds a previous claim disposition:** The provider will receive a resolution letter with the details of the decision.

**Provider Grievances and Appeals: Appeals Related to Nonmedical Necessity Claims Determinations**

Nonmedical necessity determinations refer to services such as authorization requests where Utilization Management approval is sought. For example, a member is an inpatient for three days and the provider requests an additional stay that is rejected as medically unnecessary. Nonmedical necessity determinations are reviewed by the health plan’s Utilization Management team and the final determination is made by the health plan’s medical director not to cover the services.

Appeals also may include retrospective medical necessity reviews. Requests for this kind of review must be submitted using the following guidelines:

- The request must include all pertinent information, be submitted within 365 days of a claim disposition and be submitted in writing to Anthem:

  Anthem Blue Cross and Blue Shield – Claim Appeals/Correspondence
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Appeal requests are resolved within 30 days of receipt of the written request in one of the following ways:

- **Anthem changes a previous claim disposition:** The provider will be notified of the final disposition through a RA notice indicating the additional payment due to the provider.
- **Anthem upholds a previous claim disposition:** The provider will receive a resolution letter with the details of the decision.

**Provider Grievances and Appeals: Mediation and Arbitration**

If the provider is not satisfied with the outcome of a review conducted through the provider appeal process, additional steps may be taken as stated in the Provider Agreement:

- Mediation
- Arbitration

If these processes have been exhausted, the provider may file a complaint with the Department of Health Services:

  BadgerCare Plus and Medicaid Social Security Income (SSI)
  Medicaid Managed Care Unit
  P.O. Box 6470
  Madison, WI 53716-0470
  Fax: 1-608-224-6318

**Members Grievances and Appeals**

**Member Grievances and Appeals: Filing a Grievance**

To help ensure that Anthem members’ rights are protected, all members are entitled to a grievances and appeals process. Our goal is to resolve verbal and written grievances in a timely manner and in accordance with state and federal regulations. Members are encouraged to discuss their concerns with Anthem staff, who can resolve most verbal complaints.
The member advocate oversees and coordinates the member grievance process. The member advocate coordinates the formal grievance process, initiates investigations of grievances and ensures that appropriate follow-up occurs. If the concern is not resolved to the member’s satisfaction, the member should bring the issue to the attention of the member advocate who can help the member file and resolve their grievance. The member advocate can be reached by calling 1-855-690-7800 and requesting to speak to the member advocate for Wisconsin. Complaints or grievances can also be submitted in writing from the member or the member’s authorized representative. The email address is WIQMDept@anthem.com. The representative:

- Interviews the member and records details in the tracking system.
- Investigates the complaint and seeks resolution on behalf of the member before referring the member to the grievance process.

The member also has the option to make a request to appear before the grievance committee. The phone number to call and make the request is 1-262-523-2424. The grievance committee consists of the following individuals:

- Member advocate
- Compliance manager
- Quality director
- Medical management manager
- Provider services manager

The member must file a written grievance with as much information as possible, including:

- Who is part of the grievance
- What happened
- When the incident happened
- Where the incident happened
- Why the member was not happy with the health care services

The member must attach documents that will help us investigate the problem and should mail the written grievance to the Anthem Member Services department at:

Anthem Blue Cross and Blue Shield in Wisconsin
Central Appeals Processing
P.O. Box 62429
Virginia Beach, VA 23466-2429

When the grievance committee receives a request, the committee takes the following steps:

- The member has the opportunity to meet with the grievance committee to discuss concerns about the original decision or determination.
- The grievance committee provides an initial response within ten business days.
- The grievance committee may request medical records or an explanation from the provider(s) involved in the case.
- The grievance committee notifies providers of the need for additional information either by phone, mail or fax. Written correspondence to providers includes a signed and dated letter.
- Providers are expected to respond to requests for additional information within 10 days.
- If the matter remains unresolved after 10 business days, the grievance committee makes a determination within 30 days of the initial contact.
- If the original denial centers on a treatment considered not medically necessary or experimental, additional medical information will be obtained and sent to the medical director for a second review.
If the grievance committee is unable to resolve the grievance within the 30-day period, we will notify the member in writing and will explain the reason for the delay. This may extend the case up to an additional 14 days for members, not to exceed 45 days from receipt.

Interpreter services and translation of materials into non-English languages and alternative formats are available to support members with the grievance and appeals process at no cost.

**Member Grievances and Appeals: Resolution**

Anthem investigates the member’s grievance to develop a resolution. After we make a determination, we send a resolution letter to the member outlining the following:
- Anthem staff present during the meeting
- Documents reviewed to make the determination
- Appeal options (if applicable)

**Member Grievances and Appeals: Appeals**

If a member would like to file an appeal regarding how we solved their problem, the member, member’s authorized representative or provider acting on behalf of the member must notify us within 45 days of the date on the notice of action letter. The request for an appeal must be filed in writing. Appeals are divided into the following categories: Standard appeal and expedited appeal.

**Standard appeal:** The appropriate process when a member or his or her representative requests that Anthem reconsider the denial of a service or payment for services, in whole or in part.

**Expedited appeals:** An appeal when the amount of time necessary to complete a standard appeal process could jeopardize the member’s life, health, or the ability to maintain or regain maximum function.

Members have the right to appeal Anthem’s denial of services or payment for services, in whole or in part. A denial of this type is called an action. A member or his or her representative may submit a verbal or written appeal regarding an action within 20 business days from receipt of the denial letter. With the exception of expedited appeals, all verbal appeals must be confirmed in writing and signed by the member or his or her representative.

**Member Grievances and Appeals: Response to Standard Appeals**

After Anthem receives a verbal or written appeal request, the grievances and appeals department takes into consideration and investigates the case. The member, his or her representative and the provider are given the opportunity to submit written comments and documentation relevant to the appeal. Anthem may request medical records or a provider explanation of the issues raised in the appeal by:
- Phone
- Fax (with a signed and dated letter)
- Mail (with a signed and dated letter)

Providers are expected to comply with the request for additional information within ten days.

When the appeal is the result of a medical necessity determination, a physician clinical reviewer of the same or similar specialty who was not involved in the initial decision reviews the case. The physician clinical reviewer contacts the provider if needed to discuss possible alternatives. If specialty care is in dispute, the appeal panel will include a specialist who works in the same field of care.
The steps of the appeals process are as follows:

- No later than seven business days before the appeal panel is to meet, Anthem will share with the member or his or her representative the documentation that will be presented to the appeal panel.
- Anthem will provide the names of providers consulted during the investigation and the name and affiliation of each Anthem representative on the appeal panel.
- The member or his or her representative will be notified of their right to appear in person before the appeal panel.
- The member or his or her representative may present alternative expert testimony, or request the presence of and question any person responsible for making the disputed decision.

**Member Grievances and Appeals: Resolution of Standard Appeals**
Standard appeals are resolved within 20 business days of receipt of the initial written or verbal request. Members are notified in writing of the appeal resolution, including their right to further appeal if any.

**Member Grievances and Appeals: Appeal Time Frame Extensions**
The resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to ten business days if:
- The member or his or her representative requests an extension.
- Anthem shows that there is a need for additional information and the delay is in the member’s interest.

**Member Grievances and Appeals: Expedited Appeals**
If the amount of time necessary to participate in a standard appeal process could jeopardize the member’s life, health or ability to attain, maintain or regain maximum function, the member may request an expedited appeal. Anthem will inform the member of the time frame available for providing information and that the duration for submitting an expedited appeal is limited.

**Member Grievances and Appeals: Timeline for Expedited Appeals**
Members have the right to request an expedited appeal within 20 business days of receipt of the denial letter. Expedited appeals are acknowledged by phone and, if possible, immediately. Anthem will follow up with a written acknowledgement.

If Anthem denies a request for an expedited appeal, we must:
- Transfer the appeal to the time frame for standard resolution.
- Make a reasonable effort to give the member prompt verbal notice of the denial and follow up within two days with written notice.

**Member Grievances and Appeals: Response to Expedited Appeals**
Anthem may request medical records or a provider explanation of the issues raised in an expedited appeal by:
- Phone
- Fax (with a signed and dated letter)
- Mail (with a signed and dated letter)

Providers are expected to comply with the request for additional information within 24 hours.

**Member Grievances and Appeals: Resolution of Expedited Appeals**
Anthem resolves expedited appeals as quickly as possible and within three business days. The member is notified by phone whenever possible and in writing within five days of the expedited appeal decision.
**Member Grievances and Appeals: Other Options for Filing Grievances**
After exhausting Anthem’s grievances and appeals process, if a member is still dissatisfied with the decision, the member has the right to file an appeal with the Wisconsin Division of Hearings and Appeals (DHA) by requesting a state fair hearing.

The member can file a grievance with the Wisconsin BadgerCare Plus managed care ombudsman:

Wisconsin BadgerCare Plus Managed Care Ombudsman
P.O. Box 6470
Madison, WI 53716-0470
1-800-760-0001

**Member Grievances and Appeals: State Fair Hearing**
Members may request a state fair hearing after they have exhausted all of Anthem’s internal appeal processes. The request must be filed within 45 business days of the resolution letter. The request must be submitted in writing to the state of Wisconsin:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The process is as follows:
- The state sends a notice of the hearing request to Anthem.
- Upon receipt of the request, we forward all documents related to the request to the state.
- The state of Wisconsin schedules a hearing within the county where the member lives.
- The state notifies all parties of the date, time and place of the hearing. Representatives from our administrative, medical and legal departments may attend the hearing to present testimony and arguments. Our representatives may cross-examine witnesses and offer rebutting evidence.
- An administrative law judge renders a decision in the hearing within 90 business days of the date the hearing request was made.
- If the judge overturns Anthem’s position, we must adhere to the judge’s decision and ensure the decision is carried out.

**Please note:** If the member needs special arrangements to attend the hearing due to a disability or needs English language translation services please call the Wisconsin DHA:
Phone: 1-608-266-3096
TTY: 1-608-264-9853

**Please note:** If the member needs help in filing a grievance or wants to know more about their rights, the member may call:
BadgerCare Plus/Medicaid SSI ombudsman: 1-800-760-0001
Health maintenance organization (HMO) enrollment specialist: 1-800-291-2002

**Member Grievances and Appeals: Confidentiality**
All grievances and appeals are handled in a confidential manner. We do not discriminate against a member for filing a grievance or requesting a state fair hearing. We notify members of our grievances and appeals process in the member handbook. Members may request a translated version in languages other than English.
Member Grievances and Appeals: Discrimination
Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Anthem representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and, if the member requests assistance, is assisted in doing so. We document, track and trend all alleged acts of discrimination. A grievances and appeals associate reviews and trends cultural and linguistic grievances in collaboration with a cultural and linguistic specialist.

Member Grievances and Appeals: Continuation of Benefits During Appeal
Members must file a request for a hearing with the Wisconsin DHA within ten days of receiving a notice of action letter from Anthem regarding a decision to reduce, limit, terminate or suspend benefits. After the DHA notifies Anthem that an appeal is underway, we will notify the member that they are eligible to continue receiving care. We also will notify the member that they may be liable for the costs of that care if the DHA upholds our decision. If the member requests that we continue coverage, the following conditions apply:

- If the DHA reverses Anthem’s decision, we are responsible for covering services provided during the administrative hearing process.
- If the DHA upholds Anthem’s decision, we may pursue reimbursement for all services provided to the member to the extent that services were rendered solely because of this requirement.

Anthem will continue to provide benefits until one of the following occurs:

- The member withdraws the appeal.
- The state fair hearing’s decision is adverse to the member.
- The authorization expires or the authorization service is met.

Member Grievances and Appeals: Additional Options for Filing a Grievance
An additional avenue is open to members who want to file a grievance. Members may contact the Wisconsin Office of the Commissioner of Insurance (OCI), the state agency that enforces Wisconsin’s insurance laws, and request a complaint form from the OCI:

Phone outside the Madison area: 1-800-236-8517
Phone within the Madison area: 1-608-266-0103
Members may write to:

Office of the Commissioner of Insurance
Attn: Information and Complaints Section
P.O. Box 7873
Madison, WI 53707-7873
CHAPTER 13: CREDENTIALING AND RECredentialing

Provider Services: 1-855-558-1443
Provider Services fax: 1-800-964-3627
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Credentialing Scope
Anthem credentials the following health care practitioners:

- Medical doctors
- Doctors of osteopathic medicine
- Doctors of podiatry
- Chiropractors
- Optometrists providing health services covered under the health benefits plan
- Doctors of dentistry providing health services covered under the health benefits plan including oral maxillofacial surgeons
- Psychologists who are state certified or licensed and have doctoral or master’s level training
- Clinical social workers who are state certified or state licensed and have master’s level training
- Psychiatric nurse practitioners who are nationally or state certified or state licensed or behavioral nurse specialists with master’s level training
- Other behavioral health care specialists who are licensed, certified or registered by the state to practice independently
- Telemedicine practitioners who have an independent relationship with anthem and who provide treatment services under the health benefits plan
- Medical therapists (for example, physical therapists, speech therapists and occupational therapists)
- Licensed genetic counselors who are licensed by the state to practice independently
- Audiologists who are licensed by the state to practice independently
- Acupuncturists (nonmedical doctors or doctors of osteopathic medicine) who are licensed, certified or registered by the state to practice independently
- Nurse practitioners who are licensed, certified or registered by the state to practice independently
- Certified nurse midwives who are licensed, certified or registered by the state to practice independently
- Physician assistants (as required locally)

Anthem also certifies the following behavioral health practitioners (including verification of licensure by the applicable state licensing board to independently provide behavioral health services):

- Certified behavioral analysts
- Certified addiction counselors
- Substance abuse practitioners

Anthem credentials the following health delivery organizations (HDOs):

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Freestanding surgical centers
- Behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting:
  - Adult family care/foster care homes
  - Ambulatory detox
  - Community mental health centers (CMHC)
  - Crisis stabilization units
o Intensive family intervention services
o Intensive outpatient – mental health and/or substance abuse
o Methadone maintenance clinics
o Outpatient mental health clinics
o Outpatient substance abuse clinics
o Partial hospitalization – mental health and/or substance abuse
o Residential treatment centers (RTC) – psychiatric and/or substance abuse

- Birthing centers
- Convenient care centers/retail health clinics
- Intermediate care facilities
- Urgent care centers
- Federally qualified health centers (FQHC)
- Home infusion therapy agencies
- Rural health clinics

The following health delivery organizations are not subject to professional conduct and competence review under Anthem’s credentialing program but are subject to a certification requirement process:
- Clinical laboratories (a CMS-issued CLIA certificate or a hospital-based exemption from CLIA)
- End stage renal disease (ESRD) service providers (dialysis facilities)
- Portable X-ray suppliers

**Credentials Committee**

The decision to accept, retain, deny or terminate a practitioner’s participation in a network or plan program is conducted by a peer review body, known as Anthem’s credentials committee (CC).

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer or a designee appointed in consultation with the vice president of medical and credentialing policy will designate a chair of the CC, as well as a vice-chair in states or regions where both commercial and Medicaid contracts exist. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than ten, external physicians representing multiple medical specialties. In general, the following specialties or practice types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine), surgery and behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair. CC membership may also include one to two other types of credentialed health providers (for example, nurse practitioner, chiropractor, social worker or podiatrist) to meet priorities of the geographic region as per the chair/vice-chair’s discretion. At least two of the physician committee members must be credentialed for each line of business (for example, commercial, Medicare and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/recredentialing process as needed.

The CC will access various specialists for consultation as needed to complete the review of a practitioner’s credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member: 1) believes there is a conflict of interest, such as direct economic competition with the practitioner, or 2) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant’s participation, or terminate a practitioner from participation in one or more networks or plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are
network practitioners.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate credentialing staff, medical directors and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes. Peer review protected information will not be shared externally.

Practitioners and HDOs are notified they have the right to review information submitted to support their credentialing applications. This right includes access to information obtained from any outside sources with the exception of references, recommendations or other peer review protected information. Providers are given written notification of these rights in communications from Anthem, which initiates the credentialing process. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the credentialing staff will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner’s credentials file. The practitioner or HDO will be given no less than 14 calendar days to provide additional information. Upon request, the applicant will be provided with the status of his or her credentialing application. Written notification of this right may be included in a variety of communications from Anthem, including the letter initiating the credentialing process, the provider web site or provider manual. When such requests are received, providers will be notified whether the credentialing application has been received, how far in the process it has progressed, and a reasonable date for completion and notification. All such requests will be responded to verbally, unless the provider requests a written response.

Anthem may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Anthem will not discriminate against any applicant for participation in its networks or plan programs on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran or marital status, or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the covered individuals to meet their needs and preferences, this information is not required in the credentialing and recredentialing process. Determinations as to which practitioners/HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in Anthem Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence, as reported and verified through the credentialing process.

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of Anthem’s networks or plan programs. This application may be a state-mandated form or a standard form created by or deemed acceptable by Anthem. For practitioners, the Council for Affordable Quality Healthcare (CAQH), a universal credentialing data source, is utilized. CAQH built the first national
provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their web site at www.CAQH.org.

Anthem will verify those elements related to an applicants’ legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Anthem will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

**A. Practitioners**

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>License to practice in the state(s) in which the practitioner will be treating covered individuals.</td>
</tr>
<tr>
<td>Hospital-admitting privileges at a TJC, NIAHO or AOA-accredited hospital or a network hospital previously approved by the committee.</td>
</tr>
<tr>
<td>DEA/CDS- and state-controlled substance registrations (Note: The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating covered individuals. Practitioners who see covered individuals in more than one state must have a DEA/CDS registration for each state.)</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Malpractice claims history</td>
</tr>
<tr>
<td>Board certification or highest level of medical training or education</td>
</tr>
<tr>
<td>Work history</td>
</tr>
<tr>
<td>State or federal license sanctions or limitations</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
<tr>
<td>National Practitioner Data Bank report</td>
</tr>
<tr>
<td>State Medicaid Exclusion Listing (if applicable)</td>
</tr>
</tbody>
</table>

**B. HDOs**

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation (if applicable)</td>
</tr>
<tr>
<td>License to practice (if applicable)</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Medicare certification (if applicable)</td>
</tr>
<tr>
<td>Department of Health survey results or recognized accrediting organization certification</td>
</tr>
<tr>
<td>License sanctions or limitations (if applicable)</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
</tbody>
</table>

**Recredentialing**

The recredentialing process incorporates reverification and the identification of changes in the practitioner’s or HDO’s licensure, sanctions, certification, health status and/or performance information (including but not limited to: malpractice experience, hospital privilege or other actions) that may reflect on the practitioner’s or HDO’s professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards.
During the recredentialing process, Anthem will review verification of the credentialing data, as described in the tables under Initial Credentialing, unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the network within the scope of the Anthem credentialing program are required to be recredentialed every three years, unless otherwise required by contract or state regulations.

**Health Delivery Organizations**

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. HDOs are subject to credentialing and recredentialing programs to assess whether they meet appropriate standards of professional conduct and competence within the scope of the credentialing program. As described in detail in our credentialing program standards, all network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body in addition to the licensure and other eligibility criteria. In the absence of such accreditation, Anthem may evaluate: 1) the most recent site survey by Medicare, 2) the appropriate state oversight agency or 3) a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Recredentialing of HDOs occurs every three years, unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in networks or plan programs must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. Anthem may request, and will accept, additional information from the HDO to correct incomplete, inaccurate or conflicting credentialing information. The CC will review this information and the rationale behind it as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

**Ongoing Sanction Monitoring**

To support certain credentialing standards between the recredentialing cycles, Anthem has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including but not limited to the following:

- Office of the Inspector General (OIG)
- Federal Medicare/Medicaid reports
- Office of Personnel Management (OPM)
- State licensing boards/agencies
- Covered individual/customer services departments
- Clinical quality management department (including data regarding complaints of both a clinical and nonclinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Anthem departments
- Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including but not limited to: review by the chair of the Anthem CC, review by the Anthem medical director, referral to the CC or termination. Anthem credentialing departments will report practitioners or HDOs to the appropriate authorities as required by law.
**Appeals Process**

Anthem has established policies for monitoring and recredentialing practitioners and HDOs who seek continued participation in one or more of Anthem’s networks or plan programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat network practitioners and HDOs, including those applying for participation, fairly and provides practitioners and HDOs with a process to appeal determinations terminating participation in Anthem’s networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It’s our intent to give practitioners and HDOs the opportunity to contest a termination in one or more of our networks or plan programs, including denials of request for initial participation that were reported to the NPDB and based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner’s or HDO’s suspension or loss of licensure, criminal conviction, or our determination that the practitioner’s or HDO’s continued participation poses an imminent risk of harm to covered individuals. A practitioner/HDO whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

**Reporting Requirements**

When we take a professional review action with respect to a practitioner’s or HDO’s participation in one or more of its networks or plan programs, we may have an obligation to report it to the NPDB. Once Anthem receives a verification of the NPDB report, the verification report will be sent to the state licensing board. Credentialing staff will comply with all state and federal regulations for reporting adverse determinations related to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reportable adverse actions conflict with the process set forth in the current NPDB guidebook, the NPDB guidebook will govern.

**Anthem Credentialing Program Standards**

**Eligibility Criteria – Health Care Practitioners**

Initial applicants must meet all of the following criteria in order to be considered for participation:

I. Must not be currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or FEHBP

II. Possess a current, valid, unencumbered, unrestricted and nonprobationary license in the state(s) where he/she provides services to covered individuals

III. Possess a current, valid and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his or her specialty (Note: the DEA/CDS registration must be valid in the state[s] in which the practitioner will be treating covered individuals. Practitioners who see covered individuals in more than one state must have a DEA/CDS registration for each state.)

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

I. For MDs, DOs, DPMs, and oral and maxillofacial surgeons, the applicant must have a current, in-force board certification as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Podiatric Surgery (ABPS), American Board of Podiatric Medicine (ABPM), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
a. Individuals will be granted five years or a period of time consistent with ABMS board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.

b. Individuals with board certification from the ABPM will be granted five years after the completion of their residency to meet this requirement. Individuals with board certification from the American Board of Foot and Ankle Surgery will be granted seven years after completion of their residency to meet this requirement; however, individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

c. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
   i. Previous board certification (as defined by ABMS, AOA, RCPSC or CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of ten consecutive years of clinical practice
   ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty
   iii. Specialized practice expertise, as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Anthem’s network AND the applicant’s professional activities are spent at that institution at least 50% of the time.

Note: Practitioners meeting one of these three alternative criteria will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by a delegate to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.

For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO) or AOA-accredited hospital or a network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may, at its discretion, deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a network practitioner to provide inpatient care.

Criteria for Selecting Practitioners – New Applicants (Credentialing)
   I. Submission of a complete application and required attachments that must not contain intentional misrepresentations
   II. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote
   III. Primary source verifications within acceptable time frames of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies
   IV. No evidence of potential material omission(s) on application
   V. Current, valid and unrestricted license to practice in each state in which the practitioner would provide care to covered individuals
   VI. No current license action
   VII. No history of licensing board action in any state
   VIII. No current federal sanction and no history of federal sanctions (per System for Award Management
IX. Possess a current, valid and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his or her specialty in which he or she will treat covered individuals. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating covered individuals. Practitioners who treat covered individuals in more than one state must have a valid DEA/CDS registration for each applicable state. Initial applicants who have NO DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
   a. It can be verified that this application is pending.
   b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
   c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
   d. Anthem will verify the appropriate DEA/CDS registration via standard sources.
   e. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day time frame will result in termination from the network. Initial applicants who possess a DEA/CDS registration in a state other than the state in which they will be treating covered individuals will be notified of the need to obtain the additional DEA/CDS registration. If the applicant has applied for additional DEA/CDS registration, the credentialing process may proceed if all the following criteria are met:
      i. It can be verified that this application is pending.
      ii. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
      iii. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
      iv. Anthem will verify the appropriate DEA/CDS registration via standard sources.
      v. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day time frame will result in termination from the network.
      vi. The applicant must not be currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or FEHBP.
X. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions
XI. No history or current use of illegal drugs or history of or current alcoholism
XII. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field
XIII. No gap in work history greater than six months in the past five years, with the exception of those gaps related to parental leave or immigration, where 12-month gaps will be acceptable. Other gaps in work history of six to 24 months will be reviewed by the chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern, the chair of the CC may approve work history gaps of up to two years.
XIV. No history of criminal/felony convictions or a plea of no contest
XV. A minimum of the past ten years of malpractice case history is reviewed.
XVI. Meets credentialing standards for education/training for the specialty(ies), as designated on the application, the practitioner wants to be listed under in Anthem’s network directory. This includes board certification requirements or alternative criteria for MDs and DOs and board-certification criteria for DPMs and oral and maxillofacial surgeons.
XVII. No involuntary terminations from an HMO or PPO
XVIII. No yes answers to attestation/disclosure questions on the application form, with the exception of the following:
a. Investment or business interest in ancillary services, equipment or supplies
b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization
c. Voluntary surrender of state license related to relocation or nonuse of said license
d. A NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria
e. Nonrenewal of malpractice coverage or a change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business)
f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year, post-residency training window
g. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion
h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction

The CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, the practitioner’s name and specialty.

Criteria for Selecting Practitioners – Currently Participating Applicants (Recredentialing)

I. Submission of complete recredentialing application and required attachments, which must not contain intentional misrepresentations
II. Recredentialing application signed date within 180 calendar days of the date of submission to the CC for a vote
III. Primary source verifications within acceptable time frames of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies
IV. No evidence of potential material omission(s) on recredentialing application
V. Currently participating providers must not be currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or FEHBP. If federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs to a participating practitioner, he or she will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as Anthem’s other credentialed provider network(s) at the time of identification. Special consideration regarding the practitioner’s continued participation in Anthem’s other credentialed practitioner network(s) may be requested by the vice president (VP) responsible for that network(s) if, in the opinion of the requesting VP: 1) the federal sanction, debarment or exclusion is not reflective of significant issues of professional conduct and 2) competence and participation of the practitioner is important for network adequacy. The request, with supporting information, will be brought to Anthem’s geographic credentials committee for consideration and final determination. There will be no practitioner appeal rights related to the special consideration regarding the practitioner’s continued participation in Anthem’s other credentialed provider network(s) if such participation would be permitted under applicable state regulation, rule or contract requirements.
VI. Current, valid and unrestricted license to practice in each state in which the practitioner provides care to covered individuals
VII. No current license probation*
VIII. Unencumbered license*
IX. No new history of licensing board reprimand since prior credentialing review
X. No current federal sanction and no new (that is, since the previous credentialing review) history of federal sanctions (per SAM, OIG and OPM reports, or NPDB report)*
XI. Current DEA/CDS registration and/or State Controlled Substance certification without new (that is, since the previous credentialing review) history of or current restrictions
XII. No current hospital membership or privilege restrictions and no new (that is, since the previous credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral relationship with a network practitioner of similar specialty at a network HDO who provides inpatient care to covered individuals needing hospitalization.
XIII. No new (that is, since the previous credentialing review) history of or current use of illegal drugs or alcoholism
XIV. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field
XV. No new (that is, since the previous credentialing review) history of criminal/felony convictions, including a plea of no contest
XVI. Malpractice case history reviewed since the last CC review (Note: If no new cases are identified since the last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of the last five years of malpractice history is evaluated and the criteria consistent with initial credentialing are used.)
XVII. No new (that is, since the previous credentialing review) involuntary terminations from an HMO or PPO
XVIII. No new (that is, since the previous credentialing review) yes answers on attestation/disclosure questions, with exceptions of the following:
   a. Investment or business interest in ancillary services, equipment or supplies
   b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization
   c. Voluntary surrender of state license related to relocation or nonuse of said license
   d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria
   e. Nonrenewal of malpractice coverage or change in the malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business)
   f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year, post-residency training window
   g. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion
   h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction
XIX. No QI data or other performance data, including complaints above the set threshold
XX. Recredentialed at least every three years to assess the practitioner’s continued compliance with Anthem standards

The CC will individually review any credentialed network practitioners and HDOs that do not meet one or more of the criteria for recredentialing.

* It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.
Additional Participation Criteria and Exceptions for Behavioral Health Practitioners (Nonphysician) Credentialing

I. Licensed clinical social worker (LCSW) or other master-level social work license type
   a. Master or doctoral degree in social work, with an emphasis in clinical social work, from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE)
      i. Program must have been accredited within three years of the time the practitioner graduated.
      ii. Full accreditation is required; candidacy programs will not be considered.
      iii. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association (APA) or be regionally accredited by the Council for Higher Education Accreditation (CHEA). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

II. Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master-level license type
   a. Master’s or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling, or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
      i. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
      ii. The graduate school must be accredited by one of the regional institutional accrediting bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (CACREP), or Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three years of the time the practitioner graduated.
      iii. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet the criteria, this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A practitioner with a doctoral degree in one of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and licensure to practice independently.

III. Clinical nurse specialist/psychiatric and mental health nurse practitioner
   a. Master’s degree in nursing, with specialization in adult or child/adolescent psychiatric and mental health nursing
      i. The graduate school must be accredited from an institution accredited by one of the regional institutional accrediting bodies within three years of the time of the practitioner’s graduation.
   b. Registered nurse license and any additional licensure as an advanced practice nurse/certified nurse specialist/adult psychiatric nursing or other license or certification as dictated by the appropriate state(s) board of registered nursing (if applicable)
   c. Certification by the American Nurses Association (ANA) in psychiatric nursing (Note: This may be any of the following types: clinical nurse specialist in child or adult psychiatric nursing, psychiatric and mental health nurse practitioner, or family psychiatric and mental health nurse practitioner.)
   d. Valid, current and unrestricted DEA/CDS registration where applicable with appropriate supervision/consultation by a network practitioner as applicable by the state licensing board
(Note: For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating covered individuals.)

IV. **Clinical psychologist**
   a. Valid state clinical psychologist license
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three years of the time of the practitioner’s graduation
   c. Education/training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA-accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a diplomate of the American Board of Professional Psychology.
   d. Master’s level therapists in good standing in the network who upgrade their license to clinical psychologist as a result of further training will be allowed to continue in the network and will not be subject to the above education criteria.

V. **Clinical neuropsychologist**
   a. Must meet all the criteria for a clinical psychologist listed in section 4 above and be board certified by either the American Board of Professional Neuropsychology (ABPN) or the American Board of Clinical Neuropsychology (ABCN)
   b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
   c. Clinical neuropsychologists who are not board certified or listed in the national register will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable predoctoral training
      ii. Documentation of applicable formal one-year, post-doctoral training (participation in CEU training alone would not be considered adequate)
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week)
      iv. Minimum of five years of experience practicing neuropsychology at least 10 hours per week

VI. **Licensed psychoanalyst**
   a. Applies only to practitioners in states that license psychoanalysts
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in the credentialing policy (for example, a psychiatrist, clinical psychologist or licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
   d. Practitioner shall possess a master’s or higher degree from a program accredited by one of the regional institutional accrediting bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP or the COAMFTE listings. The institution must have been accredited within three years of the time the practitioner graduates.
      i. Completion of a program in psychoanalysis registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program
      ii. A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; it is
recognized by the appropriate civil authorities of that jurisdiction; it can be appropriately verified; and it is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.

e. Meet minimum supervised experience requirement for licensure as a psychoanalyst, as determined by the licensing state

f. Meet examination requirements for licensure, as determined by the licensing state

Additional Participation Criteria and Exceptions for Nurse Practitioners, Certified Nurse Midwives and Physicians Assistants (Nonphysician) Credentialing

I. Process, requirements and verification – nurse practitioners

a. The nurse practitioner applicant will submit the appropriate application and supporting documents as required of any other practitioners, with the exception of differing information regarding education/training and board certification.

b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency, provided that that agency verifies the education, or from the certification board, if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary-source verified, in accordance with policy.

c. The license status must be that of NP, as verified via the primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered and unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid, will be notified of this and the applicant will be administratively denied.

d. If the NP has prescriptive authority (allowing the prescription of scheduled drugs), their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal company procedures. If there are in-force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.

e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:

   i. Certification program of the American Nurse Credentialing Center (www.nursecredentialing.org), a subsidiary of the American Nursing Association (http://www.nursingcertification.org/exam_programs.htm)

   ii. American Academy of Nurse Practitioners Certification Program (www.aanpcertification.org)

   iii. National Certification Corporation (http://www.nccwebsite.org)

   iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner (Note: A CPN-certified pediatric nurse is not a nurse practitioner.) (http://www.pncb.org/pnstore/control/exams/ac/progs)

   v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY (http://oncc.org)

   vi. This certification must be active and primary-source verified. If the state licensing board primary source verifies this certification as a requirement for licensure, additional verification by the company is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.
vii. American Association of Critical Care Nurses (https://www.aacn.org/certification/verify-certification) ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care

f. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO or HFAP-accredited hospital or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the NP will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

Additional notes on process, requirements and verification:

g. The NP applicant will undergo the standard credentialing processes outlined in credentialing policies 4-17. NPs are subject to all the requirements outlined in these credentialing policies, including but not limited to 1) the requirement for committee review of Level II files for failure to meet predetermined criteria, 2) recredentialing every three years, and 3) continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the NP may be listed in the company provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process. NPs will be clearly identified:
   i. On the credentialing file.
   ii. At presentation to the credentialing committee.
   iii. On notification to Network Services and to the provider database.

II. Process, requirements and verifications – certified nurse midwives

a. The certified nurse midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner, with the exception of differing information regarding education, training and board certification.

b. The required educational/training will be, at a minimum, that required for licensure as a registered nurse with subsequent additional training for licensure as a certified nurse midwife by the appropriate licensing body. Verification of this education and training will occur either via primary-source verification of the license, provided that the state licensing agency performs verification of the education, or from the certification board, if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary-source verified, in accordance with policy.

c. The license status must be that of CNM as verified via the primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered and unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in-force adverse actions regarding Medicare or Medicaid, will be notified of this and the applicant will be administratively denied.

d. If the CNM has prescriptive authority (allowing the prescription of scheduled drugs), their DEA and/or state certificate of prescriptive authority information will be requested and primary-source verified via normal company procedures. If there are in-force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

e. All CNM applicants will be certified by either:
   i. The National Certification Corporation for OB/GYN and Neonatal Nursing.
   ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.
This certification must be active and primary-source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by the company is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic credentialing committee.

f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO or HFAP-accredited hospital or a network hospital previously approved by the committee. In the absence of such privileges, the CNM must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. Should the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/GYN.

g. Additional notes on process, requirements and verifications:
   i. The CNM applicant will undergo the standard credentialing process outlined in Credentialing Policies 4-16. CNMs are subject to all the requirements of these credentialing policies including (but not limited to): the requirement for committee review for Level II applicants, recredentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
   ii. Upon completion of the credentialing process, the CNM may be listed in the company provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
   iii. CNMs will be clearly identified:
      1. On the credentialing file.
      2. At presentation to the credentialing committee.
      3. On notification to Network Services and to the provider database.

III. Process, requirements and verifications – physician’s assistants (PA)
   a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners, with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency, provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary-source verified, in accordance with policy.
   c. The license status must be that of PA, as verified via the primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid, will be notified of this and the applicant will be administratively denied.
   d. If the PA has prescriptive authority (allowing the prescription of scheduled drugs), their DEA and/or state certificate of prescriptive authority information will be requested and primary-source verified via normal company procedures. If there are in-force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
   e. All PA applicants will be certified by the National Commission on Certification of Physician’s Assistants. This certification must be active and primary-source verified. If the state licensing
board primary sources verifies this certification as a requirement for licensure, additional verification by the company is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to geographic credentialing policy 8 and submitted for individual review by the credentialing committee.

f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP-accredited hospital or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

g. Additional notes about process, requirements and verifications:
   i. The PA applicant will undergo the standard credentialing process outlined in credentialing policies 4-16. PAs are subject to all the requirements described in these credentialing policies, including but not limited to 1) committee review of Level II files failing to meet predetermined criteria, 2) recredentialing every three years, and 3) continuous sanction and performance monitoring upon participation in the network.
   ii. Upon completion of the credentialing process, the PA may be listed in the company provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
   iii. PA’s will be clearly identified:
        1. On the credentialing file.
        2. At presentation to the Credentialing Committee.
        3. On notification to Network Services and to the provider database.

HDO Eligibility Criteria
All HDOs must be accredited by an appropriate, recognized accrediting body. In the absence of such accreditation, Anthem may evaluate: 1) the most recent site survey by Medicare, 2) the appropriate state oversight agency, or 3) a site survey performed by a designated independent external entity within the past 36 months. Nonaccredited HDOs are subject to individual review by the CC and will be considered for covered individual access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three years to assess the HDO’s continued compliance with Anthem standards.

I. General criteria for HDOs
   a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to covered individuals (Note: The license must be in good standing with no sanctions.)
   b. Valid and current Medicare certification
   c. Must not be currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or the FEHBP (Note: If exclusion from Medicare, Medicaid or FEHBP occurs to a participating HDO, the HDO will become immediately ineligible for participation in the applicable government programs or provider network(s), as well as in our other credentialed provider network(s), at the time of identification. Special consideration regarding the HDO’s continued participation in our other credentialed practitioner network(s) may be requested by the vice president (VP) responsible for that network(s) if, in the opinion of the requesting VP, the following criteria are met: the federal sanction, debarment or exclusion is not reflective of significant issues of professional conduct and
competence, and participation of the HDO is important for network adequacy. The request with supporting information will be brought to Anthem’s geographic credentials committee for consideration and final determination, without HDO appeal rights related to the special consideration, regarding the HDO’s continued participation in Anthem’s other credentialed provider network(s), if such participation would be permitted under applicable state regulation, rule or contract requirements.

d. Liability insurance acceptable to Anthem
e. If not appropriately accredited, the HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem’s quality and certification criteria standards have been met.

II. Additional participation criteria for HDO by provider type

**Medical Facilities**

<table>
<thead>
<tr>
<th>Facility Type (Medical Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospital</td>
<td>CIQH, CTEAM, HFAP, DNV/NIAHO, TJC</td>
</tr>
<tr>
<td>Ambulatory surgical center</td>
<td>AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC</td>
</tr>
<tr>
<td>Birthing center</td>
<td>AAAHC, CABC</td>
</tr>
<tr>
<td>Clinical laboratory</td>
<td>CLIA, COLA</td>
</tr>
<tr>
<td>Convenient care center (CCC)/retail health clinic (RHC)</td>
<td>DNV/NIAHO, UCAOA</td>
</tr>
<tr>
<td>Dialysis center</td>
<td>TJC, CMS Certification</td>
</tr>
<tr>
<td>Federally qualified health center (FQHC)</td>
<td>AAAHC</td>
</tr>
<tr>
<td>Freestanding surgical center</td>
<td>AAAASF, AAPSF, HFAP, IMQ, TJC</td>
</tr>
<tr>
<td>Home health care agency (HHA)</td>
<td>ACHC, CHAP, CTEAM, DNV/NIAHO, TJC</td>
</tr>
<tr>
<td>Home infusion therapy (HIT)</td>
<td>ACHC, CHAP, CTEAM, HQAA, TJC</td>
</tr>
<tr>
<td>Hospice</td>
<td>ACHC, CHAP, TJC</td>
</tr>
<tr>
<td>Intermediate care facility</td>
<td>CTEAM</td>
</tr>
<tr>
<td>Portable X-ray supplier</td>
<td>FDA certification</td>
</tr>
<tr>
<td>Skilled nursing facility/nursing home</td>
<td>BOC INT’L, CARF, TJC</td>
</tr>
<tr>
<td>Rural health clinic (RHC)</td>
<td>AAAASF, CTEAM, TJC</td>
</tr>
<tr>
<td>Urgent Care Center (UCC)</td>
<td>AAAHC, IMQ, TJC, UCAOA</td>
</tr>
</tbody>
</table>

**Behavioral Health**

<table>
<thead>
<tr>
<th>Facility Type (Behavioral Health Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospital—psychiatric disorders</td>
<td>CTEAM, DNV/NIAHO, TJC, HFAP</td>
</tr>
<tr>
<td>Acute inpatient hospital – chemical dependency/detoxification and rehabilitation</td>
<td>HFAP, NIAHO, TJC</td>
</tr>
<tr>
<td>Adult family care home (AFCH)</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Adult foster care</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Community mental health center (CMHC)</td>
<td>AAAHC, TJC</td>
</tr>
<tr>
<td>Crisis stabilization unit</td>
<td>TJC</td>
</tr>
<tr>
<td>Intensive family intervention services</td>
<td>CARF</td>
</tr>
<tr>
<td>Intensive outpatient – mental health and/or substance abuse</td>
<td>ACHC, DNV/NIAHO, TJC, COA, CARF</td>
</tr>
<tr>
<td>Outpatient mental health clinic</td>
<td>HFAP, TJC, CARF, COA</td>
</tr>
</tbody>
</table>
### Facility Type (Behavioral Health Care) vs. Acceptable Accrediting Agencies

<table>
<thead>
<tr>
<th>Facility Type (Behavioral Health Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial hospitalization/day treatment—psychiatric disorders and/or substance abuse</td>
<td>CARF, DNV/NIAHO, HFAP, TJC for programs associated with an acute care facility or residential treatment facilities</td>
</tr>
<tr>
<td>Residential treatment centers (RTC) — psychiatric disorders and/or substance abuse</td>
<td>DNV/NIAHO, TJC, HFAP, CARF, COA</td>
</tr>
</tbody>
</table>

### Rehabilitation

<table>
<thead>
<tr>
<th>Facility Type (Behavioral Health Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute inpatient hospital – detoxification only facilities</td>
<td>DNV/NIAHO, HFAP, TJC</td>
</tr>
<tr>
<td>Behavioral health ambulatory detox</td>
<td>CARF, TJC</td>
</tr>
<tr>
<td>Methadone maintenance clinic</td>
<td>CARF, TJC</td>
</tr>
<tr>
<td>Outpatient substance abuse clinics</td>
<td>CARF, COA, TJC</td>
</tr>
</tbody>
</table>
CHAPTER 14: ACCESS STANDARDS AND ACCESS TO CARE

Overview
This chapter outlines Anthem's standards for timely and appropriate access to quality health care. Following guidelines set by the National Committee for Quality Assurance (NCQA), the American College of Obstetricians and Gynecologists (ACOG), and the Wisconsin Department of Health Services (DHS), these standards help ensure that medical appointments, emergency services and continuity of care for new and transferring members are provided fairly, reasonably and within specific time frames.

We recognize that cultural and linguistic barriers may affect our members’ ability to understand or comply with certain instructions or procedures. To break through those barriers and ensure that our access standards can be met, we encourage providers to access Anthem’s Cultural Competency Toolkit and Cultural and Linguistic Training. Locate this information on our website at https://mediproviders.anthem.com/wi under Provider Education. Or for additional information on cultural diversity and interpreter services, please refer to Chapter 22: Cultural Diversity and Linguistic Services in this manual.

Anthem monitors provider compliance with access-to-care standards on a regular basis. Failure to comply may result in corrective action.

General Appointment Scheduling
PCPs and specialists must make appointments for members according to the following scheduling standards:

<table>
<thead>
<tr>
<th>Nature of Visit</th>
<th>Appointment Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Examinations</td>
<td>Immediate access 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td>Urgent Examinations</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Routine Exams</td>
<td>Within 14 days of request</td>
</tr>
<tr>
<td>Behavioral Health Emergency</td>
<td>Immediately</td>
</tr>
<tr>
<td>Outpatient Treatment Post-Psychiatric Inpatient Care</td>
<td>Within three days from the date of discharge from an inpatient psychiatric hospital stay</td>
</tr>
<tr>
<td>Routine Behavioral Health Visits</td>
<td>Within ten days of request</td>
</tr>
<tr>
<td>Dental Care Appointment Standards</td>
<td>Within 90 days of request in Regions 5 and 6</td>
</tr>
</tbody>
</table>

Services for Members Under 21 Years of age
Anthem strongly recommends that our members see their PCP as soon as possible after enrollment.

<table>
<thead>
<tr>
<th>Nature of Visit</th>
<th>Appointment Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Health Assessments</td>
<td>Newborns: Within 14 days of enrollment</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td>Preventive Care Visits</td>
<td>According to the American Academy of Pediatrics (AAP) Periodicity Schedule, found within the preventive health guidelines</td>
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<th>Appointment Standards</th>
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</tr>
<tr>
<td>Postpartum Exam</td>
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</tr>
</tbody>
</table>

**Wait Times**
When a provider's office receives a call from an Anthem member during regular business hours for assistance and possible triage, the provider or another health care professional must take or return the call within 30 minutes.

**Nondiscrimination and Office Hours**
Providers must post a statement in their offices detailing hours of operation. These hours of operation must not discriminate against Anthem members enrolled in BadgerCare Plus and Medicaid SSI. The statement must include the following:
- Waiting times for appointments
- Waiting times for care at facilities
- Languages spoken

**Interpreter Services**
Anthem will ensure that members who need interpreter services have access to a telephone interpreter 24 hours a day, seven days a week, free of charge. Services include assistance during office visits and telephone assistance. To request interpreter services during business hours:
- Providers call Provider Services: 1-855-558-1443.
- Members call Member Services: 1-855-690-7800.

To request interpreter services after-hours, providers and members call the 24/7 NurseLine:
- Phone: 1-855-690-7800 (24 hours a day, 7 days a week)
- TTY: 711

Please note: To schedule face-to-face interpreter services, please allow 72 hours. To cancel, please provide 24-hour notice.

**Missed Appointment Tracking**
When members miss appointments, providers must do the following:
- Document the missed appointment in the member’s medical record.
- Make at least three attempts to contact the member to determine the reason for the missed appointment.
- Provide a reason in the member’s medical record for any delays in performing an examination, including refusals by the member.

**After-Hours Services**
Anthem’s policy, and the state of Wisconsin's requirement, is for our members to have access to quality health care services 24 hours a day, seven days a week. This kind of access means PCPs must have a system in place to ensure members may call after-hours with medical questions or concerns. Anthem monitors PCP
compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

PCPs must adhere to the answering service and answering machine protocols defined in the following sections.

**Answering Service**
Answering service or after-hours personnel must:

- Forward member calls directly to the PCP or on-call provider or instruct the member that the provider will contact the member within 30 minutes.
- Ask the member if the call is an emergency. In the event of an emergency, immediately direct the member to dial 911 or proceed to the nearest hospital emergency room.
- Have the ability to contact a telephone Interpreter for members with language barriers.
- Return all calls.

**Answering Machine Messages**

- May be used when provider office staff or an answering service is not immediately available
- Must instruct members with emergency health care needs to dial 911 or proceed to the nearest hospital emergency room
- Must provide instructions on how to contact the PCP or on-call provider in a nonemergency situation
- Must provide instructions in English, Spanish and any other language appropriate to the PCP’s practice

We offer the following suggested text for answering machines:

"Hello, you have reached [insert physician office name]. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call [insert contact phone or pager number]. You will receive a return call from the on-call physician within [time frame]."

**Please note:** Anthem prefers that PCPs use an in-network provider for on-call services. When this is not possible, PCPs must use their best efforts to ensure the covering on-call provider abides by the terms of the Provider Agreement.

**24/7 NurseLine**

Members may call the 24/7 NurseLine, our 24/7-information phone line, any time of the day or night to speak to a registered nurse. Nurses provide health information and options for any of the following:

- Authorization requests
- Emergency instructions
- Health concerns
- Local health care services
- Medical conditions
- Prescription drugs
- Transportation needs
- Access to interpreter services

Phone: **1-855-690-7800**
TTY: **711**
Continuity of Care
Anthem provides continuity of care for members with qualifying conditions when health care services are not available within the network or when the member or provider is in a state of transition.

Qualifying condition: A medical condition that may qualify a member for continued access to care and continuity of care

Qualifying conditions include but are not limited to:
- Acute conditions (for example, cancer).
- Degenerative and disabling conditions or diseases caused by a congenital or acquired injury or illness requiring a specialized rehabilitation program or a high level of service, resources or coordination of care in the community.
- Newborns who are covered retroactive to the date of birth.
- Organ transplant or tissue replacement.
- Pregnancy, with 12 weeks or less remaining before the expected delivery date through immediate postpartum care.
- Scheduled inpatient/outpatient surgery that was approved and/or precertified through the applicable DHS process.
- Serious chronic conditions (hemophilia, for example).
- Terminal illness.

States of transition may be when the member is:
- Newly enrolled.
- Moving out of the service area.
- Disenrolling from Anthem to another health plan.
- Exiting Anthem to receive excluded services.
- Hospitalized on the effective date of transition.
- Transitioning through behavioral health services.
- Scheduled for appointments within the first month of plan membership with specialists; these appointments must have been scheduled prior to the effective date of membership.

A state of transition also is applicable when the provider’s contract terminates.

Anthem providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PCPs and specialists as well as behavioral health providers. In addition, Anthem coordinates care when the provider’s contract has been discontinued to facilitate a smooth transition to a new provider.

The HMO assigns a representative to coordinate services with public health agencies or treatment programs within the HMO’s service area that are not included in the HMO’s network. These include county health agencies, crisis intervention agencies, community support programs, comprehensive community service programs or inpatient programs. The HMO works with the agency to coordinate the member’s transition to or from covered mental health and substance abuse care within the HMO’s network. Any member transitioning from crisis intervention services may access an appropriate level of ongoing care within 30 days of the crisis. The HMO is not required to pay for ongoing services outside the HMO network, unless the HMO has authorized those services.
Providers must maintain accurate and timely documentation in the member’s medical record, including but not limited to:

- Consultations
- Precertifications
- Referrals to specialists
- Treatment plans

All providers share responsibility in communicating clinical findings, treatment plans, prognosis and the member’s psychosocial condition as part of the coordination of care process. Medical management nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until a short-term regimen of care is completed or the member transitions to a new provider.

Please note: Only Anthem can make adverse determination decisions regarding continuity of care. Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members and providers may appeal the decision by following the procedures in Chapter 12: Grievances and Appeals. Reasons for continuity-of-care denials include but are not limited to:

- Course of treatment is complete.
- Member is ineligible for coverage.
- Condition is not a qualifying condition.
- Request is for change of PCP only and not for continued access to care.
- Requested services are not covered.
- Services rendered are covered under a global fee.
- Treating provider currently is contracted with our network.

Except for members who are hospitalized at the time of initial enrollment, Anthem is responsible for all covered pre-existing medical conditions as of the effective date of the member’s Medicaid eligibility.

Provider Contract Termination
Anthem will arrange for continuity of care for members affected by a provider whose contract is terminated. A terminated provider actively treating members must continue to treat members until the date of termination. PCPs must give at least a 90-day advance notice and specialists must give at least a 120-day advance notice before terminating the Provider Agreement. The exception is when the PCP or primary care clinic (PCC) provides 30% or more of Anthem services, in which case the PCP or PCC must give at least a 120-day advance notice.

After Anthem receives a provider’s notice to terminate a contract, we notify all impacted members. We send a letter at least 30 days in advance to inform the affected members about the:

- Impending termination of their provider.
- Member’s right to request continued access to care.
- Member Services phone number to make PCP changes and/or forward referrals to Medical Management for continued access-to-care consideration.

Members under the care of specialists also may submit requests for continued access to care, including continued care after the transition period. Members should contact Member Services.

Newly Enrolled Members
Our goal is to ensure that the health care of our newly enrolled members is not disrupted or interrupted. Anthem ensures continuity of care for our newly enrolled members when the member’s health or behavioral health condition has been treated by specialists. We also ensure continuity of care when the
member’s health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

Anthem will pay a newly enrolled member’s existing out-of-network provider for medically necessary covered services until that regimen of care is completed. The member’s records, clinical information and care are transferred to an Anthem provider.

Payment to out-of-network providers is made within the same time period required for providers within the network. In addition, we comply with out-of-network provider reimbursement rules as adopted by the DHS. All new enrollees receive evidence-of-coverage (EOC) membership information in their enrollment packets, which provides information regarding members’ rights to request continuity of care.

**Members Moving Out of the Service Area**
If a member moves out of the service area, Anthem will continue to provide emergency services until the member chooses a new managed health care plan.

**Second Opinions**
Anthem will help to ensure that members have access to a second opinion regarding any medically necessary covered service. When the request involves care from a specialist, a provider of the same specialty must give the second opinion. When no provider exists within the network who meets the qualification, Anthem may authorize a second opinion by a qualified out-of-network provider. This service is provided at no cost to the member.

**Emergency Transportation**
Anthem covers emergency transportation services without precertification when a member’s condition is life-threatening and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility.

Emergency transportation also is available for facility-to-facility transfers when the required emergency treatment is not available at the first facility.

**Emergency Dental Services for Adults and Children**
Emergency dental care is immediate service that must be provided to relieve the member from pain, an acute infection, swelling, trismus, fever or trauma. The nature of the emergency must be documented in the member’s medical record.
Primary Care Physicians
PCPs are the principal point of contact for our members. The PCP’s role is to provide members with a medical home. Anthem furnishes PCPs with a current list of assigned members. The PCP’s role is to:

- Provide or arrange for routine and preventative health care service.
- Make referrals for specialty care and other medically necessary services.
- Maintain members’ current medical records, including documentation of all services provided by the PCP, specialists or referral services.
- Adhere to the appointment wait time standards outlined in the Provider Agreement.

Facilitate Interpreter Services by presenting information in a language that our members or their representatives can understand.

PCPs are required to ensure their members’ medical and personal information is kept confidential as required by state and federal laws.

Out-Of-Network Referrals
We recognize that an out-of-network referral may be justified at times. The Anthem Medical Management department will work with the PCP to determine medical necessity and will authorize out-of-network referrals on a limited basis. For assistance, contact the Medical Management department:

Phone: 1-855-558-1443
Fax: 1-800-964-3627

Interpreter Services
Providers must notify members of the availability of interpreter services. Over the phone and face-to-face interpreter services are available at no cost to providers or members. Anthem providers should strongly discourage the use of minors, friends and family members acting as Interpreters. Refer to the “Cultural Diversity and Linguistic Services” chapter for further details on interpreter services.

Providers must train their answering services and on-call personnel on how to access interpreter services and accommodate non-English speaking members by having multi-lingual messages on answering machines.

Transitioning Members between Medical Facilities and Home
When medically indicated, the PCP initiates or assists with the discharge or transfer of members:

- From an inpatient facility to the appropriate skilled nursing or rehabilitation facility, or to the member’s home.
- From an out-of-network hospital to an in-network hospital or to the member’s home with home health care assistance (within benefit limits).

The coordination of member transfers from noncontracted, out-of-network facilities to contracted, in-network facilities is a priority that may require the immediate attention of the PCP. Contact the Anthem Medical Management department to assist in this process.

Notification of Admission and Services
The hospital must notify Anthem or the review organization of an admission or service at the time the member is admitted or the service is rendered. If the member is admitted or a service is rendered on a day
other than a business day, the hospital must notify Anthem of the admission or service the morning of the next business day.

**Notification of Precertification Decisions**
If the hospital has not received notice of precertification at the time of a scheduled admission or service as required by the utilization management guidelines and Hospital Agreement, the hospital should contact Anthem and request the status of the decision.

Any admission or service requiring precertification that has not received the appropriate review may be subject to post-service review denial. Generally, providers are required to perform all precertification functions with Anthem. Before rendering services, the hospital must ensure precertification has been granted or risk post-service denial.

**After-Hours Services**
All PCPs must have an after-hours system in place to ensure that our members can call with medical concerns or questions after normal office hours. The answering service or after-hours personnel must forward member calls directly to the PCP or on-call provider, or instruct the member that the provider will be in contact within 30 minutes.

**Emergencies**
The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be directed to dial 911 or to proceed to the nearest hospital emergency room immediately.

If the PCP’s staff or answering service is not available, an answering machine may be used. The answering machine message must instruct members with emergency health care needs to dial 911 or go directly to the nearest hospital emergency room. The message also must give members an alternative contact number to reach the PCP or on-call provider with medical concerns or questions.

**Language-Appropriate Messages**
Non-English speaking members who call their PCP after-hours should expect to get language appropriate messages. In the event of an emergency, these messages should direct the member to dial 911 or proceed to the nearest hospital emergency room immediately. In a nonemergency situation, members should receive instructions on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone Interpreter. All calls taken by an answering service must be returned.

**Network On-Call Providers**
Anthem prefers that PCPs use network providers for on-call services. When that is not possible, the PCP must ensure that the covering on-call provider or other provider abides by the terms of the Provider Agreement. Anthem will monitor PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

**24/7 NurseLine**
Members may call our 24/7 NurseLine information line 24 hours a day, 7 days a week to speak to a registered nurse. These nurses provide health information regarding illness, options for accessing care and availability of emergency services.
Phone: **1-855-690-7800**
TTY: **711**
**Licenses and Certifications**
Providers must maintain all licenses, certifications, permits, accreditations or other prerequisites required by Anthem and federal, state and local laws for providing medical services.

**Eligibility Verification**
All providers must verify member eligibility immediately before providing services, supplies or equipment. Because eligibility may change monthly, a member eligible on the last day of the month may not be eligible on the first day of the following month. Anthem is not responsible for charges incurred by ineligible patients.

**Continuity of Care**
PCPs are responsible for being an ongoing source of primary care appropriate to the member’s needs. We have established comprehensive mechanisms to ensure continued access to care for members when providers leave our health care program. Under certain circumstances, members may finish a course of treatment with the terminating provider. For more information, refer to Chapter 14: Access Standards and Access to Care.

**Medical Records Standards**
Medical records must be maintained in a manner ensuring effective and confidential member care and quality review. At Anthem, we perform medical record reviews upon signing a provider contract. We then perform medical record reviews at least every three years to ensure that providers remain in compliance with these standards.

Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a provider of health care from disclosing any individually identifiable information regarding a patient’s medical history, treatment, or behavioral and physical condition without the patient’s or legal representative’s consent or specific legal authority.

Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and be in compliance. For more information on medical records standards, refer to Chapter 18: Quality Assessment and Performance.

**Mandatory Reporting of Child Abuse, Elder Abuse or Domestic Violence**
Providers must ensure their office staff is familiar with local reporting requirements and procedures regarding telephone and written reporting of known or suspected cases of abuse. All health care professionals must report any actual or suspected child abuse, elder abuse or domestic violence immediately to the local law enforcement agency by telephone. In addition, providers must submit a follow-up written report to the local law enforcement agency within the time frames required by law.

**Updating Provider Demographic Information**
Demographic changes should be submitted using Anthem’s online Provider Maintenance Form, which is state-specific and available on the Availity Portal. Providers are required to inform Anthem of any changes to their practice profile, including:
- Adding or changing a business address or location where services are provided.
- Name change.
- Tax ID change.
- Provider leaving a group or a single location.
- Changing phone/fax number.
- Closing a practice location.
- Change in specialty.
- Services offered to children.
- Languages spoken.
- Notification that the provider is accepting new patients

Providers can call Provider Services at **1-855-558-1443** to notify Anthem of:

- Legal or governmental action initiated against a health care professional. (Note: This type of action includes but is not limited to: an action for professional negligence, for violation of the law, or against any license or accreditation which, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement.)
- Other problems or situations that impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement’s care review and grievance resolution procedures.

**Oversight of Nonphysician Practitioners**

All providers using nonphysician practitioners must supervise and oversee nonphysician practitioners consistent with state and federal laws. The supervising provider and the nonphysician practitioner must have written guidelines for adequate supervision. All supervising providers must follow state licensing and certification requirements. Nonphysician practitioners include the following categories:

- Nurse practitioners
- Certified nurse midwives
- Physician assistants

These nonphysician practitioners are licensed by the state and work under the supervision of a licensed physician, as mandated by state and federal regulations.

**Open Clinical Dialogue/Affirmative Statement**

Nothing within the Provider Agreement or this manual should be construed as encouraging providers to restrict medically necessary covered services or limit clinical dialogue between providers and their patients. Providers may communicate freely with members regarding the available treatment options, including medications, regardless of benefit coverage limitations.

**Provider Contract Termination**

A terminated provider actively treating members must continue treatment until the termination date. The termination date is the end of the 90-day period following written notice of termination, or according to a timeline determined by the medical group contract.

After we receive a provider’s notice to terminate a contract, we notify members impacted by the termination 30 days prior to the termination. Anthem sends a letter to inform affected members about the:

- Impending termination of their provider.
- Member’s right to request continued access to care.
- Member Services phone number to request PCP changes.
- Referrals to Medical Management for continued access-to-care consideration.

Members under the care of specialists also may submit requests for continued access to care, even after the transition period, by calling Member Services:

Phone: **1-855-690-7800**
TTY: **711**

Anthem may terminate the Provider Agreement if we determine that the quality of care or services given by a health care provider is not satisfactory. We make this determination by reviewing member satisfaction.
surveys, case management data, member complaints or grievances, other complaints or lawsuits alleging professional negligence, or quality of care indicators.

Termination of the Ancillary Provider/Patient Relationship
Under certain circumstances, an ancillary provider may terminate the professional relationship with a member, as provided for and in accordance with the provisions of this manual. However, ancillary providers may not terminate the relationship because of the member’s medical condition or the amount, type or cost of covered services required by the member.

Disenrollees
When a member disenrolls and requests a transfer to another health plan, providers are expected to work with Anthem case managers responsible for helping the member make the transition. This transition must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager will coordinate with the member, the member’s providers and the case manager at the new health plan to ensure an orderly transition.

Provider Rights
Anthem providers, acting within the lawful scope of practice, will not be prohibited from advising a member or advocating on behalf of a member for any of the following:

- The member’s health status, medical care or treatment options, including any alternative, self-administered treatment
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or nontreatment
- The member’s right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the grievances and appeals and state fair hearing procedures
- To have access to policies and procedures covering authorization of services
- To be notified of any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of our members, the denial of coverage, or payment for, medical assistance
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable law, solely based on that license or certification

Prohibited Activities
All providers are prohibited from:

- Billing eligible members for covered services.
- Segregating members in any way from other persons receiving similar services, supplies or equipment.
- Discriminating against Anthem members.

Misrouted Protected Health Information
You are not permitted to use or disclose protected health information about individuals you are not treating or have enrolled to your practice. This applies to protected health information accessible in any Anthem online tool, or sent in any medium including mail, email, fax or other electronic transmission.
Overview
At Anthem, we believe that providing quality health care should not be limited to the treatment of injury or illness. We are committed to helping providers and members become more proactive in the quest for better overall health. To accomplish this goal, we offer providers tools to assist in finding the best, most cost-effective ways to:

- Provide member treatment.
- Empower members through education.
- Encourage member lifestyle changes when possible.

We want providers to have access to the most up-to-date clinical practice and preventive health care guidelines, offered by nationally recognized health care organizations and based on extensive research. These guidelines include the latest standards for treating the most common and serious illnesses, such as diabetes and hypertension. These guidelines also include recommendations for preventive screenings, immunizations and member counseling based on age and gender.

Clinical Practice Guidelines
Providers need the latest research on treating common conditions, such as asthma, diabetes and hypertension. The clinical practice guidelines follow nationally-recognized best practices for standards of treatment and give providers a powerful tool in educating our members. The clinical practice guidelines are available on our provider website at https://mediproviders.anthem.com/wi > Medical > Clinical Practice Guidelines. The website offers the most up-to-date clinical resources and guidelines.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility for services are determined in accordance with the requirements set forth by the state.

Preventive Health Care Guidelines
Good health begins with good lifestyle habits and regular exams. We support providers in helping members take control of their own health by identifying and reducing the risk of potentially serious conditions.

The preventive health care guidelines, offered by nationally-recognized health organizations as a provider resource, are an effective tool for improving the overall health of our members by emphasizing education and behavior change. The guidelines can be accessed from the Anthem provider website under the quick link Provider Education > Manuals, Directories, Training and More > Tutorials, Reference Guides & Other Resources > Preventive Health Guidelines.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits, or a contract. Actual member benefits and eligibility are determined in accordance with the requirements set forth by the state.
Overview
Our Case Management program is a collaborative effort providing assistance to both providers and members in the coordination of complex health care. The program is designed to educate and assist members to become empowered, exercise their options to access the appropriate services, and optimize their health care benefits to meet their individual health needs. This includes Case Management staff working one-on-one with members, their families and other members of the interdisciplinary care team, using behavioral health science to promote engagement.

A case manager will perform an assessment to identify the needs of the member. In collaboration with the member, a care plan is developed. Barriers are identified within the care plan and goals are developed to work through the barriers. The case manager will periodically re-evaluate progress toward goals and address any new issues. A copy of the care plan is sent to the provider for review. After the goals are met or Case Management can no longer make an impact, the case is closed and the provider is notified of the case closure. Cases referred to Case Management may be identified by disease or condition, dollars spent, or high utilization of services.

Please note: Our Case Management department is sensitive to the cultural and linguistic diversity of our members and its impact on their interaction in the health care system. We encourage providers to become familiar with our cultural and linguistic training materials, available on the providers page of our website: https://mediproviders.anthem.com/wi. There are interpreters available to meet the needs of our members. If the provider requests an interpreter to be present at the time of the appointment with the member, Anthem makes the arrangements. Contact Provider Services at 1-855-558-1443.

Provider Responsibilities
PCPs have the responsibility of participating in the case management process by sharing information and facilitating the process as follows:
- Referring members who could benefit from case management
- Sharing information as soon the PCP identifies complex health care needs
- Collaborating with case management staff on an ongoing basis
- Referring members to specialists, as required
- Providing medical information
- Monitoring and updating the care plan to promote health care goals
- Coordinating county or state-linked services such as public health, behavioral health, schools and waiver programs

Referral Process
Providers, nurses, social workers and members or their representatives may refer members to Case Management by calling 1-844-238-4048.

Case Manager Responsibilities
The case managers will work together with the member and primary care provider as a team to provide appropriate services to the member. The case manager will assess the member’s health care status, develop a health care plan, and:
- Facilitate communication and coordination within the health care team.
- Facilitate communication with the member and his or her family in the decision-making process.
- Educate the member and provider(s) about care management, community resources, benefits, cost factors and all related topics so informed decisions may be made.
- Encourage appropriate use of medical facilities and services, with the goal of improving quality of care and maintaining cost-effectiveness on a case-by-case basis.

The Case Management department includes experienced and licensed registered nurses and behavioral health professionals, some of whom are certified case managers. The department also includes social workers who add valuable skills, allowing us to address our members’ medical, psychological, social and financial issues.

**Continued Access to Care**

New Anthem members may receive services from out-of-network, Wisconsin Medicaid-certified providers if certain guidelines are met. First, the provider must contact us to discuss the scheduled health services in advance of the service date. Second, the case must meet medical necessity.

**Continuity of Care Process**

Our case management team reviews member and provider requests for continuity of care. This team facilitates continuation with the current provider until the short-term regimen of care is complete or the member transitions to a new provider.
Overview
Anthem’s goal is continuous, measurable improvement in our delivery of quality health care. Following federal and state guidelines, we have a Quality Assessment and Performance Improvement (QAPI) program in place to advance our levels of readiness, service and care. The QAPI program, aligned with the state of Wisconsin’s quality standards, includes focused studies measuring quality of care in the following clinical and service areas:

- Childhood immunization status
- Comprehensive diabetes care (HbA1C testing and LDL-C screening)
- Chronic obstructive pulmonary disease (COPD) and chronic heart failure (CHF) care
- Healthy birth outcomes
- Lead testing of 1- and 2-year-olds
- Tobacco cessation
- Use of appropriate medication for asthmatics

All providers are expected to participate in these studies as part of our mutual goal of providing responsive, cost-effective health care that improves our members’ lives. The studies include:

- Participation in multi-disciplinary teams for problem solving
- Population studies
- Random sample-based studies
- Satisfaction surveys

We share information from these studies with providers and encourage constructive feedback. Based on the results of the previous year’s QAPI program, Anthem reviews and assesses the program’s effectiveness and develops a new work plan for the next year’s activities.

We also participate in national evaluations designed to gauge our performance and that of providers. An important measure of performance comes from the National Committee for Quality Assurance (NCQA), which annually reports the Healthcare Effectiveness Data and Information Set (HEDIS®) scores to health care plans throughout the country. This professional evaluation serves as a yearly report card and is a tool used by more than 90% of America’s health care plans to rate performance across a wide spectrum of care and service areas, including:

- Member satisfaction with care access
- Member satisfaction with claims processing
- Customer service

Anthem uses the HEDIS data to identify areas for improvement and shares the results with providers. We submit the results of the HEDIS assessment and our own quality studies annually to the Wisconsin Department of Health Services (DHS), which makes the results public. As a result, HEDIS summaries may be used by potential members to make comparisons before choosing a health care plan.

We also are committed to tracking preventable adverse medical events, also known as “never events,” with the ultimate goal of eliminating these events.
Please note: If we determine that the quality of care or services provided by a health care professional is not satisfactory, Anthem may terminate the Provider Agreement and related addendums. We make this determination by reviewing member satisfaction surveys, case management data, member complaints or grievances, other complaints or lawsuits alleging professional negligence, or quality-of-care indicators.

Quality Assessment and Performance Improvement Program
The QAPI program focuses on developing and implementing standards for clinical care and service, measuring conformity to those standards, and taking action to improve performance. The scope of the QAPI program includes, but is not limited to, the monitoring and evaluation of:

- Care and service provided in all health delivery settings.
- Internal organizational performance.
- Provider/member satisfaction.
- Provider promotion of preventive health programs and exams.
- Provider management of member health status.
- Provider site facilities and medical records.

Anthem develops an annual plan of quality improvement activities based on the results of the previous year’s QAPI program evaluation. Then we review, evaluate and revise the QAPI program’s effectiveness. The evaluation is a written description of the ability of Anthem to implement the QAPI program, meet program objectives, and develop and implement plans to improve the quality of care and service to our members. Providers support the activities of the QAPI program by:

- Completing corrective action plans, when applicable.
- Participating in the facility and medical record audit process.
- Providing access to medical records for quality improvement projects and studies.
- Responding in a timely manner to requests for written information and documentation, if a quality of care or grievance issue has been filed.
- Using preventive health and clinical practice guidelines in member care.

An overview of the QAPI program outcomes is posted on the provider website annually. You may also request a hard copy by calling Provider Services at 1-855-558-1443.

Healthcare Effectiveness Data and Information Set
HEDIS is a national evaluation and core set of performance measurements gauging the effectiveness of Anthem and providers in delivering quality care. We are ready to help when providers and their office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

- Information about the year’s selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for smooth coordination of medical record data collection

Our Quality Improvement staff will contact the provider’s office when we need to review or copy any medical records required for quality improvement studies. Office staff must provide access to medical records for review and copying.

Quality Management
Twice a year, and in accordance with NCQA standards, Anthem analyzes relevant utilization data against established thresholds for each health plan to detect current utilization levels. If our findings fall outside specified target ranges and indicate potential under-utilization or over-utilization, further analysis will occur
based on the recommendation of Anthem’s Utilization Management committee. The follow-up analysis may include gathering the following data from specific provider and practice sites:

- Case management services needed by members
- Claims payments for covered services
- Coordination with other providers and agencies
- Focus studies
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Retrospective reviews of services provided without authorization

**Best Practice Methods**

Best practice methods are Anthem’s most up-to-date compilation of effective strategies for quality health care delivery. We share best practice methods during site visits to provider offices. Member Services and Network Management departments offer policies, procedures and educational toolkits to help guide improvements. Toolkits may include examples of best practices from other offices, including:

- Resources for improving compliance with preventive health services
- Clinical practice guidelines
- Care for members with special or chronic care needs

**Member Satisfaction Surveys**

Member satisfaction with Anthem’s health care services is measured every year by the NCQA. The NCQA conducts a survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The survey is designed to measure member satisfaction with our services, including:

- Access to care
- Anthem customer service
- Provider communications
- Provider office staff performance

We distribute the results of the CAHPS survey to both members and providers. Providers should review the results, share the results with office staff and incorporate appropriate changes in their offices.

**Provider Satisfaction Surveys**

Anthem may conduct provider surveys to monitor and measure provider satisfaction with our services and identify areas for improvement. Provider participation in these surveys is highly encouraged and your feedback is very important. We inform providers of the results and plans for improvement through provider bulletins, newsletters, meetings or training sessions.

**Medical Records and Facility Site Reviews**

We conduct medical record and facility site reviews to determine provider:

- Compliance with standards for providing health care.
- Compliance with standards for storing medical records.
- Compliance with processes that maintain safety standards and practices.
- Involvement in the continuity and coordination of member care.

**Please note:** The Wisconsin DHS and Anthem have the right to enter the premises of providers to inspect, monitor, audit or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as to not unduly delay work, in accordance with the Provider Agreement.
Medical Record Documentation Standards
Anthem requires providers to maintain medical records in a manner that is current, organized and permits effective and confidential member care and quality review. Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act, which requires the following:

- Providers of health care are prohibited from disclosing any individually identifiable information regarding a patient’s medical history, mental and physical condition, or treatment without the patient's or legal representative’s consent or specific legal authority.
- Records required through a legal instrument may be released without patient or patient representative consent.
- Providers must be familiar and in compliance with the security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Medical Record Security
Medical records must be secure and inaccessible to unauthorized access to prevent loss, tampering, disclosure of information, alteration or destruction of the records. Information must be accessible only to authorized personnel within the provider’s office, Anthem, the Wisconsin DHS, or to persons authorized through a legal instrument. Records must be made available to Anthem for purposes of quality review, HEDIS and other studies.

Storage and Maintenance
Active medical records should be stored in a central medical record area and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, permitting effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Availability of Medical Records
The medical record system must allow for prompt retrieval of each record when the member comes in for a visit. Providers must maintain members' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective, professional medical review and medical audit processes

Medical records must be legible, signed and dated, and maintained for at least seven years as required by state and federal regulations.

Providers must supply a copy of a member’s medical record upon reasonable request by the member at no charge. The provider also must facilitate the transfer of the member’s medical record to another provider at the member’s request. Access to medical records and confidentiality must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit Anthem and ForwardHealth representatives to review members’ medical records for the purposes of monitoring the provider’s compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason. ForwardHealth encourages providers to use technology, such as health information exchanges, to transmit and store medical record data.

Medical Record Requirements
At a minimum, every medical record must include the following:

- The patient’s name or identification (ID) number on each page in the record
• Personal biographical data, including home address, employer, emergency contact name and phone number, home and work phone numbers, and marital status
• Entries dated with month, day and year
• Entries documented with the author’s identification and title; for example, handwritten signature, unique electronic identifier or initials
• Identification of all providers participating in the member’s care
• Information on the services furnished by these providers
• List of problems, including significant illnesses, medical conditions and psychological conditions
• Presenting complaints, diagnoses and treatment plans, including the services to be delivered
• Physical findings relevant to the visit, including vital signs, normal and abnormal findings, and appropriate subjective and objective information
• Information on allergies and adverse reactions or a notation that the patient has no known allergies or history of adverse reactions
• Information on advance directives
• Past medical history, including serious accidents, operations and illnesses; in addition:
  o For patients 14 years old and older, the record must include information about substance abuse.
  o For children and adolescents, the record must include past medical history as it relates to prenatal care, birth, operations and childhood illnesses.
• Notations concerning the use of cigarettes, alcohol and substance abuse for patients 14 years and older, including anticipatory guidance and health education
• Physical examinations, treatment necessary and possible risk factors relevant to the particular treatment
• Prescribed medications, including dosages and dates of initial or refill prescriptions
• Information about the individuals to be instructed in assisting the patient
• Medical records legible, dated and signed by the provider, physician assistant, nurse practitioner or nurse midwife providing patient care
• Up-to-date immunization record for children, or an appropriate history for adults
  o Documentation of attempts to provide immunizations (If the member refuses immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian shall be documented in the member’s medical record.)
  o Evidence of preventive screening and services, in accordance with Anthem’s preventive health practice guidelines
  o Documentation of referrals, consultations, diagnostic test results and inpatient records (Evidence of the provider’s review may include the provider’s initials or signature and notation in the patient’s medical record. The provider may indicate review and patient contact, follow-up treatment, instructions, return office visits, referrals, and other patient information.)
  o Notations of patient appointment cancellations or no-shows and the attempts to contact the patient to reschedule
  o No indication or implication that the patient was placed at inappropriate risk by a diagnostic test or therapeutic procedure
  o Documentation on whether an interpreter was used in any initial or follow-up visit

Advance Directives
Recognizing a person’s right to dignity and privacy, our members have the right to execute an advance directive, also known as a living will, to identify their wishes concerning health care services should they become incapacitated. Providers are expected to adhere to the following guidelines:
• Discuss the sensitive issues raised by advance directives with patients and their families.
• Advise members of their right to change or revoke their advance directive at any time.
• Advise members of their right to contact Member Services to request additional information about advance directives.
• Document in the member’s medical record the discussion about advance directives.
• Document in the member’s medical record whether or not an advance directive has been completed.
• Place a copy of a completed advance directive in the member’s medical record.

**Medical Record Review Process**
A member of the Quality Improvement department will call the provider’s office to schedule a medical record review on a date and time occurring within 30 days. On the day of the review, the quality improvement associate will:
1. Request the number and type of medical records required.
2. Review the appropriate type and number of medical records per provider.
3. Complete the medical record review.
4. Meet with the provider or office manager to review and discuss the results of the medical record review.
5. Provide a copy of the medical record review results to the office manager or provider or send a final copy within ten days of the review.
6. Schedule follow-up reviews for any corrective actions identified.

Providers must attain a score of 80% or greater to pass the medical record review. Anthem conducts a medical record review annually, according to our medical records standards, at select primary care sites and high-volume provider offices.

**Facility Site Review Process**
An initial site inspection is required for all provider offices participating in Anthem, regardless of other accreditation or certification. In addition:
• A site review is required as part of the initial credentialing process for new providers if that site has not been reviewed and accepted as part of Anthem’s credentialing process.
• Obstetrics/gynecology (OB/GYN) specialist sites participating in our plan and not serving as PCPs also must undergo an initial site inspection.

A member of our Quality Improvement department will call the provider’s office to schedule an appointment date and time before the facility site review due date. The department will fax or mail a confirmation letter with an explanation of the audit process and required documentation. During the facility site review, the Quality Improvement associate will:
1. Lead a prereview conference with the provider or office manager to review and discuss the process of facility review and answer any questions.
2. Conduct a review of the facility.
3. Develop a corrective action plan, if applicable.

After the facility site review is completed, our associate will meet with the provider or office manager to:
1. Review and discuss the results of the facility site review and explain any required corrective actions.
2. Provide a copy of the facility site review results and the corrective action plan to the provider or office manager or mail a final copy within 10 days of the review.
3. Educate the provider and office staff about our standards and policies.
4. Schedule a follow-up review for any corrective actions identified.

**Facility Site Review: Corrective Actions**
If the facility site review results in a nonpassing score, Anthem will notify providers immediately of the nonpassing score, all cited deficiencies and corrective action requirements. The provider office will develop and submit corrective action plans and we will conduct follow-up visits every six months until the site complies with our standards.
The provider and office staff will:
1. Make available an appointment time for the review.
2. Be available to answer questions and participate in the exit interview.
3. Schedule follow-up reviews, if applicable.
4. Complete a corrective action plan.
5. Sign an attestation that corrective actions are complete.
6. Submit the completed corrective action plan, supporting documents and signed attestation to our Quality Improvement analyst.

**Preventable Adverse Events**

The breadth and complexity of today’s health care system means there are inherent risks, many of which can be neither predicted nor prevented. However, preventable adverse events should be tracked and reduced, with the ultimate goal of eliminating these events.

Providers and health care systems, as advocates for our members, are responsible for the continuous monitoring, implementation and enforcement of applicable health care standards. Focusing on patient safety, we work collaboratively with providers and hospitals to identify preventable adverse events and implement appropriate strategies and technologies to avoid these events. Our goal is to enhance the quality of care received not only by our members, but all patients receiving care in these facilities.

Prevention of adverse events may require the disclosure of protected health information (PHI). HIPAA specifies that PHI may be disclosed for the purpose of health care operations in relation to quality assessment and improvement activities. Moreover, the information you share with us is legally protected through the peer review process and will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide the records within 10 days from the date of request.

We will continue to monitor activities related to the list of adverse events from federal, state and private payers, including never events.

**Never events**: As defined by the National Quality Forum (NQF), never events are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers.

Preventable adverse events should not occur. When they do, we firmly support the concept that a health plan and its members should not pay for resultant services.

**Please note**: Medicaid is prohibited from paying for certain health care acquired conditions (HCAC), and this ruling applies to all hospitals.
CHAPTER 19: ENROLLMENT AND MARKETING RULES

Overview
The delivery of quality health care poses numerous challenges, not the least of which is the commitment shared by Anthem and providers to act in the best interest of our members. We want our members to make the best health care decisions possible. And when members ask for our assistance, we want to provide that assistance so they make those decisions without undue influence.

We recognize that providers occupy a unique, trusted and respected part of people’s lives. Given the complexity of modern-day health care and the inherent difficulties communicating with some of the populations we serve, there are potentially serious pitfalls when providers try to assist in the decision-making process. Sometimes, even though the intent is to help make our members’ lives better, we may overstep.

For that reason, we are committed to following strict enrollment and marketing guidelines created by the Wisconsin Department of Health Services (DHS) and to honoring the rules for all state health care programs.

Enrollment Policies
Anthem members enrolled in BadgerCare Plus and Medicaid SSI may change their choice of a health care plan during the first three months of enrollment, a process called open enrollment. After 90 days, when the open enrollment period is over, members cannot change their health care plan for nine more months. This is known as the lock-in period. Members will be sent a letter advising when their lock-in period will end. When the lock-in period is over, they may change to a different health care plan, if available. Most SSI and SSI-related Medicaid members are required to choose the HMO in which they wish to enroll.

Marketing Policies
Anthem providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that he or she select membership in a particular plan. The DHS marketing practice policies prohibit network providers from making any of the following false or misleading claims:

- PCP office staff are employees or representatives of the state, county or federal government.
- Anthem is recommended or endorsed by any state or county agency, or any other organization.
- The state or county recommends that a prospective member enroll with a specific health care plan.
- A prospective member or medical recipient loses Medicaid or other welfare benefits if the prospective member does not enroll with a specific health care plan.

These policies also prohibit network providers from taking the following actions:

- Making marketing presentations, advising or recommending to an eligible individual that he or she select membership in a specific health care plan
- Offering or giving away any form of compensation, reward or loan to a prospective member to induce or procure member enrollment in a specific health care plan
- Engaging in direct marketing to members designed to increase enrollment in a particular health care plan (The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.)
- Using any list of members originally obtained for enrollment purposes from confidential state or county data sources or from the data sources of other contractors
- Employing marketing practices that discriminate against potential members other than persons specifically excluded from coverage under our contract. Providers may not discriminate based on marital
status, age, religion, gender, gender identity, national origin, language, sexual orientation, ancestry, pre-existing psychiatric problem or medical condition such as pregnancy, disability or acquired immune deficiency syndrome (AIDS)

- Reproducing or signing an enrollment application for the member
- Displaying materials only from the provider’s contracted managed health care organizations and excluding others

Providers are permitted to:

- Assist members in applying for benefits by calling Anthem or the HMO enrollment specialist for enrollment information:
  - Phone: 1-855-690-7800
  - TTY: 711
  - Health Maintenance Organization (HMO) enrollment specialist: 1-800-291-2002
- Distribute copies of BadgerCare Plus applications to potential members or refer potential members to www.access.wisconsin.gov (Medicaid SSI recipients automatically qualify for Medicaid, and therefore would simply call the HMO enrollment specialist at 1-800-291-2002).
- File a complaint with Anthem if a provider or member objects to any form of marketing, either by other providers or by Anthem representatives. Refer to Chapter 12: Grievances and Appeals for more information on the grievance process.

**Enrollment Process**

DHS determines the eligibility and enrollment for individuals seeking to enroll in BadgerCare Plus and Medicaid SSI, after which the process is as follows:

- DHS presents BadgerCare Plus Plan to eligible individuals and families.
- DHS informs Anthem of new member enrollment.
- Providers are given notice of new members assigned to their care through monthly eligibility reports. Providers access these reports by logging in to Availity, the secure provider portal on our website: https://mediproviders.anthem.com/wi. Select Login or Register to access the secure site.
- Anthem sends each new member a new member packet within ten business days of receiving the DHS monthly membership file. This packet includes the member handbook, an information card with important phone numbers and instructions for changing a PCP.

**Please note:** If a member loses BadgerCare Plus eligibility but becomes eligible again within six months or less, DHS automatically re-enrolls the member. DHS also returns the member automatically to the same health care plan and PCP they had prior to disenrollment, if available. Members may choose to switch plans if they are no longer locked in.
CHAPTER 20: FRAUD, ABUSE AND WASTE

We are committed to protecting the integrity of our health care program and the efficiency of our operations by preventing, detecting and investigating fraud, abuse and waste.

Understanding Fraud, Abuse and Waste
Combating fraud, abuse and waste begins with knowledge and awareness.

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

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

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

Examples of Provider Fraud, Abuse and Waste
The following are examples of provider fraud, abuse and waste:

- Altering medical records
- Billing for services not provided
- Billing for medically unnecessary tests
- Billing professional services performed by untrained personnel
- Misrepresentation of diagnosis or services
- Over-utilization
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling
- Under-utilization
- Upcoding

Examples of Member Fraud, Abuse and Waste
The following are examples of member fraud, abuse and waste:

- Frequent emergency room visits for nonemergent conditions
- Forging, altering or selling prescriptions
- Letting someone else use a member’s ForwardHealth identification (ID) card
- Not telling the truth about the amount of money or resources the member has for the purpose of obtaining benefits
- Not telling the truth about a medical condition to obtain medical treatment
- Obtaining controlled substances from multiple providers
- Not notifying the health plan when relocating to an out-of-service area
- Using multiple providers to obtain similar treatments and/or medications
- Using a provider not approved by the PCP
- Using someone else’s ForwardHealth ID
- Violating the pain management contract
Pain management contract: A written agreement between a provider and member that the member will not misrepresent his or her need for medication. If the contract is violated, the provider has the right to drop the member from his or her practice.

Reporting Provider or Recipient Fraud, Abuse or Waste
If you suspect either a provider (doctor, dentist, counselor, etc.) or member (a person who receives benefits) has committed fraud, abuse or waste, you have the right and responsibility to report the incident.

Provider Reporting
Providers may report allegations of fraud, abuse or waste by contacting Anthem:
Phone: 1-855-558-1443
Fax: 1-800-964-3627
Mail: Anthem Blue Cross and Blue Shield
ATTN: MSIU
P.O. Box 62509
Virginia Beach, VA 23466

Member Reporting
Members should let us know if they suspect a doctor, dentist, pharmacist, other health care providers, or another person receiving benefits is doing something wrong. Members should contact us at:
Member Services phone: 1-855-690-7800
TTY: 711

Both providers and members may report fraud, abuse and waste by completing our Waste, Fraud and Abuse Report Form online at our website: https://mediproviders.anthem.com/wi. To locate this form, select Waste, Fraud, & Abuse at the bottom of the page.

When reporting about a provider, include the following:
• Name, address and phone number of the provider
• Name and address of the facility (hospital, nursing home, home health agency, etc.)
• Medicaid number of the provider and facility, if available
• Type of provider (doctor, dentist, therapist, pharmacist, etc.)
• Names and phone numbers of other witnesses who can help in the investigation
• Dates of events
• Summary of what happened

When reporting about a member who receives benefits, include the following:
• The person’s name
• The person’s date of birth, Social Security number or case number, if available
• The city where the person lives
• Specific details about the fraud, abuse or waste

Anonymous Reporting of Suspected Fraud, Abuse and Waste
Any incident of fraud, abuse or waste may be reported to us anonymously. However, in certain instances, we may not be able to pursue an investigation without additional information. In such cases, we will need the following:
• The name of the person reporting and their relationship to the person suspected
• A call-back phone number for the person reporting the incident
Please note: The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators to maintain that person's anonymity.

Investigation Process
We do not tolerate acts that adversely affect providers or members. We investigate all reports of fraud, abuse and waste. Allegations and the investigative findings may be reported to the Department of Health Services (DHS), regulatory agencies and law enforcement agencies. In addition to reporting, we take corrective action such as:

- **Written warning and/or education:** We send certified letters to the provider or member documenting the issues and need for improvement. Letters may include education or request for recoveries or may advise of further action.
- **Medical record audit:** We may review medical records to substantiate allegations or validate claims submissions.
- **Special claims review:** A special claims review places payment or system edits on file to prevent automatic claim payment. This type of review requires a medical reviewer evaluation.
- **Recoveries:** We recover overpayments directly from the provider within 30 days. Failure of the provider to return the overpayment may be reflected in reduced payment of future claims or further legal action.

Acting on Investigative Findings
We refer all criminal activity conducted by a member or provider to the appropriate regulatory and law enforcement agencies. If a provider has committed fraud, abuse or waste, the provider:

- Will be referred to the quality management department.
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.

Failure to comply with program policy, procedures or any violation of the contract will result in termination from our plan.

If a member has committed fraud, exhibited abusive or threatening behavior, or has failed to correct issues, he or she may be involuntarily disenrolled from our health care plan, with state approval. Refer to Chapter 11: Member Transfers and Disenrollment.

False Claims Act
We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits, or causes another person or entity to submit, false claims for payment of government funds is liable for three times the damages, or loss, to the government plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains Qui Tam, or whistleblower, provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

Employee Education about the False Claims Act
As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least 5 million dollars (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the False Claims Act,
administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).

- Include as part of these written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste and abuse.
CHAPTER 21: MEMBER RIGHTS AND RESPONSIBILITIES
Member Services: 1-855-690-7800 (TTY 711)
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview
Members should be clearly informed about their rights and responsibilities so they can make the best health care decisions. Members also have the right to ask questions about the way we conduct business, as well as the responsibility to learn about their health care plan coverage.

The following member rights and responsibilities are defined by the state of Wisconsin and appear in the Anthem Blue Cross and Blue Shield (Anthem) member handbook.

Member Rights
Anthem honors civil rights and provides covered services to all eligible members regardless of:

- Age
- Color
- Disability
- Marital status
- National origin
- Race
- Religion
- Gender
- Gender identity
- Sexual orientation
- Military participation
- Arrest or conviction record

All medically necessary covered services are offered to all members. All services are given in the same way to all members. All persons or groups who work with Anthem, or who refer or suggest services to members, shall do so in the same way for all members. Translation or interpretation services are offered free of charge for those members who need assistance.

Members have the right to:
- Ask for an interpreter and have one provided during any BadgerCare Plus and/or Medicaid SSI covered service.
- Receive any information from the HMO provided in another language or another format.
- Receive health care services as provided for in federal and state law. All covered services must be available and accessible. When medically appropriate, services must be available 24 hours a day, 7 days a week.
- Receive information about the organization, its services, its practitioners, and providers and member rights and responsibilities.
- Receive information about treatment options and alternatives, including the right to request a second opinion. If an appropriately qualified network provider is not available, second opinion services from an out-of-network provider will be reimbursed at no charge to the member.
- Make decisions about his or her health care, including refusing treatment.
- Have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Be treated with respect and recognition of dignity and their right to privacy.
- Voice complaints or appeals about the organization or the care it provides.
• Make recommendations regarding the organization’s member rights and responsibilities policy.
• Be free from any form of restraint or seclusion used as means of force, control, convenience or retaliation.
• Request copies of their medical records from their providers.

**Member Responsibilities**
Members have the responsibility to:
• Show their ForwardHealth ID card each time they receive medical care.
• Make or change appointments.
• Get to appointments on time.
• Call their PCP if they cannot make it to their appointment or if they will not be on time.
• Use the emergency room only for true emergencies.
• Pay for any services they ask for that are not covered by BadgerCare Plus or Medicaid SSI.
• Treat their PCP and other health care providers with respect.
• Tell us, their PCP and their other health care providers what they need to know to treat them.
• Do the things that keep them from getting sick.
• Follow the treatment plans members, their PCP, and their other health care providers agree on.
• Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
• Tell us if they:
  o Move.
  o Change their phone number.
  o Have a change in the number of people in their household.
  o Have other insurance.
  o Become pregnant.
Overview
Anthem Blue Cross and Blue Shield recognizes that providing health care services to a diverse population may present challenges. Those challenges arise when providers need to cross a cultural divide to treat members who may have different behaviors, attitudes and beliefs concerning health care. Differences in our members' ability to read may add an extra dimension of difficulty when providers try to encourage follow-through on treatment plans. Our cultural competency toolkit, called Caring for Diverse Populations, was developed to give you specific tools for breaking through cultural and language barriers in an effort to better communicate with your patients.

Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater awareness of cultural sensitivities opens the door to the kind of interaction that makes treatment plans most effective: Has the patient been raised in a culture that frowns upon direct eye contact or receiving medical treatment from a member of the opposite sex? Is the patient self-conscious about his or her ability to read instructions?

The cultural competency toolkit provides the information you will need to answer those questions and continue building trust. The toolkit will enhance your ability to communicate with ease, talking to a wide range of people about a variety of culturally-sensitive topics. Finally, the toolkit offers cultural and linguistic training for your office staff, enabling all aspects of an office visit to go smoothly.

Providers are encouraged to access the Cultural and Linguistic Resources on the provider website: https://mediproviders.anthem.com/wi. Select Provider Education > Manuals, Directories, Training & More, and scroll down to Cultural and Linguistic Resources. Resources include a Right to Interpreter Statement, Interpreter Attendance Form, guide to Anthem Interpreter Services and a cultural competency toolkit PowerPoint.

The toolkit contents are organized into the following sections:

Improving Communications with a Diverse Patient Base
- Encounter tips for providers and their clinical staff
- A memory aid to assist with patient interviews
- Help in identifying literacy problems

Tools and Training for Your Office in Caring for a Diverse Patient Base
- Interview guide for hiring clinical staff who have an awareness of cultural competency issues
- Availability of medical consumerism training for health educators to share with patients.

Resources to Communicate Across Language Barriers
- Tips for locating and working with interpreters
- Common signs and sentences in many languages
- Language identification flashcards
- Language skill self-assessment tools

Primer on How Cultural Background Impacts Health Care Delivery
- Tips for speaking with people across cultures about a variety of culturally sensitive topics
- Information about health care beliefs of different cultural backgrounds

Regulations and Standards for Cultural and Linguistic Services
- Some key legislation
- A summary of the Culturally and Linguistically Appropriate Service Standards (CLASS), which serve as a guide on how to meet these requirements

Resources for Cultural and Linguistic Services
- A bibliography of print and internet resources for conducting an assessment of the cultural and linguistic needs of your own practice’s patient population
- Staff and provider cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for individuals with limited-English proficiency

The toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistic Workgroup, a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies, and accrediting bodies working collaboratively to improve health care regulatory compliance through public education. More information on the ICE Workgroup may be obtained on their website: www.iceforhealth.org.

Interpreter Services
For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. Anthem provides over-the-phone and face-to-face interpreters. Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as interpreters. Face-to-face interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required. Request telephone interpreter services by calling:
Providers: 1-855-558-1443
Members: 1-855-690-7800
24/7 NurseLine (after-hours): 1-855-690-7800

For after-hours interpreter services, call the 24/7 NurseLine and take the following steps:
1. Give the member’s identification (ID) number to Member Services.
2. Explain the need for an interpreter and state the language required.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the associate or 24/7 NurseLine nurse introduces the Anthem member, explains the reason for the call, and begins the dialogue.

Request face to face interpreter services by calling:
Providers: 1-855-558-1443
Members: 1-855-690-7800
Services for Members with Hearing Loss, Visual and/or Speech Impairment
Members with hearing loss or speech impairment can call 711. Members can also request face-to-face sign language interpreters at no cost. Members with visual impairments can request verbal assistance or alternative formats for assistance with printed materials at no cost.

Translation of Materials
Members can request translation of materials into non-English languages at no cost by contacting Member Services: 1-855-690-7800.