Anthem • New York

Managed Long-Term Care Plan

Provider Manual

Anthem

NYBCBS-CD-PM-047801-23

Dear Provider Partner,

Welcome to Anthem Blue Cross and Blue Shield HP (Anthem) Managed Long-Term Care (MLTC) Plan! We are thrilled to have you with us and are grateful for your participation in our network.

Anthem is a New York State-approved Medicaid MLTC Plan operating in the five counties of New York City, as well as Nassau, Suffolk, and Westchester counties. We are a 5-star rated MLTC plan, according to the New York Department of Health's 2019 Managed Long-Term Care Consumer Guide for NYC. Anthem is committed to helping our members stay healthy, safe, and living independently in the comfort of their own homes.

This is only possible through our partnership with you. Your medical services are an essential component of the high-quality coordinated care we strive to provide our members. Only with your assistance can we ensure this care is the best possible, and that it's always delivered in a caring manner that celebrates and respects our members' cultural and linguistic diversity.

The MLTC provider manual is your guide to this partnership. It contains useful information about the Anthem program and guidance regarding important regulations, policies, and procedures. Additional copies of the manual are available on request, and you will be notified regarding any changes through electronic notifications, quarterly electronic provider newsletters and, when needed, through formal mailings. Please read and retain these updates.

If you have any questions regarding the manual or its contents, please contact us at **929-946-6500**.

Thanks again for participating in our network. We look forward to working with you and your staff

Sincerely,

Anthem BlueCross BlueShield HP

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Introduction

Anthem Blue Cross and Blue Shield (Anthem) Managed Long-Term Care (MLTC) Plan, is a New York State-approved Managed Long Term Care Plan designed to assist senior and disabled adults to live safely and independently in the comfort of their own homes while maintaining their health and wellbeing.

Service Area

Anthem operates in the five counties of New York City, as well as in Nassau, Suffolk, and Westchester counties.

Eligibility Criteria

To enroll in Anthem, individuals must be:

- Medicaid-eligible and aged 18 years or older.
- Residents of Anthem service area.
- Determined eligible for MLTC according to an eligibility assessment tool designated by the New York State Department of Health (NYSDOH).
- Capable at the time of enrollment of returning to and remaining in their homes and communities without jeopardy to their health and safety, a determination based upon criteria provided by the New York State DOH, and
- In need of at least one of the following services for more than 120 days:
    - Nursing services in the home
    - Therapies in the home
    - Home health aide services
    - Personal care services in the home
    - Adult day health care
    - Private duty nursing, or
    - Consumer Directed Personal Assistance Services (CDPAS)

Please note that Anthem does not take into consideration an applicant's potential need for acute hospital inpatient services or nursing home during this 120-day period for assessing an applicant's eligibility for enrollment.

Program Goals and Care Management

Anthem's objective is to materially and measurably improve the health and quality of our member's lives through the assistance of our Care Management Teams. These teams are dedicated groups of professionals who work with PCPs and members to coordinate health and long-term care services. Services are determined according to an individualized care and service plan, itself a product of a comprehensive assessment of member needs and information obtained from member health care providers. The Care Management team works with participating providers in the Anthem network to ensure that services are of high quality and provided in a respectful manner.

The Care Management team consists of one care manager (a registered nurse), a social worker, and a Service coordinator representative.

The Care Management team's primary responsibilities are:

- Initial assessment of member.
- Management of covered services and coordination of covered services with both noncovered services and those services provided through community resources and informal supports.
- Development of individual care plans and health care goals in consultation with both member and their informal

supports.

- Ensuring health care goals are specified, including the types and frequencies of authorized covered services and noncovered services necessary to maintain the care plan.
- Monitoring the progress of members to ensure services provided are appropriate and in accord with the care plan.
- Reassessment of members as necessary, and no less frequently than once every 12 months.
- Update of member plan of care as warranted by the member's condition, and in any event at least once every 12 months.
- Evaluating whether care plans continue to meet member needs.
- When sharing confidential medical and treatment plan information with providers, ensuring that all applicable state and federal laws and regulations are followed.
- Generating and receiving referrals from providers.
- Supplying members with written notification of authorized services.
- Supplying providers with service orders and authorizations.
- Enlisting the involvement of community organizations that enhance the health and well-being of members, and
- Ensuring the care management record meets all applicable professional standards.

Covered Services and Noncovered Services

Anthem offers a wide range of long-term care and supportive services as part of its covered benefits. Covered benefits are those services paid for by Anthem. Noncovered services are not paid for by Anthem, but billed directly to Medicaid, Medicare, and other third-party payers by the provider. Such services may be included in a member's plan of care, and are coordinated by the Care Management team.

Covered Services (Covered by MLTC capitation)[1]	**Noncovered Services** (Billed Medicaid fee- for-service)
Care Management	Inpatient Hospital Services
Nursing Home Care	Outpatient Hospital Services
Home Care • Nursing • Home Health Aide • Physical Therapy (PT) • Occupational Therapy (OT) • Speech Pathology (SP) • Medical Social Services	Physician Services including services provided in an office setting, a clinic, a facility, or in the home. [2]
Adult Day Health Care	Laboratory Services
Personal Care	Radiology and Radioisotope Services
DME, including Medical/Surgical Supplies, Enteral and Parenteral Formula[3], and Hearing Aid Batteries, Prosthetics, Orthotics and Orthopedic Footwear	Emergency Transportation
Personal Emergency Response System	Rural Health Clinic Services
Non-emergent Transportation	Chronic Renal Dialysis
Podiatry	Mental Health Services
Dentistry	Alcohol and Substance Abuse Services
Optometry/Eyeglasses	OPWDD Services
PT, OT, SP or other therapies provided in a setting other than a home.	Family Planning Services
Audiology/ Hearing aids	Prescription and Non-Prescription Drugs Compounded Prescriptions
Respiratory Therapy	All other services listed in the Title XIX State Plan
Nutrition	
Private Duty Nursing	
Consumer Directed Personal Assistance Services (CDPAS)	
Services Provided Through Care Management	
Home Delivered Congregate Meals	
Social Day Care	
Social and Environmental Supports	

1 The capitation payment includes applicable Medicare coinsurance and deductibles for benefit package services. Any of the services listed in this column when provided in a diagnostic and treatment center would be included in and covered by the capitation payment.

2 Includes nurse practitioners and physician assistants acting as *physicianextenders*.

3 Enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism.

Provider Participation in the Anthem Network

Providers must complete Anthem credentialing and approval process to participate in the network. Participating providers agree to deliver quality services to our members, to comply with Anthem contractual and program requirements, and to cooperate fully with Anthem in ensuring services meet member needs.

Provider Welcome and Orientation

Participating providers receive a Welcome Letter, Anthem Provider ID, a copy of the provider manual, and information regarding the orientation requirement.

Anthem believes members receive the best care when Anthem and its providers work in true partnership with each other. The orientation establishes a foundation for this partnership, ensuring providers are properly introduced to Anthem values and approach to collaboration. Additional subjects covered in orientation include MLTC operational details, contract requirements, policies and procedures affecting the provider's provision of service, and the provider's role in maintaining and improving the member's health, safety, independence, and well-being.

Anthem expects orientation and accompanying training to be completed within three months of a provider's credentialing by Anthem. The Provider Network Relations Department will schedule on-site meetings for new providers when applicable.

Participating Provider Rights

Anthem provider partners have these rights:

- Prompt response by Anthem to any inquiry or request for assistance
- Participation in member care planning and discussion
- To request authorization for services on a member behalf, and to file an appeal if denied
- Access to all member information necessary to provide service
- To report Anthem to the appropriate regulatory body if the provider believes Anthem is unduly limiting member access to care or otherwise undermining it, and
- Prompt payment for services rendered

Participating Provider Responsibilities

Participating as a provider in the Anthem network entails responsibilities, many of which are listed below. Note that the list is not all-inclusive. Please refer to the Anthem *Provider Agreement*, the MLTC contract, and regulations governing the MLTC program to gain a comprehensive understanding of provider responsibilities.

Provider responsibilities include:

- Providing quality care for Anthem members, including:
    - Providing care within the scope of practice and in accordance with Anthem access, quality, and participation standards
    - Adhering to Anthem *Clinical Practice Guidelines* and complying with Anthem Service Standards
    - Providing care of consistent quality regardless of a member age, race, sex, religious background, national origin, disability, sexual orientation, health status, or marital status
    - Ensuring that employees or subcontractors are not on State or Federal exclusion lists and that they fully comply with all applicable laws, regulations, applicable DOH and CMS instructions, and Anthem contractual requirements;
    - Compliance with the *Americans with Disabilities Act* (*ADA*) guidelines set forth by the NYSDOH, which require

that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities of a public entity, or otherwise subjected to discrimination by such an entity. Furthermore, Anthem providers are expected to meet the access needs of member with disabilities. Physical accessibility is not limited to entry to a provider site, but also includes access to services within the site, and
    - Making a good faith effort to provide member services in a culturally competent manner, including provisions for member with limited English proficiency or reading skills, as well as provision for those of diverse cultural and ethnic backgrounds.

- Notifying Anthem Provider Network Relations Department of updates to your information, and especially of any changes that affect your ability to render service. This includes, but is not limited to:
    - Changes in provider's name and Tax ID number(s)
    - Changes in provider's address, zip code, telephone, fax, or email
    - Changes in provider's billing address
    - Changes in languages spoken in the provider's office
    - Changes in wheelchair accessibility
    - Changes in provider's health (if individual practitioner)
    - Changes in provider's licensing or permit
    - Any action or investigation initiated by a regulatory agency, and
    - Any malpractice action

- Cooperating with Anthem in meeting regulatory requirements and addressing feedback from members:
    - Ensure effective and efficient coordination of member care
    - Resolve member grievances
    - Participate with external review programs
    - Implement quality improvement initiatives
    - Address performance issues identified from Anthem *Member Satisfaction Surveys*
    - Provide regular and timely report on performance and quality of care
    - Ensure timely completion of re-credentialing and meet any applicable participation criteria required by DOH or CMS
    - Ensure proper fraud, waste and abuse detection and prevention, and
    - Ensure timely, complete, and accurate regulatory reporting

- Complying with Anthem authorization and payment polices and guidelines, including:
    - Obtaining physician orders when required
    - Obtaining prior authorization for services when required
    - Undergoing concurrent review aimed at ensuring medical necessity of services
    - Following preadmission testing guidelines if applicable
    - Notifying Anthem within 48 hours if any unauthorized *urgent* services are provided
    - Following guidelines related to submission of claims and other encounter data, and
    - Cooperation with claims payment review

- Complying with regulatory, contractual, and professional standards of practice, as well as Anthem policies and procedures. *Note that Anthem will inform you at least 30 days prior to any material modification of these policies via the Anthem website or by other reasonable means within Anthem sole discretion*.
- Notifying Anthem immediately if:
    - A clinical issue or serious concern is identified;
    - There is a change in member status;
    - A member refuses service;
    - You are unable to access the member home or provide service for any reason, or
    - Any complaint is made by or on behalf of a member.

- Maintaining confidentiality and agreeing not to disclose to any third-party Anthem trade secrets, intellectual property, and other confidential information without the prior written consent of Anthem, and
- Respecting and safeguarding Anthem member rights.

Providing Service for Anthem Members

Member Rights and Responsibilities

Anthem members have certain rights and protections. As an Anthem provider, you have the responsibility to respect and safeguard these rights.

Specifically, Anthem members have the right to:

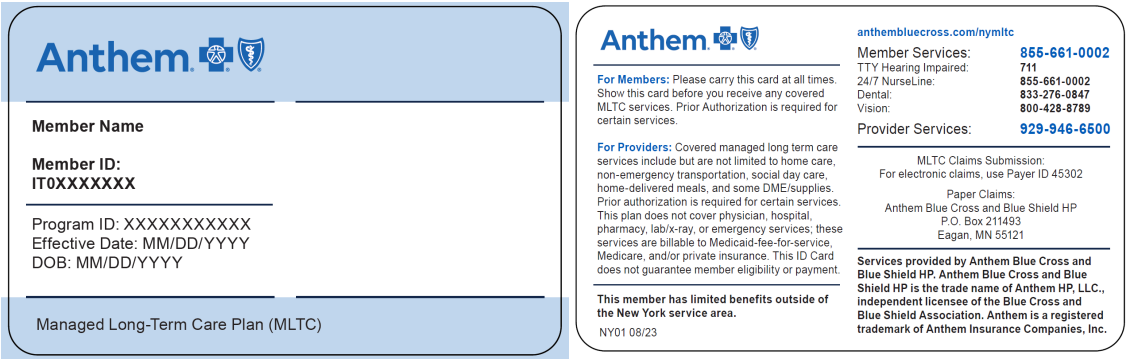
- Treatment without discrimination based on race, color, religion, gender, national origin, disability, sexual orientation, or source of payment
- Participate with the care manager (RN), physicians, and other participating providers in making decisions about their health care
- A non-smoking environment
- Receive considerate and respectful care in a clean and safe environment
- Receive, upon request, a list of health care providers participating in the Anthem provider network
- Choose and/or change their health care and other participating providers
- Be assured that participating health care providers have the qualifications stated in Anthem *Credentialing Policies and Procedures*
- Know the names, positions, and functions of any participating provider's staff and to refuse their treatment, examination, or observation
- Obtain from Anthem and their providers comprehensive information about their Plan of care and the benefits/services covered and/or provided, regardless of cost or benefit coverage. If a member is not self-directing, the information will be made available to a person who has been designated to act on that person's behalf
- Obtain this information, verbally and in writing, in a language they can understand
- Receive medically necessary care
- Timely access to care and services
- Privacy about their medical record and when they receive benefits or services
- Get information on available benefit/service options and alternatives presented in a manner and language they understand
- Obtain, at any time, a copy of their health care records, as well as the right to ask that these records be amended or corrected
- Be treated with respect and dignity
- Take part in decisions about their health care, including the right to refuse benefits and services
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Be told where, when, and how to get the services they need from their managed long-term plan of care, including how they can get covered benefits from out-of-network providers if they are not available in Anthem network
- Obtain information necessary to give informed consent prior to the start of any treatment or care
- Complain to the NYSDOH or the Local Department of Social Services, to use the New York State Fair Hearing System, and in some instances request a New York State External Appeal
- Appoint someone to speak for them about their care and treatment, and to be present and take part in any discussions about their care and the benefits and services provided, and
- Make advance directives and plans about their care

Anthem members also have responsibilities. Specifically, they are required to:

- Provide Anthem, its participating physicians, and other providers with accurate and relevant information about their medical history and health so that appropriate treatment and care can be rendered.
- Keep scheduled appointments or, when cancelling them, to give as much notice as possible in accordance with the provider's guidelines for cancellation.
- Update their Anthem record with accurate personal data, including changes in name, address, phone number, and additional health insurance carriers.
- Treat with consideration and courtesy all Anthem personnel, and the personnel of any agency or health care provider to which they are referred.
- Be actively involved in their own health care by seeking and obtaining information, by discussing treatment options with their Care Management team, and by making informed decisions about their health care.
- Follow plans and instructions for care that they have agreed to with their practitioner.
- Understand their health conditions and participate in developing mutually agreed upon treatment goals, to the degree possible.
- Understand Anthem benefits, policies, and procedures as outlined in their *Member Handbook*, including policies related to prior approval for all services that require such approval.
- Request and receive all covered benefits through Anthem.
- Contact Anthem when they need help or have a question.
- Follow the plan of care that was agreed upon and request changes as needed
- Make every effort to pay Anthem any Medicaid surplus amount owed;
- Maintain Medicaid eligibility, and
- Notify Anthem when they go away or are out of town

Member Eligibility and Verification of Coverage

Every Anthem member will receive an ID card that will have the member name and identification number. This card, which identifies an individual as an Anthem member, should be presented by the member when seeking covered services.



However, possession of the ID card does not guarantee the member's eligibility for service on the day the service is rendered. It is the provider's responsibility to verify the eligibility of each member prior to rendering services through electronic, telephonic, or other means Anthem makes available. Member eligibility can be checked through E-PACES or by calling the Anthem Provider Service Line at **929-946-6500**.

Anthem should be contacted by providers to be made aware of any information relating to the possible ineligibility of any member to participate in Anthem MLTC Program and/or receive covered services through Anthem. This includes reporting any individual claiming to be a member who does not present an ID card.

Please note that Anthem is not liable for services rendered to individuals ineligible for covered services at the time services are rendered.

Non-English Speaking or Disabled Members

Anthem is committed to ensuring that all its member have unfettered access to its services and that the experience of non-English speaking and/or disabled member is a positive one. Anthem MLTC's diverse staff provides language assistance, and a supplemental language assistance line is available to fill any gaps. Anthem also accommodates visually impaired and hearing impaired members in compliance with the requirements of the *ADA*.

Providers are similarly expected to address the language needs of Anthem members, as well as the special needs of its visually impaired and hearing impaired member.

Service Referrals and Authorizations

Service authorizations are care decisions based on a comprehensive member assessment, medical necessity, clinical guidelines, and with input from the member's, family, physician, and other persons involved in the care of the member. Upon development or update of the person-centered plan of care, a service plan is developed. This service plan details all covered services to be provided to the member and specifies the scope, duration, and frequency of the services. The Care Management team works with the member to select the appropriate providers to render services, makes service referrals, and ensures that authorization is in place for providers to render the services.

For services requiring prior authorization, Anthem will send service authorizations to providers via the Anthem MLTC Provider Portal. Providers are advised to check the portal regularly to obtain updated information on service authorizations. It is the responsibility of the provider to ensure authorizations are in place prior to rendering services.

Transition of Care for Fee-For-Service Members in Mandatory Counties

There are *transition/continuity of care* requirements for each Anthem member who is receiving community-based long-term services and supports for the following:

- Personal Care Services
- Consumer Directed Personal Care (CDPAS)
- Home Health Services
- Private Duty Nursing
- Adult Day Health Care, and
- Lombardi (LTHCP)

All members receiving such services at the time of enrollment must continue to receive those services under their pre-existing service plan for at least 90 days after enrollment or until a care assessment has been completed by Anthem, whichever is later. In addition, the recipient/worker relationship is to be preserved for the same 90-day period.

Members and providers acting on behalf of member have the right to file an appeal (standard or expedited, if warranted) for any reduction, suspension, denial, or termination of previously authorized services. Members have the right to continuation of authorized services pending the appeal and the right to a fair hearing if Anthem renders an adverse determination (either in whole or in part) on appeal.

Consequently, any individual receiving community-based long-term services and supports via fee-for-service Medicaid who is enrolling under any circumstance will receive 90 days continuity of care from Anthem. Further, if there is an appeal or fair hearing as a result of any proposed reduction, suspension, denial, or termination of previously authorized services, Anthem will comply with appropriate decisions stemming from these proceedings. Finally, if the member requests a State Fair Hearing to review Anthem decision on appeal, Anthem will provide aid-to-continue until the Fair Hearing decision is issued.

Services Requiring Authorization and Physician Orders

All covered services require prior authorization **except** for the following:

- Routine dental care referrals and services covered under Liberty Dental
- Routine vision exam and services covered under Superior

The following covered services require a physician's order as part of the prior authorization process:

- ADHC
- DME (ambulation devices, not for home safety equipment)
- Home health care
- Medical supplies (that require ongoing refill)
- Prosthesis/Orthotics
- Nursing home care
- Personal care
- Rehabilitation services
- Respiratory therapy services
- Private duty nursing
- CDPAS

Covered Services	Authorization	Physician Order
Care Management	None Required	None Required
Nursing Home Care	Required	Required
Home Care • Nursing • Home Health Aide • Physical Therapy (PT) • Occupational Therapy (OT) • Speech Pathology (SP) • Medical Social Services	Required	Required
Adult Day Health Care	Required	Required
Personal Care	Required	Required
Consumer Directed Personal Care	Required	Required
DME, including Medical/Surgical Supplies, Enteral and Parenteral Formula, and Hearing Aid Batteries, Prosthetics, Orthotics and Orthopedic Footwear	Required	Required
Personal Emergency Response System	Required	None Required
Non-emergent Transportation	Required	None Required
Podiatry	None Required	None Required
Dentistry	None Required	None Required
Optometry/Eyeglasses	None Required	None Required
Rehabilitation Services: Physical Therapy, Occupational Therapy, & Speech Therapy	Required	Required
Audiology/ Hearing aids	Required	None Required
Respiratory Therapy	Required	Required
Nutrition	Required	None Required
Private Duty Nursing	Required	Required
Home Delivered or Congregate Meals	Required	None Required
Social Day Care	Required	None Required
Social and Environmental Supports	Required	None Required

Requesting Authorization

Providers may request authorizations on behalf of a member, including an authorization for a new service or a request for a concurrent review in order to change an existing service being provided. Requests may be made either verbally or in writing.

Immediately upon receipt of the request, the care manager will reach out to the provider to discuss the circumstances informing the request in order to determine whether it should be handled within the standard time frame or on an expedited time frame.

Time Frames for Anthem Decision on Authorization Requests

A review will be performed on an expedited time frame if Anthem or the member provider believes a delay in service authorization could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

The required time frames for processing authorization requests are as follows.

- **Prior Authorization:** If the request is for a *new service* and the care manager determines that the time frame should be
  - ***Standard***, Anthem will make a determination within three business days of its receipt of necessary information, but no more than 14 days from the receipt of the request;
  - ***Expedited***, Anthem will make a determination within 72 hours of receipt of necessary information.

- **Concurrent Review:** If the request is to *increase the amount* of service already being provided and the care manager determines that the time frame should be
  - ***Standard***, Anthem will make a determination within one business day of receipt of necessary information, but no more than 14 days from receipt of the request;
  - ***Expedited***, Anthem will make a determination within one business day of receipt of necessary information, but no later than 72 hours from the receipt of the request.

- If the request is for home health care services following an inpatient admission, the request will be handled as expedited, and the determination will be made within one business day after receipt of necessary information, but no later than 72 hours after receipt of the request. If home care services following an inpatient admission stay are requested and the next day is a Friday/holiday, a determination will be made within 72 hours.
- Extensions of up to 14 calendar days may be requested by the member or by a provider on the member's behalf (written or verbal). Anthem may also initiate an extension if it can justify the need for additional information and if the extension is in the member's interest. In all cases, the extension reason must be well-documented.

An extension may be initiated for additional documentation and must be in the best interest of the member. The reason for the extension is documented on the notice.

- The requested service must be medically necessary (necessary to prevent, diagnose, correct, or cure conditions in the member that cause acute suffering, endanger life, result in illness or infirmity, interfere with the member's capacity for normal activity, or threaten some significant handicap)
- The requested service must reasonably be expected to achieve its purpose
- The requested service will allow the member to remain healthy and in his/her home safely

In making a determination for a service authorization request, the care manager may consult with the member's physician, other service providers, the care management supervisor, the Anthem medical director, and/or clinical consultants/peer reviewers, as necessary.

Use of Clinical Consultants or Clinical Peer Reviewers

Following the latest clinical and regulatory guidelines the utilization nurse will make decisions on the authorization requests. They will consult with stakeholders on a necessary basis. The determination is then sent to the medical Director for final approval.

Authorization for Out-of-Network Use

Anthem will grant a request for service with an out-of-network provider if any of the following is true:

- The member is newly enrolled in Anthem and has been receiving services from the out-of-network provider, thus qualifying for authorization for services up to 90 days for transition/continuity of care, and the provider agrees to

accept Anthem reimbursement as payment in full and abide by Anthem policies and procedures
- The member's provider leaves Anthem network, thus qualifying the member for authorization of services for up to 90 days from notice to the member to transition him/her to another Anthem provider, so long as the provider agrees to accept the same payment rate and abide by Anthem policies and procedures as in the past
- The member is in a medical emergency situation and the provider's service is needed to stabilize the member's status and prevent harm, or if it is impractical to arrange for an Anthem provider to render the service
- There's no Anthem provider with the required expertise or qualification, or such provider is not readily accessible or available to the member

All out-of-network authorizations will be granted for as short a period of time as possible to allow time to find an in-network alternative or in order to establish a provider contract with the out-of-network provider. This will mean either a one-time authorization for certain services (for example, DME, orthotics, prosthetics, home repairs, and transportation) or, for services that require continued care (for example, home health care and personal care), a **maximum of one month of service authorization** at a time.

Emergency/Urgent Situations

Members who contact Anthem indicating they are experiencing a medical or behavioral emergency are instructed to contact **911** or to go to the nearest emergency facility. Covered services that are medically necessary to stabilize or treat an emergency condition do not require prior authorization. Anthem does require member to notify Anthem within three days of the receipt of such emergency services so that Anthem can review the member care plan for any needed adjustments. If an adjustment to services is appropriate, the care plan will be revised accordingly.

To the extent that Anthem is involved in arranging for the service in the emergency, authorization of the service provision will be for a period covering three days. For the service to continue, an authorization request must be made unless the care manager deems continued service to be medically necessary.

If a provider, member, or member's representative on behalf of the member, calls Anthem to request a service and there appears to be grounds for urgency, the request will be handled as an expedited request. This means we will:
- Request information needed in order to make a determination, and
- Send the member an acknowledgement of service authorization request that also confirms the request is being handled as an expedited request, and lists any information required.

Authorizations for CDPAS

Providers should use the *Physician's Order for Personal Care/Consumer Directed Personal Assistance Services Form*. Please email it to CDPAS@Anthem.com.

A sample of the *Physician's Order for Personal Care Form* can be found in the back of this manual (***Exhibit A***).

Participating providers in Anthem network are required to provide service to members in accordance with standards set by Anthem except when a longer time frame is required by the member. The standards are outlined below.

Service	Standard
Adult Day Health Care	Placement must occur within 14 days
Audiology	Standard visit within 7 days Emergency visit within 48 hours
Consumer Directed Personal Care	Initial visit must occur on the date and time specified by Anthem
Dentistry	Standard visit within 28 days Emergency visit within 24 hours
DME/Supplies	Delivery of supplies must occur within 72 hours unless custom order
Home Health Care	Initial visit must occur within 24 hours
Meals (Home/Congregate)	Date and time specified by Anthem
Nursing Home	Facility Placement must occur as quickly as possible
Nutritional Counseling	Service must be provided within 14 days
Optometry	Standard visit within 7 days Emergency visit within 24 hours
Orthotics & Prosthetics	Measurements taken within 14 days
Personal Care	Initial visit must occur on the date and time specified by Anthem
Podiatry	Standard visit within 7 days Emergency visit within 24 hours
Private Duty Nursing	Date and time specified by Anthem
Rehabilitation Services (PT, OT, ST)	Initial visit must occur within 72 hours (in home)
Respiratory Therapy	Initial visit within 7 days (not in home)
Social Day Care	Initial visit must occur within 24 hours
Social & Environmental Supports	Placement must occur within 14 days
Social Work Services	Delivery within 14 days unless custom ordered
Transportation	Service must be provided within 14 days

Specific Requirements by Provider Type

Participating providers are required to comply with all regulatory and professional standards of practice. They are also responsible for acquiring physician orders whenever required by law, as well as for determination of medical necessity and/or third-party reimbursement. The care manager and interdisciplinary care team may assist in obtaining orders if the participating provider has been unsuccessful, but primary responsibility for obtaining orders is the participating provider's. Additional responsibilities by provider type are listed below.

Home Care Participating Provider Responsibilities

- Obtain physician orders
- Develop the home aide plan for requested services
- Supervise the aide in accordance with state and federal regulations
- Ensure that individuals who are both family members of Anthem members and aides are **not** assigned to handle the care of the Anthem family member
- Notify member in advance of the name(s) of any assigned staff
- Notify member in advance of any need for replacement of staff and of the name(s) of replacement staff
- Confirm the daily attendance of staff. To assure the safety of our members, Anthem recommends that all home care participating providers implement an electronic attendance program in addition to any manual verification programs. Agencies not utilizing electronic attendance programs must verify attendance of staff providing service to Anthem members on a daily basis, and agency protocol on aide attendance verification must be made available to Anthem upon request

- Submit evaluation and progress notes within one business day of requestby Anthem for authorization purposes and within five business days of request forquality assurance purposes
- Fully cooperate with the Anthem Care Management Department's inquiries regarding a member's status, even if a given episode of care doesn't result in any payment by Anthem to the participating provider. Such cooperation may be verbal or written
- Immediately notify Anthem whenever a clinical issue or serious concern regarding a member is identified. This includes, but is not limited to, falls, hospitalizations, changes in member status, member refusals of service, any inability to access a member's home to provide service for any reason. Participating providers are also responsible for relaying any complaint made by or on behalf of the member to Anthem

Nursing Home/Skilled Nursing Facility (SNF) Participating Provider Responsibilities

- In the context of a short-term stay (up to six months):
  - Determine the type of health insurance coverage the prospective resident has and whether or not the SNF is authorized to serve the member
  - Submit initial evaluations, assessments, and plans of care (including short and long-term goals) within one week of admission. Subsequent progress notes and/or plan of care updates should be submitted at least monthly or within one business day of request by Anthem for authorization purposes
  - Obtain authorization for any covered service outside of the daily rate, and
  - Assist in the Medicaid recertification process

- In a long-term placement context:
  - Determine eligibility for Institutional Medicaid and other third-party coverage, as well as whether the SNF is authorized to serve the member
  - Submit conversion applications for member placed in long-term care
  - Identify any admission as an MLTC admission
  - Collect the Net Available Monthly Income (NAMI), which will later be deducted from payments
  - Submit resident monthly summaries to the Anthem care manager
  - Include the Anthem care manager in case conference
  - Obtain authorization for any covered service outside of the daily rate, and
  - Assist in the Medicaid recertification process.

Note: *Anthem member must be eligible for Institutional Medicaid to remain in an SNF for long term care.*

Adult Day Health Care Provider Responsibilities

- Be able to provide:
  - Clinic visits, defined as care or an occasion of service less than three hours in duration,or
  - Part day care, defined as clinic care longer than three hours but shorter than five hours, or
  - Full day care, defined as clinic care longer than hours but shorter than 24 hours, or
  - Evening care, defined as clinic care provided after 5 P.M., but not including an overnight stay, or
  - Night care, defined as clinic care for less than 24 hours in a day in a SNF and including, as a minimum, an overnight stay in the facility.

- Arrange for indirect or direct provision of the following services to members:
  - Medical services, including admission and medical history, physical examinations, consultations by medical specialists when needed, and necessary orders formedication, diet, physical therapy, occupational therapy, and supportive services
  - Nursing services, under the direct supervision of a registered professional nurse, based on periodic and continuing evaluations of each member need for nursing care
  - Dental care, provided in accordance with State guidelines for dental care

- Rehabilitation therapy and speech-language pathology services, including the arrangement of transportation for such services
- Pharmaceutical services, including supervision for use and administration of prescribed drugs, as appropriate, and
- Supportive services, including laboratory, X-ray, and other such services

- Place members within 14 days of request
- Develop or arrange for the development of a written review and evaluation plan within 30 days for each member
- Review and evaluate the member status no less than yearly, and more often as indicated by changes in the conditions or circumstances of the member
- Develop and maintain a health record for each member that compiles current health reports and information pertaining to a member care. The record should include all planning, and should be promptly entered, dated, and signed by the individual providing the information or prescribing the service. It should also be kept in a place conveniently accessed by authorized staff.

Adult Social Day Care Provider Responsibilities

- Comply with New York State Office of Aging Social Adult Day Care Regulations.
- Comply with all HCBS Settings Final Rules.
- Perform a psychosocial assessment to determine member's functional capability and impairment.
- Reassess functional capacity when appropriate, including whether the member still has the capacity for safe participation in the program.
- Develop individual service plans for consumers, caregivers, and informalsupports. These should:
  - Be developed within 30 days
  - Be reviewed at least semi-annually
  - Promote the highest possible functional level
  - Build on existing capabilities and/or focus on development of new capabilities or compensation, and
  - Specify expected outcomes

- Provide services to functionally, physically, or cognitively impaired individuals that must include:
  - Socialization
  - Supervision
  - Social Care Assistance

Note: *Transportation may be provided but is not mandatory.*

- Provide nutritious meals and snacks as scheduled and upon participants' request.

Please note:

- Authorization shall be for 90 days based on a psychosocial assessment. A reassessment will then be made to ensure a functional or clinical need for services exists.
- The Social Adult Day Care (SADC) program must communicate on a monthly basis with Anthem care manager regarding the member's functional status and the schedule of visits. This communication must include documentation of the following:
  - Indication the member is benefiting from intermittent socialization and group activity due to a clinical, functional, or cognitive impairment, and that the member requires ongoing personal care assistance and socialization to prevent further decline in their condition, and
  - Prior to submitting claims for services provided, the SADC program must reconcile daily attendance sheets with member's scheduled attendance. Only claims for those days a member actually attended the SADC program should be submitted for payment. Claims submitted for days that member did not attend the SADC program will be considered fraudulent and will be reported to the State and other appropriate authorities

Podiatry Services

Services include routine foot care when the member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot or when performed as a necessary and integral part of the treatment of diabetes, ulcers and infections. Covered podiatry services exclude routine foot care, the treatment of corns and calluses, the trimming of nails and other hygienic care of the feet in the absence of a pathological condition, unless precertified.

DME and Medical Supply Participating Provider Responsibilities

- Verify primary payer coverage and eligibility prior to delivery of products.
- Acquire physician orders whenever required by regulation or local, state, or federal law, and/or third-party reimbursement.
- Exhaust all other payment sources prior to billing Anthem.
- Deliver requested products in a timely manner.

Note: It is the responsibility of the participating provider to determine whether Medicare covers the item or service being billed. If the service or item is covered or if the participating provider does not know if the service or item is covered, the participating provider must first submit a claim to Medicare, as Anthem is always the payer of last resort. If the item is normally covered by Medicare, but the participating provider has prior information that Medicare will not reimburse due to same or similar, duplicate, or excessive deliveries, the information should be communicated to the Anthem care manager prior to delivery.

Home Delivered Meal Provider Responsibilities

- Provide nutritionally balanced meals that meet 1/3 of the daily Recommended Dietary Allowance (RDA).
- Serve hot meals, with no more than two preapproved cold meals served per week.
- Make meal deliveries each weekday except for agreed-upon holidays, or as specified in contract
- Monitor those members receiving home-delivered meals. Meal deliverers must have direct, face-to-face contact with the member at the time of delivery, except if the meal provider dropships frozen meals
- Communicate with the case manager or caseworker about changes in member's needs or when the member suspends services due to hospitalization or an extended visit away from home
- Serve a variety of appealing foods and make approved menus available to member. Members must have the opportunity to offer input on meal planning and meal service
- Deliver meals within the time frame stated to member, and explain the agency's policies and procedures to member
- Establish emergency procedures for circumstances such as inclement weather or vehicular breakdown and ensure members are notified when meals can't be delivered or will be late
- Ensure delivery people are appropriately trained and supervised
- Prepare food according to principles of nutritional health and safety

Transportation Services

Transportation services are coordinated through our partner ModivCare. Their contact information is:

ModivCare, LLC
32 Old Slip, 4th Floor
New York, NY 10005
Telephone: **877-831-3146**
Fax: **877-564-5912**

Additional phone numbers:

- To request livery/ambulette/wheelchair/stretcher transport for NYC members: **877-564-5925**
- If there is an issue with transportation or to register a complaint: **877-831-3146**

Rules for ordering transportation:

- A member family, caregiver, or Brooklyn medical provider can request NEMT services for member with certain conditions. ModivCare takes requests for routine transportation by phone, **877-831-3146** and Fax: **877-564-5912**
- Monday through Friday from 8 a.m. to 5 p.m. Requests may be submitted online 24 hours a day
- Please submit requests for routine transportation 72 hours in advance of the trip
- Requests for urgent transportation are taken by phone 24 hours a day, 7 days a week
- Requests for emergency medical service should be directed to **911**, not ModivCare
- Member must reside less than one half (½) of a mile from transit stop
- Member's appointment must be less than one half (½) of a mile from transit stop
- Member is ambulatory and physically and mentally capable of walking the distance before and after appointment unescorted
- If members are able to utilize mass transit and are traveling to a medical practitioner who participates in the Public Transit Automated Reimbursement (PTAR) system, they must request a MetroCard directly from that medical practitioner. If the medical practitioner does not participate in PTAR, member may request transportation from ModivCare
- If a medical practitioner has previously requested transportation for a member, has already filled out the *Medical Necessity Form* (*MNF*), and the medical needs of the member have not changed, then the member may book the ride themselves with ModivCare
- Members are expected to attend services in their Common Medical Marketing Area (CMMA). The CMMA is a 5-mile area around a member's home address. Members can attend services outside their CMMA if so referred by a practitioner or if specialist services are required that are unavailable in the CMMA
- Members and medical practitioners can request that a specific transportation company provide their transportation. ModivCare will make every effort to assign transportation to the requested transportation provider

Member Capabilities required for each mode of transport:

- **Bus/Subway:** If members reside less than one half (½) of a mile from transit stop and if member's appointment is less than one half (½) of a mile from transit stop
- **Livery:** the member can walk to the curb, board and exit the vehicle unassisted, but cannot utilize the bus or subway
- **Ambulette Ambulatory:** the member can walk, but requires driver assistance from residence to the medical appointment
- **Ambulette Wheelchair:** the member is a wheelchair user and requires either a lift-equipped or roll-up wheelchair vehicle, as well as driver assistance
- **Stretcher Van:** the member is confined to bed, cannot sit in a wheelchair, and does not require medical attention/monitoring during transport
- **BLS Ambulance:** the member is confined to bed, cannot sit in a wheelchair, and requires medical attention/monitoring during transport for reasons such as isolation precautions, oxygen not self-administered by the patient, or a sedated patient
- **ALS Ambulance:** the member is confined to bed, cannot sit in a wheelchair, and requires medical attention/monitoring during transport for reasons such as IV therapy requiring monitoring, cardiac monitoring, or a tracheotomy

Claims Submission

Anthem has contracted with **Relay Health** to adjudicate our provider claims. Relay Health is responsible for accepting Anthem provider claims as well as for ensuring proper adjudication in the standard time frames required by the NYSDOH. Anthem providers are required to submit claims for services reimbursed from Anthem on a fee-for-service basis. It is essential that claims be submitted in a timely and accurate manner.

Payment for services rendered is subject to verification that the member was enrolled in Anthem at the time the service was provided, as well as the provider's compliance with Anthem care management and prior authorization policies at the time of service.

Providers should verify member eligibility at the time of service to ensure the member is enrolled in Anthem. Failure to do so may affect claim payment. Additionally, note that member may retroactively lose their eligibility with Anthem after the date of service. Therefore, verification of eligibility is not a guarantee of payment. Claims submitted for services rendered without proper authorization (as applicable) will be denied for failure to obtain authorization. No payment will be made.

Billing Time Frame Requirements

Providers are encouraged to file claims as soon as possible and no later than 120 days from the date on which covered services were provided.

- For claims subject to recovery through Coordination of Benefits (COB) rules, providers must submit claims to Anthem or its delegate, as secondary payer, within 120 days of Anthem provider's receipt of payment and/or Explanation of Benefits (EOB) from the primary payer.

Claims not submitted within these time frames may be denied for untimely submission. Claims denied for untimely submission will only be paid if and when the provider can demonstrate that the late submission was the result of an occurrence outside the provider's control, and that the provider has otherwise demonstrated a pattern of timely submission.

Clean Claims

A *clean claim* is defined as a claim that has no defect, impropriety, or lack of substantiating documentation. Such documentation includes the information necessary to meet the requirements for encounter data, as well as a completed *UB-04* or *CMS-1500* form, their respective successor forms, or alternative electronic equivalents for covered services. Note that electronic equivalents must conform to all *HIPAA Administrative Simplification Act* requirements for electronic transactions. Additionally, these forms must comply with standard CMS coding guidelines, and/or other government program requirements where applicable. Clean claims require no further documentation, information, or alteration in order to be processed and paid in a timely manner by Anthem.

Prior to being processed for payment, all claims are reviewed for completeness and correctness of the required data. The following information must be included in a claim for it to be considered clean:

REQUIRED DATA	*UB-04*	*CMS-1500*
Patient Name	✓	✓
Patient Date of Birth	✓	✓
Patient Sex	✓	✓
Subscriber Name & Address	✓	✓
Anthem Member ID Number	✓	✓
Coordination of Benefits (COB)/other insured's information	✓	✓
Date(s) of Service	✓	✓
ICD-10Diagnosis Code(s) including 4th & 5th Digit if Required	✓	✓
CPT-4 Procedure Code(s)	✓	✓
HCPCS Code(s)	✓	✓
Service Code Modifier (if applicable)	✓	✓
Place of Service	N/A	✓
Service Units	✓	✓
Charges per Service and Total Charges	✓	✓
Provider Name	N/A	✓

REQUIRED DATA	*UB-04*	*CMS-1500*
Provider Address / Phone Number	N/A	✓
National Provider Identifier – NPI	✓	✓
Provider Tax ID Number	✓	✓
Anthem Provider ID Number	✓	✓
Nursing Home / Facility Name and Address	✓	N/A
Type of Bill	✓	N/A
Admission Date and Type	✓	N/A
Condition Code(s)	✓	N/A
Patient Discharge Status Code	✓	N/A
Occurrence Code(s) and Date(s)	✓	N/A
Value Code(s)	✓	N/A
Revenue Code(s) and Corresponding CPT/HCPCS Code(s) (outpatient services)	✓	N/A
Principal, Admitting, and Other ICD-9 Diagnosis Code(s)	✓	N/A
Present on Admission (POA) Indicator (if applicable)	✓	N/A
Attending Physician Name and NPI	✓	N/A
Anthem Authorization Number	✓	N/A

The UB-04 form should be used by facilities and billing on behalf of employed providers.
CMS 1500 forms and UB-04's can be used to bill fee-for-service encounters.

Preferred Claim Submission Method

Anthem strongly encourages providers to submit claims electronically.

Electronic Claims Submission

Providers should test electronic claims as soon as possible upon joining Anthem network. Claims may be submitted through Change Healthcare. Please use Anthem payer ID number: 45302.

Please note: Emdeon, Emdeon One and MD Online are now doing business as Change Healthcare.

Any claim submitted incorrectly will be denied. All electronic claim submissions should be *HIPAA*-compliant and use only 837 format. This minimizes clerical errors and expedites processing of claims, resulting in faster payment.

To begin submitting claims for Anthem electronically, please contact our clearinghouse at **866-742-4355**.

Electronic Funds Transfer (EFT)

PaySpan Health gives providers the option to receive electronic payment directly to their bank accounts.

There are immediate benefits to signing up for PaySpan Health:
- **Improve cash flow:** electronic payments can mean faster payments, leading to improvements in cash flow.
- **Maintain control over bank accounts:** allows **total** control over the destination of claim payment funds. Multiple practices and accounts are supported.
- **Match payments to EOP:** Associate electronic payments quickly and easily to an advice/voucher.

Registering Your Practice

Signing up for PaySpan Health is simple, secure, and will only take 5 to 10 minutes to complete. To enroll, you must register as a user on the PaySpan Health website.

Using your web browser, go to **http://www.payspanhealth.com.** Enter your unique registration code and PIN, provided **in a separate correspondence that will be sent via USPS to each provider.** Have your bank routing and account information found on a check, not a deposit slip, available.

A step-by-step guide for registration is available online.

Paper Claims Submission

Paper claims may be submitted in lieu of electronic claims and may be used prior to completion of electronic billing arrangements in order to comply with timely filing requirements. Company invoices, statements, or spreadsheets will not be accepted. Paper claims should be completed in their entirety, including but not limited to the following data elements:

All *CMS-1500* claims must include:

- Member name
- Payer-specific member ID number of 11 digits: a group of 9 digits followed by a group of 2 digits (typically "00")
- Date of birth
- Members insurance carrier name
- Provider name, Tax ID number, and NPI number
- Date of service that falls between the effective and expiration dates printed on the authorization
- Valid place of service code
- Service code such as HCPCS/CPT® (the billed service code **must** match the code that is listed in the authorization)
- Number of units
- Co-insurance claims must include a copy of the primary insurer EOB
- Valid diagnosis code
- Valid place of service

All *UB-04* claims must include:

- Member name
- Payer-specific member ID number of 11 digits: a group of 9 digits followed by a group of 2 digits (typically "00")
- Date of birth
- Members insurance carrier name
- Provider name, Tax ID Number, and NPI number
- Date of service that falls between the effective and expiration dates printed on the authorization.
- Service code such as HCPCS/CPT (billed service code **must** match the code that is listed in the authorization)
- Number of units
- Co-insurance claims must include a copy of the primary insurer EOB
- Valid bill type
- Valid revenue code
- Valid value code(s) and occurrence code(s)
- Applicable admit dates

Please mail claims to:

MLTC Claims Submission
Anthem BlueCross BlueShield HP
P.O. Box 211493
Eagan, MN 55121

Claims Payments

Anthem, or its delegate, will pay claims within 30 days of receipt, so long as the claim is clean and submitted in an electronic format. Clean claims submitted by other means, such as paper or facsimile, will be paid within 45 days of receipt.

Claims Inquiries

Providers may call Anthem's Provider Service Line at **929-946-6500** to inquire on the status of claims.

Submitting a Corrected Claim

Corrected claims should be submitted when data has changed from the original submission of the claim. As an example, a corrected claim should be submitted if any of the following data changes: service dates, procedure codes, units, charges, diagnosis codes.

Corrected claims should not be submitted if a claim was denied for lack of authorization or if there was a retroactive rate change, rather a claim dispute should be filed.

When submitting a corrected claim to Anthem please ensure that the following data elements are present:

- *CMS-1500* form, use Item Number 22
    - Resubmission code
        - 7 Replacement of prior claim (used to correct a previously submitted bill)
        - 8 Void/cancel of prior claim (used to indicate this bill is an exact duplicate of an incorrect bill previously submitted)
    - Original Ref. No.
        - Anthem Claim ID of the claim that is being corrected
- *UB-04* form
    - Field 4 Bill Type
        - 4th Digit requirement
- 7 Replacement of Prior Claim (used to correct a previously submitted bill)
- 8 Void/Cancel of a Prior (used to indicate this bill is an exact duplicate of an incorrect bill previously submitted)
    - Field 64 Document Control Number
        - Anthem claim ID of the claim that is being corrected

Please keep in mind that Anthem will adjust the original claim in its entirety based on the claim ID presented on the claim form.

Common errors to avoid:

- **Error**: Underpayment of corrected claims
    - Original claim ID is processed for 5 lines, 4 are paid, line 5 unpaid due to invalid charges.
    - New corrected claim submitted only for line 5.
    - Anthem will reverse the entire original claim and process the new claim.
        - Anthem processes new claim and pays line 5.
        - Provider is now underpaid as lines 1-4 were reversed and replaced by line 5.
- **Solution**: submit the corrected claim with all 5 lines, with line 5 now having charges.
- **Error**: Claim denied for lack of authorization
    - Original claim denied
    - New corrected claim has no data element changes
        - Anthem may reverse the entire original claim and deny for the same reason
        - Deny for invalid corrected claim as no data has been changed
- **Solution**: Submit a claim dispute (refer to **Requests for Review and Reconsideration of a Claim Section**)

Authorizations issued with a weekly frequency

Anthem may issue authorizations with a weekly frequency, where a week is defined as starting on Sunday and ending on Saturday. Units authorized for a single week only apply for that week, unused units cannot be applied to prior weeks or banked for use in future weeks.

Examples of services which may receive an authorization with a weekly frequency are CDPAS, Meals on Wheels, Social Day Care, and Personal Care

To avoid payment issues please ensure that services billed with an approved weekly frequency do not exceed the approved units for that week. The processing week, with or without updates to authorizations are calculated as Sunday to Saturday. Anthem will conduct post payment review to ensure weekly units are not exceeded. Please refer to the section titled **Overpayments and Overpayment Recoveries** for detail on the process Anthem will utilize when an overutilization of an approval is identified.

Requests for Review and Reconsideration of a Claim

Please note that the process described here does not apply to utilization management determinations concerning medical necessity.

Providers dissatisfied with a claim determination must submit a written request for review and reconsideration (including supporting documentation) within 60 calendar days from the date on the provider's Explanation of Payment (EOP). The EOP details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim.

All written requests for review and reconsideration must include a copy of the EOP, the claim, supporting documentation, and a written statement explaining why you disagree with Anthem determination. The following should also be included:

- Provider's name, address, and telephone number
- Member name and Anthem identification number
- Date(s) of service
- Anthem claim number
- A copy of the original claim if applicable
- A copy of the EOP from another insurer or carrier along with supporting records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule
- Evidence of eligibility verification for the date of service
- Evidence of timely filing – *Insurance Carrier Rejection Report* (Please note: Anthem does not accept copies of certified mail, overnight mail receipts, or documentation from internal billing practice software as proof of timely filing.)

The written request must be sent to:

Anthem Blue Cross and Blue Shield
Appeals and Grievances
1985 Marcus Avenue, Suite 150
Lake Success, NY 11042

Anthem will investigate all written requests for review and reconsideration and issue a written explanation as to why the claim has been reprocessed or the initial denial has been upheld. The explanation will be issued within 45 days from the date of receipt of the provider's request for review and reconsideration.

Anthem will not review or reconsider claim determinations that are not appealed according to the procedures set forth above.

Coordination of Benefits (COB)

Anthem providers are expected to cooperate with Anthem or its delegates in evaluating possible subrogation claims, and to properly coordinate benefits in accordance with applicable laws and coordination of benefit guidelines. If Anthem is not the primary payer, providers are expected to bill the payer(s) with primary liability prior to submitting bills for the same service to Anthem or its delegates. Providers must also provide Anthem or its delegates with relevant information collected from member regarding coordination of benefits. If Anthem is not the member's primary payer, provider compensation will be no more than the difference between the amount paid by the primary payer(s) and the applicable rate under the *Provider Agreement*.

Payment in Full/Member Held Harmless

Anthem providers agree to look solely to Anthem for payment of covered services rendered and to accept payment from Anthem as payment in full. Under no circumstances should a provider bill, charge, or seek compensation of any sort from member or persons acting on member behalf for covered services.

Although providers may bill members if a service is not covered and is provided on a fee-for-service basis, members must first be advised in writing that the service is a non-covered service, and that the member is liable for the non-covered service. Again, such consent must be acquired ***prior*** to providing the service.

Overpayments and Overpayment Recoveries

Anthem periodically reviews payments made to providers to ensure accuracy. Such reviews are pursuant to the terms of the provider contract and are part of Anthem utilization review and fraud control programs. If Anthem identifies instances of overpayment, it will provide a notice to the provider of overpayment, as well as methods for recoupment of the overpayment consistent with Section 3224b of the New York State Insurance Law.

Additionally, Anthem will pursue overpayment recovery efforts if:

- A reasonable belief of fraud, intentional misconduct, or abusive billing exists, or
- Required by a state or federal government program.

Providers may request that Anthem offset the overpaid amount against future payments or submit a refund check made payable to Anthem within 30 calendar days of the date of overpayment notice. Failure to refund the overpayment within 30 days of the date of the overpayment notice will result in the overpayment balance being deducted from the next claim payment. Providers should also include a statement in writing regarding the purpose of the refund check to ensure proper recording and timely processing of the refund.

All communication related to overpayment and any refund checks should be directed to:

Anthem Blue Cross and Blue Shield
Finance Department
1985 Marcus Avenue, Suite 150
Lake Success, NY 11042

Compliance

Provider Compliance Training

Anthem requires providers to conduct compliance and *HIPAA* privacy and security training to all employees at hire and annually thereafter. The training must include at a minimum:

***HIPAA* Privacy and Security Training**

The training must summarize privacy and security requirements in accordance with the federal standards established pursuant to *HIPAA*, and relevant state requirements. Training should include, but is not limited to, discussion of:

- Proper uses and disclosures of PHI
- Member rights
- Privacy and security safeguards

Fraud, Waste and Abuse (FWA) Training

This training must include, but is not limited to, discussion of:

- Laws and regulations related to fraud, waste and abuse (*False Claims Act*, Anti-Kickback statute, *Deficit Reduction Act)*
- Obligations of the provider, including provider employees and provider sub-contractors and their employees, to have appropriate policies and procedures to address fraud, waste, and abuse
- The process for reporting suspected fraud, waste and abuse
- Protections for employees and subcontractors who report suspected fraud, waste and abuse, and
- Types of fraud, waste and abuse that can occur

Code of Conduct

Anthem is dedicated to adhering to the highest ethical business standards and legal compliance. The practice of ethical business judgment, ethical personal behavior, as well as compliance with applicable laws, policies, and procedures are expected of all Anthem employees. The Code of Conduct details the fundamental principles, values, and procedures to address misconduct. It is intended to deter wrongdoing and promote:

- Honest and ethical conduct within the workplace and with our members
- Compliance with all applicable governmental laws, rules and regulations
- Prompt internal reporting of violations and compliance concerns, and
- Prompt response to violations and compliance concerns

Fraud, Waste, and Abuse (FWA)

Anthem is committed to the prevention, detection, and deterrence of health care fraud, waste, and abuse practices according to applicable federal and state statutory, regulatory, and contractual requirements.

Providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the ICD, CPT, HCPCS, and/or *Universal Billing Revenue Coding Manual* as a means of increasing reimbursement, may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be legible, support the level of care and service, and be contemporaneous, to support claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including, but not limited to, warnings, monitoring, administrative sanctions, suspension, termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines, and other penalties.

Participating providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to fraud, waste, and abuse (§ 423.504), providers and their employees must complete an annual FWA training program.

Fraud and Abuse

To demonstrate Anthem is committed to preventing and detecting any fraud and abuse activities by member, providers, or staff, or any third parties, Anthem has adopted a *zero-tolerance* policy towards fraud and abuse.

If you know or suspect someone is misusing the Medicaid program through fraud, abuse, or overpayment, you can report it in the following ways:

1. Calling Anthem Toll-Free Anonymous Compliance Hotline at **833-480-0010**.
2. Sending an email to: MLTCComplianceOfficer@Anthem.com
3. Writing the Compliance Department Directly at:

   Anthem Blue Cross and Blue Shield
   Attention: Compliance Department
   1985 Marcus Avenue, Suite 150
   Lake Success, NY 11042

Potential fraud, waste, and abuse related to Medicaid and other New York State funded programs will be reported to the SDOH and the Office of the Medicaid Inspector General (OMIG).

All reports filed by you or another on your behalf will be treated confidentially.

Delegated Entities

Anthem compliance responsibilities extend to entities that, by written contract, perform functions or services on behalf of Anthem. While certain activities may be delegated, Anthem is ultimately responsible and accountable to the federal and state agencies for all services performed by its delegated entities. It is the responsibility of Anthem to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards, and Anthem policies and procedures.

Anthem may require a corrective action plan or quality improvement plan if the delegated entity's performance is unsatisfactory. The delegated entity must cooperate with Anthem and work diligently and continuously to implement any corrective action plan or quality improvement plan required by Anthem to Anthem's satisfaction.

Anthem requires delegated entities to have at a minimum:

- Compliance plan/Code of Conduct
- *HIPAA* privacy and security training
- Compliance/FWA training
- Disaster recovery and business continuity

Appeals and Complaints

Addressing Member Problems and Concerns

Anthem is focused on addressing member problems as quickly as possible. Depending on the nature of the issue, either the complaint process or appeal process may be more appropriate.

Filing of a complaint or appeal by member will result in no change in their service or treatment by either Anthem staff or health care providers. Anthem will also continue to safeguard member privacy and provide any help necessary to complete the filing process. This includes providing member with interpreter services or assistance if they have vision and/or hearing problems. Providers may assist members with a complaint or appeal, as may member friends or relatives.

What is a Complaint?

A complaint is any communication by a member or provider to Anthem of dissatisfaction about the care and treatment members receive from our staff or providers of covered services. For instance, dissatisfaction with behavior by a staff member or with the quality of a service received may be expressed with a complaint. Complaints will be reviewed by the Grievance Department, and if the complaint pertains to clinical matters, personnel reviewing the complaint will include a licensed, certified, or registered health care professional.

Complaint Process

A complaint may be filed, in person, verbally or in writing. Upon being received by Anthem, the complaint will first be recorded, and then the appropriate staff will oversee its review. Anthem will also send a notification letter to the member indicating his complaint is received, as well as a description of the review process. The complaint will be reviewed, and a written answer provided within one of two time frames:

- If a delay would significantly increase the risk to a member's health, Anthem will provide a complaint decision within 48 hours of all information being received; no longer than 7 days after the receipt of the complaint
- For all other types of complaint, Anthem will notify member of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if so requested or if Anthem needs more information and the delay is in the member's interest

Anthem response will include a description of findings and the complaint decision.

State and Federal Complaint Options

A member, the member's Representative, or the provider may file a complaint at any time. To pursue complaints with the NYSDOH, call **866-712-7197** or email at mltctac@health.ny.gov.

Appealing a Complaint Decision

If a member is not satisfied with Anthem, due to a decision concerning a complaint, a second review of the issue may be initiated by filing a complaint appeal. This must be filed in writing and within 60 business days of receipt of our initial decision about the complaint. Once Anthem receives an appeal, a written acknowledgement is sent containing information regarding the name, address, and telephone number of the individual Anthem has designated to respond to the appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters. None of the individuals reviewing the appeal are permitted to have been involved in the initial decision.

Time frames for Handling Complaint Appeals

For standard appeals, Anthem will make the appeal decision within 30 business days of receiving all information necessary for the decision. If a delay in making the decision would significantly increase the risk to a member health, Anthem will use the expedited complaint appeal process. For expedited complaint appeals, Anthem will make the appeal decision within two business days of receipt of necessary information. For both standard and expedited complaint appeals, Anthem will provide members with written notice of the decision. The notice will include detailed reasons for the decision and, in cases involving clinical matters, the clinical rationale for the decision.

After a determination is made on the complaint appeal, there are no further appeals.

Actions and Appeal of Actions

What is an Action?

Any of the following constitutes an action when performed by Anthem:

- A denial or limited authorization of a requested service
- A restriction, reduction, suspension, or termination of a previously covered service
- Denial of payment for services, either in whole or in part
- Failure to provide timely services
- Determination that a requested service is not a covered benefit
- Failure to make grievance, appeal, and grievance appeal determinations or notifications within the required time frames
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

An action is subject to appeal. (See **How do I File an Action Appeal?** below for more information.)

Timing of Notice of Action/Explanation of Payment (EOP)

If Anthem decides to deny or limit requested services or decides not to pay for all or part of a covered service, a notice will be sent when the decision is made. A letter will be sent to the member at least 10 days prior to the restriction, reduction, suspension, or termination of authorized services.

Contents of Notice of Action/Explanation of Payment (EOP)

Notices Anthem sends regarding an action will:

- Explain the action taken or intended to be taken
- Cite the reasons for the action, including the clinical rationale, medical necessity criteria, and any processes, strategies, or evidentiary standards used, if any, and the right of the enrollee to receive, upon request and free of charge, access to and copies of all documents, records, and other information relevant to the adverse benefit determination
- Describe the right to file an appeal with Anthem (including whether a right to the State's external appeal process exists)
- Describe how to file an internal appeal and the circumstances under which an expedited review of the internal appeal can be requested
- Describe the availability of the clinical review criteria relied upon in making the decision (if the action involves issues of medical necessity, or if it involves a treatment or service that is experimental or investigational)
- Describe the information, if any, which must be provided by the member and/or the provider in order for us to render a decision on appeal

The notice will also contain information regarding the right to a State Fair Hearing after exhausting Anthem one level of appeal:

- It will explain the difference between an internal appeal and a Fair Hearing

- It will state that an internal appeal must be filed prior to requesting a Fair Hearing
- It will explain how to request a Fair Hearing
- It will state that if Anthem is restricting, reducing, suspending, or terminating an authorized service and the member wants services to continue while the appeal is decided, an internal appeal must be requested within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later
- It will explain that Anthem will not act in any manner as to restrict the right to a Fair Hearing or to influence a member decision to pursue a Fair Hearing

How do I file an Action Appeal?

If members don't agree with Anthem initial Adverse Determination, a plan appeal may be filed. Such a filing triggers a review of our initial ruling in order to determine if it is correct. The member, member's representative or providers have 60 calendar days from the date of the Initial Adverse Determination to request a plan appeal.

An appeal may be filed in person, verbally or in writing. If verbally, Anthem provides the member with a summary of the appeal in writing, either as part of the acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal. An enrollee's written consent is required for representatives to request plan appeal, grievance or fair hearing on their behalf. Providers may request appeal, grievance or fair hearing, but may not request Aid Continuing.

Note: New York requires that Member exhaust the Plan's internal appeal process before a member, or anyone on behalf of a member, may request a State Fair Hearing or an External Appeal

How do I Contact Anthem to file an Appeal?

Anthem can be reached at **855-800-4683** (TTY/Services, call **711**), Fax **718-368-6267** email MLTCgrievanceandappeals@Anthem.com or by mail:

Anthem Blue Cross and Blue Shield
Appeals and Grievances
1985 Marcus Avenue, Suite 150
Lake Success, NY 11042

Anthem will record the member appeal upon receiving it, and then appropriate staff will oversee its review. A notification letter will be sent indicating the appeal is received and describing how it will be processed, and then knowledgeable clinical staff who were not involved in the initial decision or action that is being appealed will review the appeal.

How Long Will It Take Anthem to Decide an Action Appeal?

Standard Appeal Process

Anthem will process appeals on the standard time frame, sending a written decision as quickly as the member's health condition requires, and in any event no later than 30 days from the day Anthem receives the appeal. (The review period can be increased up to 14 days if so requested by the member, or if Anthem needs more information and the delay is in the member's interest.) During Anthem review, members will have a chance to present their case in person and in writing. They will also have the chance to look at any records that are part of the appeal review.

Anthem will then send member a notice regarding the appeal decision. It will identify both the decision made and the date of the decision.

If Anthem reverses a decision to deny, limit, reduce, suspend, or terminate requested services, and services were not furnished while a member's appeal was pending, Anthem will provide the member with the disputed services as quickly as her health condition requires.

If the member or a provider acting on the member's behalf feels that taking the time for a standard appeal could result in serious risk to the member health or life, an expedited review of the appeal of the action may be requested. If the expedited appeal request is approved, a decision will be made within 72 hours. The review period can be increased up to 14 days if the member requests an extension, or if Anthem needs more information and the delay is in the member's interest.

If Anthem does not agree with a request to expedite an appeal, Anthem will make its best effort to member of the denial and the appeal will be handled as a standard appeal. A written notice of such decision will be sent within two days of receiving the request.

If a standard action appeal is filed with Anthem and the original decision is upheld, the Member will receive a Final Adverse Determination which provides the member with the rights to a Fair Hearing and External Appeal rights.

Expedited Appeal Process

If the member, the member's representative or the provider feels the time required for a standard appeal could result in serious risk to the life or health of the member, an expedited review of the appeal may be requested. Anthem will issue a decision within 72 hours. The review period can be increased up to 14 days if the member requests an extension or if Anthem needs more information and the delay is in the member's interest.

Member Options If Anthem Denies an Appeal

If an appeal decision is not totally in the member favor, the member will receive a Final Adverse Determination notice explaining the rights to request a Medicaid Fair Hearing from New York State and how to obtain it, as well as information regarding who can appear at the Fair Hearing on the member's behalf. Additionally, for some appeals, member will receive information regarding the right to request to continue receiving while a Hearing is pending, as well as instructions on how to make the request.

A Fair Hearing must be requested within 120 calendar days, from the date of the Final Adverse Determination. If Anthem denies the appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an external appeal of our decision.

State Fair Hearings

A Fair Hearing may be requested from New York State if the member received a Final Adverse Determination or the time for the Plan to decide the internal appeal has expired including any extensions. Also, if there is no response to the internal appeal, the member may request a Fair Hearing. A Fair Hearing can overrule Anthem final decision. A Fair Hearing must be requested within 120 calendar days of the date of the Final Adverse Determination notice. Members must exhaust Anthem internal appeal process before they can ask for a Fair Hearing.

The State Fair Hearing process allows a member's services to continue while the member is waiting for the case to be decided. If Anthem sends a member a notice about restricting, reducing, suspending, or terminating services the member may continue receiving services until the Fair Hearing is decided.

If the State Fair Hearing Officer reverses Anthem decision, we are required to ensure that the member receives the disputed services within 72 hours.

Although the member may request services continue while waiting for the Fair Hearing decision, if the Fair Hearing is not decided in the member's favor, the member may be responsible for paying for the services that were the subject of the Fair Hearing.

File a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

Request a Fair Hearing online using the form:

https://otda.ny.gov/oah/FHReg.asp.

Mail a Printable Request Form

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

Fax Fair Hearing Request Form to: **518-473-6735**

Request by Telephone

800-342-3334

TTY line: **711** (request that the operator call **877-502-6155**)

Request in Person

New York City
Office of Temporary and Disability Assistance
Office of Administrative Hearings
14 Boerum Place, 1st Floor
Brooklyn, New York 11201

For more information on how to request a Fair Hearing, please visit: **http://otda.ny.gov/hearings/request/**

State External Appeals

If an appeal is denied because Anthem determines the service is not medically necessary or is experimental/investigational, members may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for either Anthem or New York State, but who are qualified and approved by New York State. Members do not have to pay for an external appeal.

When Anthem denies an appeal for lack of medical necessity or on the basis of the service being

experimental/ investigational, Anthem will provide member with information about how to file an external appeal, as well as a filing form. If members want the external appeal, they must file the form with the New York State Department of Financial Services within four months from the date of the Final Adverse Determination notice.

The external appeal will be decided within 30 days the reviewer will then inform the member and Anthem of the final decision within two business days of the decision being made.

A faster decision may be received if the member's doctor indicates a delay will cause serious harm to the member's health. This is called an expedited external appeal. The external appeal reviewer will decide such an appeal in 72 hours. The reviewer will then inform the member and Anthem of the decision immediately by either phone or fax. Later, a letter will also be sent that informs the member of the decision.

Member may ask for both a Fair Hearing and an external appeal. If they ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will supersede the external appeal.

Maintaining Provider Participation Status

Credentialing

Anthem only contracts with providers meeting necessary credentialing requirements, which establish they are in possession of the proper qualifications to perform contracted services. Providers must have a clean record and be in good standing with federal, state, and local government agencies. Additionally, they must have a reputation for rendering quality services. After initial credentialing, providers are re-credentialed on a regular basis by Anthem, ensuring providers continue to maintain credentials, comply with the provider contract, and demonstrate sensitivity toward Anthem members.

Credentialing Committee

The Credentialing Committee is responsible for credentialing and re-credentialing Anthem network providers.

It is comprised of:
- Chief Medical Officer, as Chair
- Director of Provider Relations or his/her designee, as Facilitator
- Director of Compliance
- Director of Utilization Management
- Director of Quality Assurance and Improvement or his/her designee
- Provider Network Manager
- Two or more representatives from Anthem provider community knowledgeable in the technical aspects and current practice standards of the serviceareas under review

Initial Credentialing Requirements

Providers must pass the initial credentialing in order to join Anthem network.

This entails:
- A record clean of State sanctions or exclusions, including sanctions or exclusions by Medicaid or Medicare
- A malpractice history that is not unduly negative
- Documentation to establish competence and standing

Additionally, individual practitioners (such as podiatrists, audiologists, dieticians, social workers, and therapists) must

provide:

- Curriculum Vitae
- Copy of current and valid NYS license and license number
- Copy of current and valid DEA or CDS certificate, as applicable
- Copy of malpractice liability coverage certificate with required levels of coverage
- Copy of Board certification certificate, if applicable
- Signed statement giving Anthem permission to make inquiries to other institutions and agencies (primary source verification) regarding the practitioner's background or competence

All other practitioners (such as adult day health care and social day centers, certified home health agencies, licensed home care agencies, skilled nursing facilities, DME providers, and PERS programs) must provide:

- Copy of Medicare provider agreements with CMS, if applicable
- Copy of current and valid NYS license
- Copy of malpractice liability coverage certificate with required levels of coverage
- Proof of Worker's Compensation Insurance
- Proof of accreditation and/or a copy of Social Adult Day Care Certification, if applicable
- Proof of Home Health Care Registration
- Signed statement giving Anthem permission to make inquiries to other institutions and agencies (primary source verification) regarding the provider's background or qualifications

Once the credentialing process is completed, an executed contract is countersigned by Anthem and a copy sent to the provider. At this point, the provider is considered a participating provider of Anthem network.

OIG/OMIG Exclusion Screening

Federal law prohibits the payment by any Federal or State healthcare program (including Medicare and Medicaid) for any items or services furnished by a person or entity excluded from participation from these programs. A check is performed prior to hire, and on a monthly basis thereafter, to confirm that employees and vendors are not so excluded.

The following websites may be used to perform the required screening:

- OIG List of Excluded Individuals/Entities (LEIE): **http://exclusions.oig.hhs.gov**
- NYS Office of Medicaid Inspector General Exclusions Listing: **http://www.omig.state.ny.us/daa/content/view/72/52**
- System for Award Management (SAM): **https://www.sam.gov/portal/SAM/#1**

If a provider or vendor is found on an exclusion list, she must be prohibited from performing any work directly related to Federal or State healthcare programs. Furthermore, documentation of exclusion checks must be maintained to establish that providers and vendors have been properly screened on a monthly basis.

On-Site Reviews

Anthem sometimes conducts on-site reviews to evaluate the suitability of a provider's service site. These reviews are performed for all providers operating in sites other than member's homes, including, Social Adult Day Care Centers and for Consumer Directed Personal Assistance Providers.

Delegated Credentialing for Vision and Dental Services

Anthem delegates credentialing for dental and vision providers to entities contracted for the provision and management of these services. As part of the contracting process, such entities submit copies of their policies and procedures, a description

of their credentialing and re-credentialing criteria, and other relevant processes to Anthem Credentialing Committee for approval. Anthem also requires these entities to certify that all providers participating in their respective networks meet Anthem credentialing requirements.

Re-credentialing

Anthem requires participating providers to be re-credentialed at least once every three years. The re-credentialing process ensures continued maintenance of credentials, contract compliance and performance, and demonstrated sensitivity in meeting the needs of Anthem members.

A re-credentialing application is sent to the provider 32 months from the current credentialing appointment date (at least 120 days prior to the expiration of the credentialed status). Providers are required to update the application and submit all requested documentation at this time.

Once the application and accompanying documentation are received, verification of credentials and standing will be conducted using primary (or similarly acceptable) sources. The re-credentialing committee will also consider member feedback on provider performance as indicated by member grievances and member satisfaction survey results. The results of quality, on-site, utilization management, and medical record reviews will also be considered by the committee.

If a provider fails the re-credentialing process, Anthem will suspend or terminate provider participation and will notify the provider of its decision. Note that independent of the credentialing and re-credentialing processes, a provider's participation in Anthem network may be suspended or terminated for cause at any time.

Appealing Adverse Credentialing or Re-credentialing Determinations

Network providers have the following rights in relation to adverse credentialing or re-credentialing determinations:

- To appeal adverse decisions on a credentialing or re-credentialing application
- To review information submitted with the credentialing application
- To correct erroneous information collected during the credentialing process
- To be informed of the status of a submitted credentialing or re-credentialing application, and
- To be notified of these rights

Anthem complies with all state and federal mandates governing appeals by providers denied participation in Anthem network. Rejected providers will be notified in writing of the reason for the denial and may submit a request for an appeal as outlined therein. Note that the request for appeal must be received by Anthem within 30 days of the date of the rejection letter. The written request should be sent to:

Anthem Blue Cross and Blue Shield
Credentialing Appeals Committee
1985 Marcus Avenue, Suite 150
Lake Success, NY 11042

Such a request must be accompanied by an explanation as to why the credentialing committee should review its decision, as well as any documents and materials supporting re-credentialing. The appeal request must also adequately address the concerns of the credentialing committee that drove the denial of participation for the provider.

Demographic Update

It's critical that the information in our provider files is accurate, current, and complete. To ensure the plan and our members have the most accurate information about your practice, please complete the Provider File Change Form whenever your practice information is updated or changed. (Please refer to ***Exhibit B***).

Provider Termination and Obligations upon Termination

If Anthem decides not to renew a provider contract, the provider receives written notice of the decision 60 days prior to the date of termination. Anthem may also terminate the contract for any reason if 90 days' written notice is given. Such written notice will include the following:

- The reason(s) for the termination, and
- Except in cases of non-renewal, notice that the provider has the right to request a hearing or review in accordance with applicable state law (if the provider is an individual physician or other individual provider licensed under Title 8 of the New York Education Law).

Independent of the re-credentialing process, Anthem may suspend or terminate a provider's participation in the network for cause at any time. Participation will be terminated immediately, and the provider denied the right to a review if:

- Anthem determines that the provider's actions or proposed actions threaten imminent harm to patient care
- Anthem determines that the provider has engaged in fraud
- A final disciplinary action has been taken by a state licensing board or other governmental agency that impairs or limits the provider's ability to practice
- The provider becomes uninsured or uninsurable with regard to professional liability coverage
- The provider dies
- The provider becomes disabled for a period of time exceeding three months such that the provider is unable, in the opinion of a physician selected by Anthem, to fulfill his or her contractual obligations with Anthem
- The provider becomes ineligible to participate in Medicare and Medicaid programs, or
- The provider takes any public or private action clearly contrary to the best interests of Anthem

Once providers are notified of contract termination, they may submit a request for an appeal as outlined in the letter of rejection/termination sent by Anthem. Such a request must be received within 30 days of the date of the rejection/termination letter.

Please send appeal requests sent to:

Anthem BlueCross BlueShield HP
Credentialing Appeals Committee
1985 Marcus Avenue, Suite 150
Lake Success, NY 11042

When a provider initiates termination of the participation agreement with Anthem, any payments accrued to the provider are payable by Anthem prior to termination. Additionally, the provider has the following obligations:

- Providers won't seek compensation from member for covered services delivered prior to the effective date of termination
- Providers will continue to permit Anthem access to member records, and to provide Anthem with copies of all records of services rendered to members on or prior to the effective date of termination
- Providers will cooperate fully with Anthem in the transfer of members to other providers and ensure that provision for medically necessary services is in place prior to suspension of the provider's services
- If necessary, providers are obligated to continue care for a member for up to 180 days following notice of termination or until such time as Anthem makes alternate arrangements for member, whichever first occurs

Please note that termination procedures are subject to the provisions of the provider agreement. If there is a conflict between the provisions in the provider manual and the provider's agreement, the terms of the provider agreement will supersede those of the manual.

Provider Network Monitoring & Evaluation

Provider Network Monitoring

Anthem regularly conducts reviews of its provider network to ensure it supplies members with meaningful choice, timely access to providers, and that it accommodates special member needs. Network development is guided by these reviews, incorporating Anthem ongoing assessment of any service issues and Anthem performance in resolving these issues.

Provider Performance Monitoring

Anthem, the Department of Health (DOH), and their designees have the right to monitor participating providers' performance of contracted services. This includes, but is not limited to, the quality, appropriateness, degree of access to, and the timeliness of such services. The monitoring may take place during normal business hours, or any other time a provider's contracted functions are being conducted, and may be achieved through inspection or any other reasonable means.

Providers are required to cooperate with and reasonably assist Anthem, DOH, and their designees when this monitoring is being performed.

Providers are evaluated on the following criteria:

- Maintenance of credentialed status (after both credentialing and re-credentialing, and by ensuring timely re-credentialing)
- Compliance with not only contractual standards, but also the policies and procedures outlined in the provider manual and subsequent communications
- Accuracy of billing and the existence of any patterns of error, as determined through documentation of service provision, and
- Satisfactory performance of services, as indicated by:
    - Absence of provider-related member complaints or satisfactory redress of such complaints
    - Service provision within the established service time frame guidelines in the previous section
    - Timely and satisfactory implementation of any corrective action plan established in follow up to an identified issue, and
    - Clean results from audit or reviews conducted (for example, financial, quality review, and record keeping)

Documents collected and reviewed include, but are not limited to:

- Medical Record Notes
- Attendance Sheets
- Activity Records
- Time Slips
- Sign in logs/attendance sheets
- DME delivery tickets
- Trip Verification
- Monitoring Reports from Network Providers

Addressing Provider Performance Issues

The Provider Relations Department (Department) promptly notifies providers when any performance issues requiring action arise, documenting communications in the provider record (including the date, the individual communicated with, and a brief summary of issue and resolution).

The process for addressing performance issues involving member grievances is set forth in Anthem grievance policies and procedures, elaborated on above.

Progress on performance issues that are not grievance-related is regularly checked by the Department until the issue is fully resolved. Any issue that is unresolved for more than a month will result in written notification.

If necessary, the Department may follow up with active monitoring and intervention. This may include, but is not limited to:
- Communicating performance feedback to providers
- Provision of technical assistance or training, and
- A face-to-face meeting to rectify identified issues

A failure to resolve issues may result in the Department pursuing more serious measures. These include, but are not limited to:
- A formal review by Anthem Provider Performance Review Committee
- A formal notice of non-compliance to the provider, along with a request for corrective action plan
- A formal notice to the provider of Suspension of Participation or Pending Contract Termination

Quality Assurance and Performance Improvement (QAPI)

As part of Anthem Quality Assurance and Performance Improvement (QAPI) initiative, a committee of interdisciplinary professionals reviews provider metrics every quarter, including operational, clinical, and outcome data. The goal of the review is improvement of the quality and appropriateness of care, as well as an increase in member satisfaction.

Toward these ends, provider performance is evaluated according to these criteria:
- The quality and quantity of services rendered
- Provider's availability and accessibility
- Presence of any operational and clinical practice performance issues
- Timeliness and effectiveness of any performance issue resolution, and
- Both clinical and non-clinical member outcomes

Anthem supplies feedback to providers regarding their overall performance and on performance issues that require provider follow up. Such feedback may include, but is not limited to:
- Results from member satisfaction surveys, utilization reviews, and staff and member feedback
- Member grievances filed against the provider, and
- Non-compliance with contractual requirements or Anthem policies and procedures

Non-compliance or poor performance on the part of providers will result in a request for a corrective action plan by Anthem, and unsatisfactory progress may result in disciplinary action that includes suspension or termination of the provider agreement.

Consumer Directed Personal Assistance Program (CDPAP) Monitoring

CDPAP providers are monitored annually to confirm compliance with Anthem quality and conduct standards.

Definitions and Acronyms

Self-Directing Consumer: an individual capable of making choices regarding his or her activities of daily living, including choices regarding the type, quality, and management of the consumer directed personal assistance, 2) who understands the impacts of these choices, and 3) is able to assume responsibility for the results of these choices.

Consumer: a recipient of medical assistance determined eligible to participate in the CDPAP by a social services district.

Consumer Directed Personal Assistant (CDPA): an adult who provides consumer directed personal assistance to a consumer under the instruction, supervision, and direction of either the consumer or the consumer's designated representative. Note that a consumer's spouse, parent, or designated representative may not serve as that consumer's CDPA. However, any other adult relative of the consumer may serve as the consumer's CDPA so long as the relative doesn't reside with the consumer. An exception to this last prohibition is made if the amount of care the Consumer requires makes it necessary for the relative to reside with the consumer.

Designated Representative: an adult of sufficient capability to whom a self-directing consumer has delegated authority to instruct, supervise, and direct the CDPA. With respect to a non-self-directing consumer, a *designated representative* is the consumer's parent, legal guardian, or, subject to the social services district's approval, a responsible surrogate who is willing and able to perform these responsibilities on the consumer's behalf. The designated representative may not be the CDPA, a Fiscal Intermediary's employee, representative, or affiliated person.

Stable Mental Condition: a condition that is not expected to exhibit sudden deterioration or improvement, and that does not require frequent medical evaluation in order to alter the consumer's plan of care.

Fiscal Intermediary (FI): an entity contracted with a social services district to provide wage and benefit processing for CDPAs.

Provider Relations Auditing

The Personal Assistant files of Fiscal Intermediaries are regularly audited by Provider Relations to ensure:

- Each Personal Assistant has his or her own file
- Time sheets for the Personal Assistant exist
- Presence of the Employment Application
- Presence of a CV
- Presence of a *W4* Tax form
- Presence of health records establishing the consumer's health status was assessed prior to service delivery
- Proof of Personal Assistant training by the consumer
- Proof of training by a Registered Professional Nurse certifying that the Personal Assistant can perform a Skilled Nursing Task *(if applicable)*

Fiscal Intermediary files are regularly audited by Provider Relations to ensure the following items are present for each consumer:

- An individual file
- A contract between the consumer and Fiscal Intermediary
- Signed agreement outlining consumer's responsibilities
- Assessment that includes
    - Physician Order
    - Nursing Assessment

    - Social Assessment
- Plan of Care
- CDPAP Notice of Decision of Initial Authorization, Reauthorization, or Denial
- CDPAP Notice of Intent to Increase, Reduce or Discontinue *(if applicable)*
- CDPAP Agreement between the LDSS and the Consumer/Designated representative
- Copies of Authorizations and Re-Authorizations
- Substitute Assistant designation in case Personal Assistant is unavailable

Provider Relations reviews CDPAP Policies and Procedures to ensure existence of a procedure:

- To notify Anthem within five business days of any changes in the consumer's medical condition or social circumstances, including, but not limited to, any hospitalization of the consumer or change in the consumer's address or telephone number
- For the consumer to notify the Fiscal Intermediary in within 24 hours of any changes in the employment status of each CDPA
- For attesting to the accuracy of each time record for each CDPA
- For transmitting the CDPA's time records to the Fiscal Intermediary
- For timely distribution of each CDPA's paycheck
- For checking sanctioned individuals against the Excluded Provider List on a monthly basis
- For arranging and scheduling substitute coverage when a CDPA is temporary unavailable for any reason
- For monitoring the ability of the consumer to fulfill his or her responsibilities under the CDPAP
- For notifying the Fiscal Intermediary and/or Anthem of any disclosure of information that Anthem has taken reasonable measures to maintain as confidential, and which derives independent economic value from not being generally know or readily ascertainable by the public (proprietary information). Proprietary information includes the compensation arrangements between Anthem and the Fiscal Intermediary, the amount the Fiscal Intermediary pays the CDPA, and any other information relating to Anthem business that is not public information.

Provider Relations representatives also confirm the following:

- Existence of a document acknowledging and agreeing that:
    - Any person who receives, directly or indirectly, an overpayment from the Medicaid program is obligated to report and return the overpayment within 60 days of the identification of the overpayment. Failure to do so may expose the person to liability under the *False Claims Act*, including whistleblower actions, treble damage and penalties, and
    - That the Office of the Medicaid Inspector General or Anthem may suspend payments of the Fiscal Intermediary and CDPA, if applicable, pending an investigation of a credible allegation of fraud against the Fiscal Intermediary or CDPA, unless the state determines there is good cause not to suspend such payments.
- Compliance with applicable labor laws, including laws guaranteeing equal employment opportunities to CDPAs
- Existence of an agreement between the Fiscal Intermediary and consumer stipulating that the consumer or the consumer's representative shall:
    - Comply with applicable NYSDOH regulations regarding the responsibilities of the providers enrolled in the medical assistance program, and
    - Manage the plan of care authorized by Anthem, including recruiting and hiring a sufficient number of CDPAs to provide services as set forth in the plan of care authorized by Anthem; training, supervising and scheduling each CDPA; terminating the CDPA's employment with the consumer; and assuring that each CDPA completely and safely performs the personal care services, home health aide services, and skilled nursing tasks included on the Consumer's Anthem-approved plan of care.

Collaboration with Anthem Team

Several Anthem departments work closely with providers to ensure members receive quality care. Below is a brief description of each of thesedepartments.

Network and Provider Relations Department

The Network and Provider Relations Department maintains and supports Anthem provider network. The department is responsible for:

- Provider recruitment and contracting;
- Credentialing and re-credentialing of providers;
- Scheduling provider orientations and training to inform providers about Anthem programs, policies, and procedures;
- Developing communication initiatives to keep network providers informed and engaged, as well as issuing regular communications such as notices, updates, and information on general topics of interest;
- Ensuring providers receive notice of important changes in Anthem policies and procedures, of Anthem decisions regarding provider participation status, and of any compliance issues;
- Monitoring provider performance and facilitating resolution of Member grievances regarding provider performance;
- Answering provider questions and supplying technical assistance as necessary;
- Claims payment inquiries and resolutions, and
- Facilitating communication between providers and Anthem Care Management and Quality Assurance/Improvement personnel on care issues.

Care Management Department

The Care Management Department is responsible for planning and coordinating all aspects of member care. Every Anthem member is assigned a Care Management team consisting of a nurse care manager and a social worker. This team works with providers in the following ways:

- Makes provider referrals and works with providers to ensure service arrangements meet member needs
- Supplies required service authorizations
- Conveys pertinent member information to providers, enabling providers to render their services;
- Solicits input from providers on member status and needs
- Handles provider requests for service authorizations made on behalf of member

Member Services Department

The Member Services Department works with Anthem providers in the following ways:

- Supplies confirmation of member eligibility status
- Facilitates communication with member care management team
- Assists in arranging transportation services, and
- Supplies assistance with special member needs, such as language translation services

Grievance and Appeal Units

The Grievance and the Appeals Units work with providers in the following ways:

- Handle any appeals providers file on behalf of members, and
- Review grievances relating to provider performance

Quality Assurance and Improvement Department

Through its oversight of Anthem operations and clinical practices, the Quality Assurance and Improvement Department ensures timely identification and resolution of issues affecting the quality of care supplied to Anthem members.

The Department works with providers in the following ways:

- Conducts audits both of member records and of operations at providers' sites
- Reviews quality of care supplied by providers
- Conducts ember satisfaction surveys in conjunction with the Member Services and Provider Network Relations departments, assisting with the development and implementation of provider corrective action plans in response to negative feedback, and
- Supports the provider credentialing and re-credentialing processes

Anthem Partnership with You!

Anthem considers each of our providers a partner in caring for our members, so we work closely with them to ensure member needs are met. Only together can we maximize Member satisfaction and positive outcomes.

Committee Participation and Feedback Opportunities

To strengthen our partnership, we invite providers to provide feedback and participate on our committees. Opportunities include:

- Becoming a member of Anthem Quality Assurance Committee
- Acting as a peer reviewer on the Provider Credentialing and Re-Credentialing Committee
- Providing feedback on or assisting in the design and planning of Quality Improvement initiatives
- Supplying feedback on your experience with Anthem through our provider satisfaction surveys

Please contact the Provider Relations Department for further information at **929-946-6500**.

Referral Process

Please refer to the Anthem MLTC Provider Portal User Guide posted on the MLTC Provider Portal at **mltcprovider.anthem.com** for an overview of the MLTC Provider Portal referral process. This website is for MLTC providers and services for Anthem.

After Anthem Receives the Referral

Once a referral is received, Anthem contacts the potential member within 48 hours in order to:

- Discuss the services Anthem offers and conduct eligibility screening
- Ensure newly eligible MLTC applicants are directed to Maximus for the Conflict Free Evaluation and Enrollment Center screening and CFEEC-UAS administration (New York Independent Assessor evaluation)
- Arrange to have an Assessment Nurse conduct a home visit/a video assessment, and
- Answer any questions the potential member may have

Marketing Guidelines for Anthem Providers

Anthem welcomes the assistance of provider partners in marketing Anthem services to eligible individuals, but providers must comply with marketing guidelines established by New York State.

These guidelines are as follows:

- Providers may not engage in marketing practices or distribute marketing materials that mislead, confuse or defraud eligible persons, the public, or any government agency.
- Providers may not misrepresent the Medicaid program, the Medicaid MLTC program, or policy requirements of the State or its agents (counties).
- Marketing materials must accurately reflect general information applicable to the average consumer, such as the plans providers have contracts with.
- Marketing activities may not discriminate on the basis of a potential member health status, prior health service use, or need for future health care services.
- Plans or Providers may not conduct "cold call" telephone solicitations. Door to door solicitation is also prohibited.
- Providers may not provide mailing lists of their patients to Anthem or any other Plan.
- Providers may not disseminate any information regarding mandatory enrollment requirements.
- Providers may give permission to Anthem marketing representatives to conduct marketing activities at their facilities. If Anthem participates in these activities, Anthem must prominently display a list of all other Plans operating in the county or borough.
- Anthem will not require providers to distribute Anthem-prepared communications to their patients.
- In the event that providers are no longer affiliated with a particular Plan, but remain affiliated with other participant Plans, providers may notify their patients of their new status and the impact the change has on the patient.
- All marketing activities shall be conducted in an orderly and non-disruptive manner and shall not interfere with the privacy of potential enrollees or the general community.
- Providers may not offer material or financial gain to Medicaid beneficiaries as an inducement to enroll. Specifically, providers and Plans may only:
    - Make reference in marketing materials and activities to benefits/services offered under the program, and
    - Offer nominal gifts with a fair market value of no more than $5.00, and such gifts must be offered regardless of a potential enrollee's intent to enroll.
- Providers shall not pay any individual, or accept in payment from a Plan, any commission, bonus, or similar compensation based on numbers of referrals or Medicaid-eligible persons enrolled in the MLTC.

REMINDER: Medicaid recipients may never be told by their provider that they have to join a plan immediately. Recipients have to make a selection when they receive their official notice from the State or its designees or are seeking community-based long-term care services in mandatory counties.

Exhibit A

PHYSICIAN'S ORDER FOR PERSONAL CARE/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

COMPLETE ALL ITEMS **INCOMPLETE FORMS WILL BE RETURNED TO THE PHYSICIAN**

1. Patient Identifying Information (Use additional paper if necessary)

PATIENT NAME	CIN	DATE OF BIRTH	SEX
ADDRESS APT/STREET CITY STATE ZIP CODE			

TELEPHONE NO. ( )	MEDICARE NO.	IF CURRENTLY HOSPITALIZED: Name of Hospital	DATE OF ADMISSION:	ANTICIPATED DATE OF DISCHARGE
TO ABOVE ADDRESS? ☐ YES ☐ NO IF NO EXPLAIN:				

2. General Information

PHYSICIAN NAME	LICENSE #	TELEPHONE NO. ( )
ADDRESS STREET CITY STATE ZIP CODE		
If the examination was conducted by a Physician's Assistant, Specialist's Assistant, or Nurse Practitioner, Identify: Name _____ Profession:_____ License #:_____		
PLACE OF EXAMINATION:_____ DATE OF EXAMINATION:_____ (30 days of Physician's signature date)		

3. Medical Findings

NOTE: Indicate **N/A** if an item does not apply to this patient or **Unk** if the requested information is unknown to the physician signing this form.

Height:_____ Weight:_____

For the condition(s) requiring personal care:

Primary Diagnosis _____ ICD-9-CM Code_____

Secondary Diagnosis_____ ICD-9-CM Code_____

Describe the patient's current medical/physical condition_____

_____

_____

Is the patient's condition stable? ☐ YES ☐ NO

Is the patient appropriate for Hospice Care? ☐ YES ☐ NO

Describe the current treatment plan and therapeutic goals including the prognosis for recovery: _____

_____

_____

Describe any prohibited activities or functional limitations: _____

_____

_____

Is the patient self-directing? ☐ YES ☐ NO

Is the patient able to summon help by any means? ☐ YES ☐ NO

If No, explain _____

_____

Is the patient able to ambulate independently? ☐ YES ☐ NO With devices? ☐ YES ☐ NO Other Assistance? ☐ YES ☐ NO

Describe: _____

_____

Is the patient continent of bowel? ☐ YES ☐ NO Of bladder? ☐ YES ☐ NO

Catheter/Colostomy Needs: _____

List all current medications (prescription and OTC) and note dosage and frequency and any special instructions (attach additional sheet if necessary):

_____

_____

_____

_____

Can the patient self-administer medications: ☐ YES ☐ NO

If the patient requires a modified diet or has other special nutritional or dietary needs, describe:_____

_____

_____

Please indicate any task, treatments or therapies currently received, or required by the patient: _____

_____
_____
_____

Does the patient require assistance with, or provision of, skilled tasks (e.g. monitoring of vital signs, dressing changes, glucose monitoring, etc.)?

☐ YES ☐ NO If Yes, please indicate: _____

_____

_____

Based on the medical condition, do you recommend the provision of service to assist with skilled tasks, personal care and/or light housekeeping tasks?

☐ YES ☐ NO

Contributing Factors:

Describe contributing factors including but not limited to the social, family, home or medical (e.g. muscular/motor impairments, poor range of motion, decreased stamina, etc.) situation that may affect the patient's ability to function, or may affect the need for home care or that may affect the patient's need for assistance with skilled tasks, personal care tasks and/or light housekeeping. Please include any other information that may be pertinent to the need for assistance with home care services.

_____
_____
_____
_____
_____
_____
_____
_____

IT IS MY OPINION THAT THIS PATIENT CAN BE CARED FOR AT HOME. I HAVE ACCURATELY DESCRIBEDHIS OR HER MEDICAL CONDITION. NEEDS AND REGIMENS, INCLUDING ANY MEDICATION REGIMENTS, AT THE TIME I EXAMINED HIM OR HER. I UNDERSTAND THAT I AM NOT TO RECOMMEND THE NUMBER OF HOURS OF PERSONAL CARE SERVICES THIS PATIENT MAY REQUIRE. I ALSO UNDERSTAND THAT THIS PHYSICIAN'S ORDER IS SUBJECT TO THE NEW YORK STATE DEPARTMENT OF HEALTH REGULATIONS AT PARTS 515, 516, 517 AND 518 OF TITLE 18NYCRR, WHICH PERMIT THE DEPARTMENT TO IMPOSE MONETARY PENALTIES ON, OR SANCTION AND RECOVER OVERPAYMENTS FROM PROVIDERS OR PRESCRIBERS OF MEDICAL CARE, SERVICES OR SUPPLIES THAT ARE UNNECESSARY, IMPROPER OR EXCEED THE PATIENT'S DOCUMENTED MEDICAL CONDITION ARE PROVIDED OR ORDERED.

INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT

Physician's Signature _____ Date _____
(Must be within 30 days of date of examination)

PLEASE SIGN AND RETURN COMPLETED FORM WITHIN 30 CALENDAR DAYS OF EXAMINATION TO:

_____

_____
_____

New York State Department of Health

PHYSICIAN'S ORDER FOR PERSONAL CARE/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

INSTRUCTIONS

COMPLETE ALL ITEMS. ***(Attach additional sheets, if necessary)***. **INCOMPLETE FORMS WILL BE RETURNED TO THE PHYSICIAN. INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT.**

1. **Patient Identifying Information**
   - **Patient Name.** Enter the patient's name.
   - **CIN.** Found on the patient's Medical Assistance ID card.
   - **Date of Birth.** Enter the patient's date of birth.
   - **Sex.** Enter the patient's gender.
   - **Address and telephone number.** Enter the patient's address and telephone number.
   - **Medicare #.** Enter the patient's Medicare number if available.
   - **If currently hospitalized.** If the patient is hospitalized at the time of completion of the physician's order, indicate the name of the hospital, date of admission, and anticipated date of discharge.
   - **Discharge to above address. I**f the patient is to be discharged to an address other than the address listed above please explain.
   - **General Information**
2. **Physician's Name, License #, Address, Telephone**. Enter information for the physician signing the order. Enter either the physician's license number as issued by the New York State Department of Education or the provider billing number issued by the New York State Department of Health Medicaid Management Information System.

- **Examination conducted by other than a physician**. If patient was examined, and the order form completed by a physician's assistant, specialist's assistant, or nurse practitioner, complete the required information.

- **Place of Examination.** Indicate the location (office, clinic, home, etc) of the examination of the patient.

- **Date of Examination**. Enter the date the patient was examined. This must be within 30 days of the date the physician signed the form.

3. Medical Findings

Note: Indicate **N/A** if an item does not apply to this patient or **Unk** if the requested information is unknown to the physician signing this form.

- **Height, Weight.** Enter the patient's height and weight.

- **Primary and Secondary Diagnosis.** Enter the primary and secondary diagnosis with ICD-9-CM codes for the primary and secondary conditions which result in the patient being evaluated for home care services.

- **Describes the current condition.** Describe the patient's current medical/physical condition, including any relevant history.

- **Stability.** Check **Yes** if the patient's condition is not expected to show marked deterioration or improvement. **A stable medical condition** shall be defined as follows:
  (a) the condition is not expected to exhibit sudden deterioration or improvement; and
  (b) the condition does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and
  (c) (1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or
  (2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

- **Hospice.** If the patient's condition is terminal, indicate if the patient is appropriate for Hospice services.

- **Describe the current treatment plan**. Include therapeutic goals and prognosis for recovery and anticipated duration of the current treatment plan.

- **Limitations.** Indicate any functional limitations or prohibited activities.

- **Self-Directing.** Indicate if the patient is self-directing. Self-directing means that the patient is capable of making choices about activities of daily living, understanding the impact of the choices, and assuming responsibility for the results of the choices. A **No** response to this item should be reflected in the description of the patient's condition as documented in the applicable section.

- **Able to Summon Help.** Check **Yes** if the patient is able to summon assistance in an emergency situation by any means. If the patient is not able to summon assistance, check **No** and explain.
- **Ambulation.** Indicate the patient's ability to ambulate independently, or with the need for assistance or devices. Specify assistance/devices used or needed.

- **Bowel/Bladder.** Indicate if the patient is continent. Describe any catheter or colostomy needs.

- **Medications Required**. List all prescription and over-the-counter medications the patient is taking and note dosage, frequency and any special instructions.

- **Medication Administration**. Indicate the patient's ability to self-administer medications.

- **Dietary Needs.** Indicate if the patient has special nutritional or dietary needs, i.e. low salt or high potassium.

- **Tasks/Treatments/Therapies.** Indicate any tasks, treatments or therapies which the patient receives or requires in the home and describe.

- **Need for completion/assistance with skilled tasks.** If the patient requires assistance with skilled tasks including, but not limited to, glucose monitoring, wound care, vital signs, describe the need for such assistance.

- **Recommendation to provide assistance.** Check **Yes** if, in your opinion, the patient can be maintained in his or

her home with provision of home care services.

- **Contributing factors to need for assistance**. Please indicate the functional deficits that support the need for the provision of home care services. Please include any pertinent information you may have regarding the patient's surroundings, physical condition or other factors that may affect the ability of the patient to function in the community or the patient's need for assistance with personal care tasks.

4. **Physician's Signature/Date of completion.** The signature of the ordering physician as identified in Item 2. Note that by signing this document, the physician certifies that the patient's condition and needs are accurately described. Forms lacking a signature and/or date are not acceptable.

5. **Return Form To.** The local district or other case management entity to whom the form is to be returned.

Exhibit B

PROVIDER FILE CHANGE FORM

Please use this form in place of your office letterhead when submitting changes to Anthem. All fields must be completed to process the request. Please print clearly and legibly. You must include a signed and dated W9 and your current Liability Insurance face sheet showing amounts and expiration date.

Type of Change: □ Add □ Change □ Delete Effective Date of Change: _____
Month/Day/Year

SECTION 1: Current Information

Legal Facility /
Organization Name: _____

d/b/a Trade Name: _____

Street Address: _____

City/State/Zip Code + 4: _____

Phone #: _____ Fax #: _____

TIN: _____ NPI:_____

Email:_____

SECTION 2: New Office Information

Legal Facility /
Organization Name: _____

d/b/a Trade Name: _____

Street Address: _____

City/State/Zip Code + 4: _____

Phone #: _____ Fax #: _____

TIN: _____ NPI:_____

Other:_____

You may return this form along with your signed and dated W9 and Liability Insurance face sheet to the Provider Relations Department by:

Fax: (718) 368-6269 or Email: providerrelations@Anthem.com

By signing this form, you are authorized on behalf of your organization and attest this information is accurate and correct.

Name (please print):_____

Signature:_____

Date of Request: _____

Hours of Operation & Contact Information

Anthem normal hours of operation are Monday through Friday, 9 a.m. to 5 p.m. EST.

Provider Relations

General Questions	**Tel: 929-946-6500** **Fax: 718-368-6269** **Email: providerrelations@Anthem.com**
Policies and Procedures	
Provider Orientation and Training	
Credentialing and Re-credentialing	
Claims and Payments	
Performance Management	

For inquiries regarding enrollment, eligibility, benefits, authorizations, claims, & appeals, please call Anthem's Provider Service Line at **929-946-6500**.

Fax service requests and all clinical documentation to Anthem's Care Management team at **718-368-6267**.

Send CDPAS Physician Orders to CDPAS@Anthem.com

Provider Services: 800-450-8753
https://providers.anthem.com/ny