

Anthem Behavioral Health

**Administrative
Policies and Procedures**

Physician and Provider Manual

June 2008

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SECTION 1

Introduction

Anthem Behavioral Health has prepared this manual to assist you by providing important information concerning our policies and procedures for individual physicians, practitioners, group practices, service programs and facilities. It is intended to supplement your Participating Provider/Facility Agreement with Anthem Blue Cross and Blue Shield. Revisions will be issued periodically, with important updates communicated through mailings and our provider newsletters. Remember to incorporate these updates into your manual.

Anthem Behavioral Health reserves the right to amend this manual, and retains the right to interpret any terms or provisions.

The following terms as used in this manual are defined for you here:

Participating provider means a duly licensed provider, including a physician, a non-physician practitioner, a hospital, a skilled nursing facility, a residential treatment facility, a mental health or substance use treatment clinic that has entered into a written agreement to provide covered services to Anthem members.

Payor means person or entity that is liable for funding payments under a Plan.

Plan means any health plan this is sponsored, underwritten or administered by Anthem or by an entity with which Anthem has agreed to provide access to the applicable network of participating providers, as any Plan may be amended from time to time.

Program or product means the health maintenance organization (HMO), preferred provider organization (PPO) or other types of health delivery models, administrative services, Plan designs and product descriptions that are provided or arranged by Anthem and that are specifically described in this Administrative Policies and Procedures Manual.

Members Served

Anthem Behavioral Health administers the behavioral health benefits for members of the following Anthem plans and products:

- *BlueCare Health Plan* (including *State BlueCare*)
- *Century Preferred* (including *State Preferred*)
- Anthem employees with HMO (BlueCare) and PPO coverage
- *BlueCard*
- *Century 90*
- Federal Employee Program (FEP) *Standard Option* and *Basic Option*
- *PPO USA* (National Accounts)
- New England Health Plans (*HMO Blue New England* and *BlueChoice New England*) effective 01/01/2008
- Empire HMO/POS Effective 01/01/2008

Anthem Behavioral Health does **not** administer behavioral health benefits for the following Anthem plan.

- *BlueCare Family Plan*


Further information on the administration of these plans and products can be found in the *Behavioral Health Quick Reference Guide*.

New Plans, Products and Programs

When new plans or programs are introduced, Anthem Behavioral Health, at its discretion, may select current and new providers for participation based on the network needs of the new product. Under the terms of the Participating Provider/Facility Agreement, Anthem Behavioral Health will communicate to providers new product enrollment within 30 days after the payor or Plan has notified Anthem Behavioral Health.

Inquiries

Anthem Behavioral Health – East is located at 370 Bassett Road, North Haven, CT 06473

 Toll-Free **800-934-0331**

Anthem Behavioral Health maintains a toll-free access telephone line that links members with clinical intervention services 24 hours/day, seven (7) days/week. Physicians and providers may use the toll-free number to reach our care management department to certify or authorize services.

For general inquiries, providers may call **800-934-0331** during normal business hours from 8:30 a.m.-5:00 p.m., Monday-Friday. Anthem Behavioral Health is staffed with dedicated professionals who are able to assist you with the following:

Customer Service

- Verification of member benefits
- Authorization procedures
- Referral services

Care Management

- Authorization issues

Provider Relations

- Network participation
- Credentialing/contracting
- Reporting practice changes

Quality Improvement

- Health promotion programs
- Quality improvement activities
- Clinical complaints/appeals
- Clinical policies

Claims

- Claims are handled by Anthem Blue Cross and Blue Shield in the Northeast Region

Use of Proprietary Information

All information, policies, procedures, systems, protocols, utilization and financial data provided to participating providers by Anthem Behavioral Health or Anthem Blue Cross and Blue Shield remains confidential and proprietary and is only to be used by participating providers in connection with the performance of their responsibilities under their participating provider agreement. Providers are to cease use of and return to Anthem Behavioral Health all such proprietary information upon termination of their network status.

SECTION 2

Care Management / Quality Management Programs

The goal of Anthem Behavioral Health is to facilitate the delivery of quality behavioral health care through the effective use of resources, while measuring outcomes and satisfaction via continuous quality improvement methodologies.

The objectives of the Care Management and the Quality Management Programs include:

- Providing access to or arrange for cost efficient, quality behavioral healthcare.
- Assessing the needs of members and facilitate access to appropriate health care resources.
- Administering benefits in a consistent manner based on objective information and criteria.

- Maximizing availability of resources for behavioral health care by providing proactive coordinated care in ambulatory and facility based settings.
- Continually improving the quality of our services.

Anthem Behavioral Health recognizes that its goals and objectives may only be accomplished through collaboration and communication with physicians, practitioners, and providers as well as with members. Anthem Behavioral Health uses guidelines and criteria in its care management and quality management programs. These criteria are developed with provider input and are updated at least annually.

Cultural Competence

It is important to Anthem Behavioral Health that members have access to providers who meet their special needs and preferences, and that providers are sensitive to these needs. In view of this, we ask you to assess your practice in terms of racial, ethnic, creed, gender, cultural, and linguistic needs and preferences of your population, and that you take these special preferences into account. If you have the capacity to meet a specific need, please be sure Anthem Behavioral Health is aware of this. If you do not have the capacity to meet a special need, please feel free to call Anthem Behavioral Health so that we may assist the member in locating a provider who can meet the member's special needs.

Open Dialogue

Anthem Behavioral Health places no restrictions of any kind on open dialogue between you and your patients. You are encouraged to discuss all treatment options, regardless of costs or coverage. You may also advocate on your patients' behalf, or file complaints with Anthem Behavioral Health or government agencies about our practices that you may believe affect quality or access of care.

Referral and Triage

Members may access behavioral health services through self-referral, through Anthem Behavioral Health, or by referral from another practitioner or provider. Anthem Behavioral Health has adopted the following standards to facilitate members' prompt access to behavioral health care:

- **Non-life threatening emergency needs -- must be seen within six (6) hours.**
When the severity or nature of presenting symptoms is intolerable but not life threatening to the member.
- **Urgent needs -- must be seen within 48 hours.** Urgent calls concern members whose ability to contract for their own safety, or the safety of others may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Urgent needs have the potential to escalate into an emergency without clinical intervention.
- **Routine office visits -- must be within 10 business days.** Routine calls concern members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.

Adherence to these standards is monitored by Anthem Behavioral Health via several methods. Monitoring is accomplished by a) assessing the availability of appointments via phone calls by Anthem Behavioral staff to the provider's office, b) analysis of member complaint data and c) analysis of member satisfaction. Providers are expected to make best efforts to meet these access standards for all members. Repeated failure may result in sanctions on network participation.

Anthem Behavioral Health maintains a toll-free member access telephone line available 24 hours a day, seven (7) days per week. Referral assistance is available to members and providers. For emergent and urgent calls, members will be referred to participating providers. Routine referrals are made during normal business hours.

Medically Necessary or Medical Necessity

Coverage for medically necessary services may be eliminated or reduced as a result of non-clinical factors such as benefit limits, coverage exclusions and prior authorization requirements.

Anthem Behavioral Health's care management determinations are based solely on determinations of medical necessity and benefit coverage. No incentives, financial or otherwise, are used to encourage denials. All Anthem

Behavioral Health clinical reviewers are compensated by salary, by time spent, or per case flat rates, without reference to the case outcome or overall company utilization rates.

"Medically necessary" or "medical necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Clinical Criteria

Anthem Behavioral Health utilizes an internally developed written utilization review decision protocol based on credible medical evidence to assist in determining medical necessity. The criteria were designed specifically for managed behavioral healthcare, and are reviewed on an ongoing basis by the National Clinical Advisory Committee. Adult, as well as child and adolescent level of care criteria are used for each level of care setting. These criteria contain general elements, which are required in all criteria sets, as well as specific admission and continued stay criteria for each criteria set. Detailed copies of the criteria are available by calling Anthem Behavioral Health at 800-934-0331.

Levels of Care

Below is a brief description of the more commonly used levels of care. Alternative levels of care may be provided on an individual basis under the care management program.

- **Acute inpatient:** Acute inpatient hospitalization is defined as treatment in a hospital psychiatric unit that includes 24-hour nursing and daily active treatment under the direction of a psychiatrist. Acute psychiatric treatment is appropriate in an inpatient setting when required to stabilize patients who are in acute distress and return them to a level of functioning in which a lesser level of intense treatment can be provided. A need for acute inpatient care occurs when the patient requires 24-hour nursing care, close observation, assessment, treatment and a structured therapeutic environment that is available only in an acute inpatient setting.
- **23-hour observation:** When a patient presents in crisis, an appropriate intervention may include a facility-based form of crisis stabilization that provides a medically safe environment for a period of up to 23 hours. During such time, the patient can be assessed, initially treated, stabilized, and possibly triaged to a lower level of care. The results of the assessment and the patient's response to treatment guide the recommendation as to the most appropriate level of care. An admission to a 23-hour bed also affords the opportunity to mobilize the patient's social support network. 23-hour observation provides a setting as restrictive and intensive as acute inpatient. This may be the most appropriate level of care for patients, who may show evidence of a psychiatric emergency, but there is the possibility that the symptoms may resolve quickly with intensive treatment and/or further evaluation before an inpatient admission is recommended.
- **Partial hospital:** Partial hospitalization (sometimes called day treatment) is a structured, short-term treatment modality that offers nursing care and active treatment in a program that is operable at a minimum of six (6) hours per day, five (5) days per week. Patients must attend a minimum of six (6) hours per day when participating in a partial program. Patients are not cared for on a 24-hour per day basis, and typically leave the program each evening and/or weekends. Partial hospitalization treatment is provided by a multidisciplinary treatment team that includes a psychiatrist. Partial hospitalization is an alternative to acute inpatient hospital care and offers intense, coordinated, multidisciplinary clinical services for patients who are able to function in the community at a minimally appropriate level and do not present an imminent potential for harm to themselves or others.

- **Intensive outpatient (IOP):** Intensive outpatient is a structured, short-term treatment modality that provides a combination of individual, group, and family therapy. Intensive outpatient programs meet at least three (3) times per week, providing a minimum of three (3) hours of treatment per session. Intensive outpatient programs must be supervised by a licensed mental health professional. Intensive outpatient treatment is an alternative to inpatient or partial hospital care and offers intensive, coordinated, multidisciplinary services for patients with an active psychiatric or substance related illness who are able to function in the community at a minimally appropriate level and present no imminent for harm to themselves or others.
- **Traditional outpatient:** Outpatient treatment is a level of care in which a licensed mental health professional provides care to individuals in an outpatient setting, whether to the patient individually, in family therapy, or in a group modality. Traditional outpatient treatment ranges in time from medication management (e.g. 15 – 20) minutes to 30 – 50 minutes or more for the psychotherapies.

Practice Guidelines

Anthem Behavioral Health recognizes the need for reducing variation in practice patterns among providers while maintaining the ability for individuality based upon patient needs. Practice guidelines, defining nationally accepted parameters of practice, have been adopted for use by network providers. These guidelines are based upon published research and expert consensus. Additional guidelines are adopted, as needed, based on population needs such as high-risk or high-volume diagnoses or services. Current practice guidelines include those for treating individuals with depressive disorders and substance use disorders.

Complete copies of these practice guidelines are available by calling Anthem Behavioral Health at **800-934-0331**, or may be viewed on our website at **anthem.com** > Providers > Connecticut > Enter > Plans & Benefits > Anthem Behavioral Health > Clinical Practice Guidelines.

Coordination of Care

Between behavioral health and medical providers

Anthem Behavioral Health requires that participating providers initiate and maintain timely communications with members' primary care physicians to promote sharing of clinical information for comprehensive treatment and continuity of care, when appropriate, e.g. in cases of possible coexisting medical conditions, medications or other medical concerns. At the time of the initial appointment or earliest practical time thereafter, providers should discuss with the member the importance of coordinated care.

Between behavioral health providers providing treatment to the same patient

Anthem Behavioral Health also requires that participating providers initiate and maintain contact with other behavioral health providers or consultants and health care institutions where appropriate. In these situations, the behavioral health primary clinician should discuss the importance of communication with other behavioral health providers or consultants/ institutions.

Communication should be initiated early in the treatment, and maintained with periodic updates. The following information should be communicated:

- Diagnosis
- Treatment plan summary
- Medications
- Referrals
- Availability for consultation

Anthem Behavioral Health has developed the *Primary Care Coordination Form* to assist you. You may use this form (Attachment A), or your own letter format, or communicate telephonically. All of the above discussion points should be clearly noted, dated, signed, and recorded in the member's clinical treatment record.

Providers should assess members for possible coexisting medical conditions throughout the course of treatment and exchange information with members' primary care physician about any findings.

Prior Authorization for Intensive Services (Inpatient (IP), Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Ambulatory Detoxification)

It is the responsibility of the provider to verify the eligibility of each member at the start of treatment. This may be done by calling the service number on the back of the member's identification card. Please have the following information when you call:

- patient's name, date of birth, and subscriber identification number
- subscriber's name, date of birth, employer group (if applicable)
- information about any other insurance the patient may have

The customer service representative will provide you with the status of the member's coverage and applicable member cost shares. If you have questions about the benefits available or authorization process for any treatment, ask the customer service representative.

Members may have a point-of-entry (POE) product or a point-of-service (POS) product. Anthem Behavioral Health participating facilities must be used for POE or in-network POS benefits. An exception would be in the case of a life threatening emergency. For outpatient treatment, Anthem Behavioral Health participating providers must be used for POE or in-network POS benefits.

As a participating provider, you are required to comply with all certification / authorization review processes.

All care management reviews are conducted by Anthem Behavioral Health's care management department. All of our care managers are licensed behavioral health professionals, with a minimum of three (3) years clinical experience. All of our physician reviewers are board certified and licensed. A physician is available to discuss any denial decision with you.

The following is a brief overview of various processes with which you may be involved.

Prior Authorization

All admissions to IP, PHP or IOP must be prior authorized and are included in the continued stay review program. Prior authorization is accomplished through a discussion between the treating provider (or his/her representative) and an Anthem Behavioral Health care manager. The participating provider should be prepared to discuss the following relevant clinical information during initial and concurrent authorization reviews:

- Diagnosis (DSM-IV, Axis I-V)
- Approximate date of onset of illness
- Reason for admission, precipitant(s) to admission
- Psychiatric history including treatment history
- Substance abuse history
 - If yes:
 - Substances used, amounts, frequency, route?
 - Periods of sobriety? Last use?
 - Legal/occupational/family/interpersonal factors
 - Withdrawal symptoms
 - Physical problems
 - Treatment history
 - AA involvement/attendance
- Family history
- Lethality, as evidenced by:
 - Suicidal? Contract for safety? (explain)
 - Previous attempts? (explain)
 - Homicidal? Contract for safety? (explain)
 - Previous attempts? (explain)
- Overt aggression
- Level of restriction
- Functional impairment
- Response to previous treatment
- Treatment goals and plan (estimated length of stay, specific interventions, precautions for risk behavior)

- Medication (dosages and responses)
- Family involvement
- Expected outcomes
- Discharge plan
- Communication with medical and other behavioral health providers

The care manager will discuss the information with you, and will either authorize a specific number of days or services, or will refer the case to a medical director, or other appropriate clinical peer reviewer. If the care manager cannot authorize the requested level of care, and no other option is felt to be appropriate by you, as the treating provider, the case will be referred to a clinical peer reviewer for upper-level review. The clinical peer reviewer may contact you directly to discuss the case. On concurrent review, in addition to the above information, the care manager will be discussing the patient's response to treatment, and progress toward discharge.

It is essential that each patient has an outpatient appointment scheduled within seven (7) days of discharge, and that he/she has a written reminder of this appointment upon discharge. This requires the cooperation of the facility as well as the treating provider. Anthem Behavioral Health will be reviewing compliance with this requirement. If there is an obstacle to this occurring, please call the care manager to discuss.

Emergency authorization for life-threatening emergency conditions may be authorized up to two (2) business days following an emergency admission. Anthem Behavioral Health will review the admission for medical necessity upon notification.

Expedited continued stay reviews are available to providers treating members who are admitted to a Connecticut acute care hospital for emergency conditions, and whose life will be endangered or serious injury or illness will occur if discharge or delays in treatment occur. For expedited continued stay reviews, Anthem Behavioral Health is obligated to make review staff available during the hours 8:00 a.m. to 9:00 p.m. ET. Review staff members are available by our toll-free access telephone line with a secondary voice-mail answering system. The attending provider may call in expedited continued stay requests to Anthem Behavioral Health's care management department between the hours of 8:00 a.m. and 6:00 p.m. ET. Requests shall include all clinical information necessary to conduct the review. If Anthem Behavioral Health fails to respond to the attending provider's request for expedited review within three (3) hours of transmission of the request, and all necessary clinical information has been communicated, the request is deemed approved.

Prior Authorization of Outpatient Services

Outpatient treatment must be prior authorized, and this is accomplished through the Outpatient Treatment Report (OTR) (Attachment B). The number of annual visits not subject to prior authorization differs by product. It is your responsibility as the provider of care to complete the OTR and send it to Anthem Behavioral Health. An Anthem Behavioral Health care manager will review the information, and either authorize a specific number of sessions within a specific period, or may request additional information from you. If care cannot be authorized by the care manager, the case will be referred for peer review. However, when necessary, direct telephone dialogue between utilization management (UM) staff and providers will be initiated to provide education regarding UM practices, or to clarify a treatment plan that is vague or unclear. Symptom and diagnostic information will be considered to determine if a specific approved clinical protocol applies. If so, then this protocol will be used to evaluate the proposed treatment plan. If a specific protocol does not exist for the diagnostic picture, general UM clinical criteria for outpatient care will be utilized along with member benefit coverage.

OTR Submission by Product	# Initial Visits	OTR Required
<i>BlueCare HMO, BlueCare Plus</i>	12	Before 13 th visit each calendar year
<i>Century Preferred (PPO)</i>	12*	Before 13 th visit each calendar year
<i>Federal Employee Program (FEP)</i>	8	Before 9 th visit each calendar year
<i>State BlueCare</i>	20	Before 21 st visit each calendar year
<i>State Preferred</i>	20	Before 21 st visit each calendar year
<i>NEHP (effective 01/01/08)</i>	12	Before the 13 th visit each calendar year
<i>Empire HMO/POS</i>		Please call the number on the back of the member's card for specific information
Notes:		
<ul style="list-style-type: none"> ▪ *Certain municipal groups have pass-through visits (frequently greater than 12) specified in their health benefit contract. ▪ Medical management services (CPT® code 90862) do not require prior authorization. 		

Psychological Testing

Anthem will provide coverage for four (4) hours of psychological testing (CPT code 96101) or nine (9) hours of neuropsychological testing (CPT code 96118) without clinical review for behavioral health diagnoses. Notification of the testing is still necessary to allow for authorization entry. Please continue to use the current *Request for Psychological Testing* form to notify Anthem that testing is occurring (Attachment C). The provider need only complete the demographic information and indicate the number of hours of testing requested and the CPT code. If more testing hours are required, then the Request for Psychological Testing form must be filled out completely by the provider and sent to Anthem Behavioral Health before testing. An Anthem Behavioral Health consulting clinical psychologist will review the information, and you will be informed of the outcome. Telephonic requests for testing authorization will not be accepted.

Ambulatory crisis services, such as ambulatory detoxification and ECT must be prior authorized, via a telephone call to Anthem Behavioral Health.

Response Timeframes

All authorizations are conducted according to the timeliness standards established by Anthem Behavioral Health, unless law requires a shorter timeframe. All response times begin from receipt of all necessary information required to conduct the review.

Type of Review Request	Determination Made Within
Urgent Prior Authorization	1 calendar day
Non-Urgent Prior Authorization	2 business days
Continued Stay Review	1 business day
Expedited Continued Stay Review	3 hours (if received 8am-6pm)
Outpatient Treatment Review	2 business days
Retrospective Review	30 business days

Complaints and Appeals

You are welcome to express to us your concerns regarding our services. Anthem Behavioral Health will work to address your concerns as quickly as possible. All complaints are recorded and analyzed for opportunities for us to improve the quality of our service.

Members and their providers may request an appeal of any clinical determination issued by Anthem Behavioral Health. Appeals are reviewed by licensed clinical peer reviewers. Procedures for filing an appeal are described in Anthem Behavioral Health 's appeal process.

Appeal Process

Questions may be posed about the member's health benefit plan. Since most questions can be handled informally, these questions should be addressed by contacting member service/customer service utilizing the telephone number provided on the back of the member's identification card. Participating providers should call **800-934-0331**. In addition, information about the following appeal process may be obtained by contacting member service/customer service.

The appeal process is available to the member, the provider, or the duly authorized representative of the member or provider. This appeal process applies to any adverse utilization review determination (which is considered an adverse pre-service claim determination) or any adverse non-utilization review determination (which is considered an adverse post-service claim determination) that involves a denial, reduction or termination of, or a failure to make payment to or on behalf of a member, in whole or in part, for a benefit under the member's health benefit plan. Utilization review determinations, such as prior authorization or concurrent review, are determinations where receipt of a benefit, in whole or in part, is conditioned upon approval of the benefit in advance. Non-utilization review determinations concern issues relating to the member's health benefit plan such as eligibility for benefits, coverage of claims, or claims processing.

First Level Appeal

If a determination is not satisfactory, this is considered an adverse utilization review determination or an adverse non-utilization review determination and a first level appeal review may be requested. The first level appeal review request can be initiated orally, electronically or in writing within one hundred eighty (180) days from the date that the initial adverse utilization review determination or the adverse non-utilization review determination is received. Written first level appeal review requests should be mailed to:

Anthem Behavioral Health First Level Appeal Review
370 Bassett Road, Building 3, Floor 2
North Haven, CT 06473

A first level appeal review request should include copies of any additional documentation supporting the appeal. A first level appeal determination will be issued, in writing, within fifteen (15) days from the date that the first level appeal review request is received regarding an adverse utilization review determination or within thirty (30) days from the date the first level appeal review request is received regarding an adverse non-utilization review determination. The written determination will be issued within five (5) business days from the date the appeal decision is made. The written determination will state the decision; the specific reason(s) for the decision with reference to the specific health benefit plan provisions on which the decision is based, if applicable, and general information about the next step in the appeal process.

If the first level appeal determination regarding an adverse utilization review determination is not satisfactory, a member of a fully insured health plan or a self-insured governmental health plan which is not subject to the Employee Retirement Income Security Act of 1974 (ERISA), who is diagnosed with a condition that creates a life expectancy of less than two (2) years and the denial is based on the grounds that the proposed service is experimental, may seek information (including the application) regarding an external appeal process administered by the Insurance Department without completing the second level appeal review request through Anthem.

Second Level Appeal

If the first level appeal determination is not satisfactory, a second level appeal review may be requested. The second level appeal review request can be initiated orally, electronically or in writing to the second level appeal panel within sixty (60) days from the date that the first level appeal determination is received regarding an adverse utilization review determination or within ten (10) days from the date that the first level appeal determination is received regarding an adverse non-utilization review determination. At this time, an in-person presentation, telephonic conference, videoconference or conference via other form of acceptable technology may be requested. If the second level appeal review request regarding an adverse non-utilization review determination is received by Anthem more than ten (10) days from the date that the first level appeal determination is received, the time period in excess of that ten (10) days will be considered a request for an extension by the member. Such an extension shall be granted for a period of up to sixty (60) days from the date that the first level appeal determination is received. Written second level appeal requests should be mailed to:

Anthem Blue Cross and Blue Shield

Second Level Appeal Panel
370 Bassett Road, P.O. Box 1038
North Haven, CT 06473-4201

A second level appeal review request should include copies of any additional documentation supporting the appeal. A second level appeal determination will be issued in writing within fifteen (15) days from the date that the second level appeal review request is received regarding an adverse utilization review determination or in writing within twenty (20) days from the date that the second level appeal review request is received regarding an adverse non-utilization review determination. The written determination will be issued within five (5) business days from the date the appeal decision is made. The written determination will state the decision, the specific reason(s) for the decision with reference to the specific health benefit plan provisions on which the decision is based, if applicable, and general information about the next step in the appeal process.

Legal Rights

If the member's health benefit plan is sponsored by the member's employer, and is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), and the member is dissatisfied with any decision after the second level appeal determination is rendered, the member has a right to bring a civil action under §502 (a) of ERISA.

Other Member Rights

- In the event of an emergency or life-threatening situation, or when a claim involves urgent care, or when a member who is diagnosed with a condition that creates a life expectancy of less than two (2) years and the denial is based on the grounds that the proposed service is experimental, an expedited first or second level appeal review may be requested. A determination will be issued within one (1) business day from the date the expedited first or second level appeal review request is received.
- The member is entitled to receive upon request and free of charge, reasonable access to, and copies of, any documents, records, and other information relevant to the member's claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse utilization review or non-utilization review determination, the specific rule, guideline, protocol, or other similar criterion will be provided to the member free of charge upon request.
- If the adverse determination is based on a medical necessity, or experimental treatment, or other similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the health benefit plan to the member's medical circumstances will be provided free of charge upon request.
- If a consultant's advice was obtained in connection with a member's adverse determination, without regard to whether the advice was relied upon in making the benefit determination, the consultant will be identified upon request.
- After completion of both the first and second level appeals for an adverse utilization review determination or an adverse non-utilization review determination based on medical necessity, a member, the provider or the duly authorized representative of the member or provider for a member of a fully-insured health plan or a self-insured governmental health plan which is not subject to the Employee Retirement Income Security Act of 1974 (ERISA) may seek information (including the application) regarding an external appeal process administered by the Insurance Department by contacting: State of Connecticut, Insurance Department, P.O. Box 816, Hartford, CT 06142-0816 or by calling 860-297-3910. An external appeal must be submitted to the State of Connecticut Insurance Department within thirty (30) days from the date of the second level appeal determination.
- The member, the provider, or the duly authorized representative of the member or provider may, at any time, seek further review of an adverse determination by writing to the Insurance Commissioner at: State of Connecticut, Insurance Department, Consumer Affairs, P.O. Box 816, Hartford, Connecticut 06142, or by calling 860-297-3910.

Clinical Quality Improvement Activities

As a participating provider, you have agreed to cooperate and comply with Anthem Behavioral Health's quality improvement activities.

Anthem Behavioral Health is committed to improving the quality of clinical care, clinical services, and member services. Several programs have been implemented in an effort to positively affect outcomes.

- **Follow-up after discharge for mental illness:** This program supports the HEDIS® (Health Care Effectiveness Data Information Set) effectiveness of care measure for follow-up visits after hospitalization. All members hospitalized with a psychiatric disorder should have a follow-up visit within seven (7) days of discharge. Anthem Behavioral Health care managers work with participating facilities and practitioners to ensure that the member has an appointment before he/she is discharged. Anthem Behavioral Health Quality staff contacts provider offices and members to verify appointments and ascertain what mechanisms offices utilize to remind patients of scheduled appointments and what policies they have to work with patients regarding missed appointments.
- **Depression education program/antidepressant medication management:** This program supports the HEDIS® effectiveness of care measure for antidepressant medication management. Members newly diagnosed with depression should remain on prescribed antidepressant medication for a minimum of six (6) months. In addition, these members should be seen for at least three (3) medication management visits during the acute treatment period (first 12 weeks). Anthem Behavioral Health works with the health plan in developing interventions to educate providers and members about the importance of adequate medication management for those members diagnosed with depression and started on antidepressant medication.
- **Bipolar medication compliance:** This program identifies those members, age 18 or older with a Bipolar 1 diagnosis who have been non-compliant with their bipolar medications. Prescribers of those medications are communicated this information about their patient via a faxed letter.
 - ✓ **Initiation and Engagement of Alcohol and Other Drug (AOD) Treatment:** This program supports the HEDIS® measure for identification and treatment of members with an alcohol or other drug primary or secondary diagnosis. Specifically, this measure focuses on the percentage of adults and adolescents who initiate treatment through either an AOD inpatient admission or outpatient service and an additional AOD outpatient service within 14 days. Engagement of AOD treatment is designed to assess the degree to which the members engage in treatment with two additional AOD services with 30 days of initiation of treatment. Anthem Behavioral Health works with the health plan to develop interventions regarding this measure.
 - ✓ **Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD):** This program supports the HEDIS measure for treatment of children with ADHD. Specifically, this measure focuses on children who have been prescribed an ADHD medication and have one follow-up visit with a practitioner with prescriptive authority within the first 30 days. The maintenance measure is that members should remain on the medication for at least 210 days and have at least two additional follow-up visits with a practitioner within nine (9) months after the initial 30 days. Anthem Behavioral Health works with the health plan to develop interventions regarding this measure.

Member Satisfaction Surveys

At least annually, Anthem Behavioral Health surveys members for their levels of satisfaction with Anthem Behavioral Health 's services. Anthem Behavioral Health matches survey responses to individual providers if indicated.

Provider Satisfaction Surveys

At least annually, Anthem surveys physicians and providers including Behavioral Health providers for levels of satisfaction with services pertaining to areas such as utilization management and claims.

SECTION 3

Network Participation

Network Selection

Anthem Behavioral Health is responsible for maintaining a broad spectrum of network services that includes professionals in psychiatry, clinical psychology, clinical social work, advanced nursing, addiction medicine, and other behavioral health disciplines. Participating providers are selected based primarily on skills, experience, and geographical and specialty needs.

Before a provider can begin to treat members, the provider must successfully complete the credentialing and application process, and sign an Anthem Blue Cross and Blue Shield Participating Provider Agreement. Additionally, successful applicants must:

- Demonstrate expertise in child, adolescent, and/or adult treatment.
- Have no history of serious ethical or malpractice complaints.
- Demonstrate ability to meet required minimum access standards.
- Agree to follow applicable Anthem Behavioral Health policies, procedures, and treatment protocols, as communicated to them by the health plan or by Anthem Behavioral Health.

All Anthem Behavioral Health participating practitioners must be state licensed and/or state certified for independent practice in their discipline. Facilities must be state licensed, and be accredited by a recognized accrediting body such as JCAHO, CARF, or COA.

Participating Physician, Provider and Group Agreements

About our Agreements

Your participation with Anthem commercial plans and programs is determined by your completion and Anthem's formal acceptance of your participating provider agreement (group or solo) and credentialing application (as appropriate). To avoid delays in compensation and gaps in participation, it is important that you contact Anthem whenever there is a change in your practice.

- A signed participation agreement between a solo physician/health care professional or provider group and Anthem is applicable to office locations, approved by Anthem and the practitioner or group that renders services to our members under the same tax ID number.
- **Participation confirmation and effective dates:** *Physicians or providers who have applied for participation should not provide services as a participating provider to members of any Anthem plan or program until such time as he/she receives a formal notification from Anthem that he/she is a participating provider.* This notification will specify the effective date of participation and which programs and/or products are included in the participation. Any services provided to members before the effective date will be considered out-of-network services.
- **Defining solo vs. group practices:** Determinations on whether a practice receives a solo or group agreement are based on the following solo provider and group provider criteria:
 - **Solo providers** are identified as those who provide us with a social security or tax ID number (TIN) that is tied to their name alone.
 - **Group providers** are identified as those who provide us with a TIN that is tied to either their name as a PC, LLC or partnership, or to a group business name.
- **If you practice both as a member of a group and as a solo practitioner,** and you are submitting the Anthem agreement, *you must sign an individual agreement in addition to the group agreement in order to be participating in both arrangements.* A separate agreement is required for each tax ID number under which you are billing.
- **Changing your practice:** If a participating physician or provider, or group of providers leaves a participating group practice and joins or forms another group practice, *participation does not automatically continue for those providers.* Depending on the situation, a new group agreement and/or signature sheet may need to be completed and submitted in order to continue participation in Anthem's networks with the new group. Services to our members are not eligible for in-network coverage until such time as the physician or provider receives a formal notification from Anthem of his/her participation under the new group agreement and the effective date.

- **Keep our members up to date!** Each provider is responsible for informing members about the provider's participation status with Anthem so members can maximize their benefits and make informed decisions about their care.
- **Adding members to group practices:** It is important that new members of group practices promptly apply for participation in order to maintain participation consistency within the practice and ensure that members see network physicians and health care professionals to maximize the value of their health care benefits. **Important note: A new member of a participating Anthem provider group is NOT a participating provider until such time as he/she is credentialed, and/or contracted with Anthem, and receives written notification of his/her effective date.**
- Participation through a provider sponsored organization: In circumstances where Anthem contracts with an IPA, PHO or other provider sponsored organization, you may be required to execute an individual or group agreement with Anthem in addition to your agreement with the contracting organization

When to submit an agreement

An agreement may be submitted along with a credentialing application to the Provider Relations Department, Anthem Behavioral Health, P. O. Box 651, North Haven, CT 06473:

- When a physician, health care professional or provider group chooses to apply for participation in any Anthem network.
- When a physician or health care professional joins a group practice that is participating in any Anthem network.
- When a physician or provider in a group practice that is participating in any Anthem network wishes to also maintain a solo practice and retain membership in that network under the solo practice.
- When a physician who has a solo practice or is a member of a group practice wishes to join an IPA, PHO or other provider sponsored organization that has an agreement with Anthem (this may not be required for membership in all such arrangements.)

Please call Anthem Behavioral Health at **800-934-0331** for the most current contracting/credentialing documents.

How to Complete an Agreement

When completing an Anthem agreement and associated credentialing form, please be sure you follow the instructions carefully and fill out all required information. Please keep the following "Do's" and "Do Not's" in mind:

Do:

- **Include the street address of the primary office location where appropriate** (post office boxes without the actual physical address listed are not acceptable).
- **Sign on the appropriate line** (physician or health care professional signature stamps are not acceptable).
- **Submit only original agreements for consideration;** copies of the agreement will not be eligible for processing.
- **Include a signed *Represented Provider Certification and Authorization* (signature) sheet when completing a group agreement.**

Do Not:

- **Use white-out or make cross-outs on the agreement** (the presence of white-out and/or cross-outs will render the agreement unacceptable).
- **Complete a section that is reserved for Anthem use only.**

You may obtain group and solo agreements and credentialing applications by contacting Anthem Behavioral Health at **800-934-0331**.

Credentialing Process

Physicians and health care professionals who participate in Anthem's credentialed networks and who are providing services to Anthem members must meet Anthem credentialing standards. As part of the credentialing process, each

applicant is screened against a set of standards that meet the stringent requirements of the National Committee for Quality Assurance (NCQA).

Anthem Behavioral Health also follows NCQA credentialing guidelines regarding on-site visits. Anthem Behavioral Health conducts on-site visits to potential high-volume offices before the provider's application is submitted to the Anthem Blue Cross and Blue Shield Credentialing Committee.

The provider represents that the information reported in his/her credentialing application is true and correct. Anthem Behavioral Health should be promptly notified of any changes in the information contained in any credentialing application within seven (7) days of such change. Physicians should follow the processes established by CAQH for the CAQH credentialing application.

Professional Practitioner Credentialing/Recredentialing

Our credentialing program allows us to meet the expectations of the marketplace, while helping to ensure practitioners providing services met minimum credentialing standards. It also helps participating physicians feel confident when referring members to other network specialists.

If a physician or health care professional is joining your practice, he/she must apply for credentialing in the *BlueCare Health Plan* and/or *Century Preferred* networks to be eligible for compensation for in-network services.

The Credentialing Application Process

- Providers applying for initial credentialing **must** complete a form online through the CAQH Universal Credentialing DataSource website (see additional information below).
- For information on how to obtain a CAQH ID number and to be added to Anthem's CAQH roster, contact Anthem Behavioral Health.

The CAQH Credentialing Website

The Council for Affordable Quality Healthcare (CAQH) is a not-for-profit alliance of 24 of the nation's largest health plans and their trade associations, including Anthem Blue Cross and Blue Shield. CAQH's Universal Credentialing DataSource is a secure, online database that helps eliminate the need to fill out and submit multiple credentialing applications.

With the innovative CAQH system, each physician or healthcare provider submits just one standard application to a single database that is designed to meet the needs of the health plans participating with the database. Benefits include:

- Providers can easily update their information at anytime, and will be asked every 120 days whether the information on file is complete and accurate. Participating health plans will be automatically notified when the healthcare provider's information changes.
- Participating health plans can access the credentialing information at any time, as long as the provider has authorized it.
- Individual health plans continue to do the data verification and review, and make an independent decision about whether a provider meets that organization's standards for participation.
- There is no cost for physicians and other healthcare providers to submit information to the credentialing data collection system.

To learn more about CAQH and view an online demonstration of the credentialing data system, visit the CAQH Web site at www.CAQH.org, or speak with your provider relations representative. You may also contact the CAQH Help Desk at 888-599-1771 for more information.

Credentialing Criteria

Specific credentialing criteria include, but are not limited to:

- A valid, current, unencumbered license in state(s) in which the practitioner practices and participates with.
- A current, valid, unrestricted controlled substance license (DEA-Federal). A practitioner whose DEA is currently limited, revoked or suspended may not be considered for participation.

- A full, unrestricted controlled substance registration certificate (CSR) for practitioners practicing in those states which issue a state-issued drug registration.
- Board certification within five years of completion of training in the specialty in which credentialing is sought.
- A current professional liability policy of not less than \$1 million per occurrence and \$3 million aggregate.

Ongoing Requirements - Licensing, Recredentialing

As a contracted physician or health care professional, you are a key participant in our health care delivery system helping to promote high-quality, cost effective care to members. Once you are accepted for participation in the network:

- **Licenses, board certification, as applicable, and medical malpractice** requirements must be maintained
- **Recredentialing** is performed at least every 36 months. Since Anthem recredentials its participating providers using information obtained from CAQH's Universal Credential Data Source, you must provide your recredentialing information to CAQH.
- Information retrieved from CAQH's Universal Credentialing DataSource is used to credential and recredential participating providers.

As part of the credentialing and recredentialing process, Anthem conducts primary source verification of provider information. This includes, but is not limited to licensing boards, specialty certifying boards and the National Practitioner Data Bank (NPDB).

Provider Rights Regarding Credentialing

Providers have the right to review information obtained by Anthem. When physicians or health care providers apply for credentialing or recredentialing with Anthem, they have a right to:

- Review information submitted to support their credentialing application, including information obtained from any outside source*, with the exception of references, recommendations or other peer-review protected information, or if such information is afforded confidentiality under state or federal law.
- Correct erroneous information submitted by another source.
- Be informed of the status of their credentialing or recredentialing application upon request.

* Please note: Anthem is not required to reveal the source of information if such disclosure is prohibited by state or federal law.

Clinical Practice Information Process

Anthem maintains a process to gather clinical practice information about participating providers as part of its Quality Improvement Program. Anthem's process includes:

- Monitoring of utilization patterns, particularly with respect to under utilization
- Review of clinical practices, including access
- Treatment record audits
- Clinical practice guidelines audits
- Review of member complaints
- Analysis of member satisfaction surveys
- Outcomes of quality improvement activities

Clinical practice information is incorporated into the recredentialing decision. If the credentialing committee identifies an area where the provider does not meet standards, the committee might recommend approval contingent on a corrective action plan, or contract termination. Clinical practice information is reviewed periodically with providers to achieve overall quality improvement goals.

Facility/Program Requirements

Whether credentialing a facility with one or more programs or an individual organization, the facility is required to submit a completed application with the following attachments:

- JCAHO accreditation, CARF, or COA certification
- State licenses required for each program
- Adequate malpractice insurance
- Malpractice claims history
- General liability insurance
- Any sanction activity information
- Accessibility and scope of available programs
- Policies and procedures addressing life safety, quality assurance, utilization review, and risk management activities.
- Facility application sheet

JCAHO, CARF, or COA accreditation is required for all inpatient mental health and substance use facilities.

Provider Sanctions and Termination

Anthem Behavioral Health encourages resolution of provider performance issues through consultation and education, but occasionally further action is required to ensure quality service delivery and protection of members. Anthem Blue Cross and Blue Shield may impose provider sanctions for issues related to quality of care or contract compliance. Some of the factors used to determine whether to sanction a network provider or terminate network privileges include, but are not limited to, the following:

- Report of quality of care concerns and critical incidents
- Failure to submit required reports and follow authorization procedures
- Provider's utilization for inpatient and / or outpatient cases, by diagnoses and acuity level, falls significantly above or below average rates, and such variations are not supported by generally prevailing clinical practice
- Negative results from member satisfaction surveys
- Negative results from quality indicators
- Billing members for amounts that exceed the compensation stated in the participating provider agreement.

Network Termination

Professional provider participating status may be terminated for cause, and Anthem may terminate or suspend participation immediately:

- (i) when necessary for the health or safety of members,
- (ii) if found that the participating agreement was entered into based on fraud or misrepresentation;
- (iii) when a provider engages in any fraudulent activity related to the terms of the participating agreement;
- (iv) upon issuance of final determination by a disciplinary agency limits ability to practice.

Professional provider participation may be terminated by a party without cause upon prior **written notice** to the other party. Termination is guided by the time stated in your Anthem Blue Cross and Blue Shield Participating Provider Agreement.

Rights and Obligations upon Termination

When network participation terminates for any reason, the rights and obligations under the terms of the participating provider agreement terminate, except as expressly provided for in the agreement or in the administrative policies and procedures.

Members' Rights to Continuing Treatment When Network Participation Ends

When a provider resigns or is terminated for reasons other than quality of care concerns, members may continue active treatment with their provider at in-network benefit levels for a period not to exceed 90 days. This period is to be used to conclude treatment or transition members to participating providers.

Participating Provider Appeals of Sanctions Policy and Procedure

I. Purpose

The following identifies and describes the policy and procedure associated with participating provider appeals of any decision by Anthem to terminate for cause the participation agreement with a participating provider or to summarily suspend for cause such a participating provider's network participation (the "appealable action"). This policy and procedure applies only to participating providers under the direct contract with Anthem. This policy and procedure shall not apply to (i) any termination that is on the grounds of the provider's fraud or payment or claim abuses against Anthem; (ii) any termination that is without cause; or (iii) any termination if the terminated agreement specifies a different method of appeal to the terminated provider.

II. Policy

It is the policy of Anthem to deal fairly with its participating providers. If a participating provider is no longer allowed to continue participation in an Anthem provider network for reasons related to cause under the terms of the provider's participating agreement, then the provider may appeal such decision in accordance with the following procedure.

III. Procedure

Request for Hearing

If a participating provider is aggrieved by an appealable action, the participating provider may request in writing a hearing as described below. The request for a hearing (Notice of Appeal) must be submitted to the Anthem Medical Director within thirty (30) days following the participating provider's receipt of notice of Anthem's appealable action. Anthem's notice of appealable action to a participating provider shall include a copy of this policy and procedure.

The Anthem Medical Director shall schedule a hearing to occur not more than twenty (20) business days after receipt of the participating provider's Notice of Appeal unless the participating provider agrees to a hearing at a later date or unless a panel cannot reasonably be convened within such twenty (20) business days through no fault of Anthem. Notice of the time and place of the hearing as well as a list of witnesses expected to testify on behalf of shall be given to the provider at least ten (10) business days prior to the date scheduled for the hearing.

If the participating provider fails to appear at the hearing or if the participating provider fails to file a timely Notice of Appeal, the participating provider shall be deemed to have waived his or her rights to the hearing and to any subsequent appellate review; provided, however, that the panel may, for good cause, continue the hearing. Good cause shall not include any circumstances reasonably avoidable by the participating provider.

Composition of the Panel

The hearing panel (the "panel") shall consist of three (3) individuals who are appointed by Anthem. None of the individuals selected shall have participated directly in the appealable action. At least one of the individuals shall be a member of the Anthem medical policy council or any specialty panel reporting to the medical policy council who is not in direct economic competition with the participating provider.

Provider's Rights at Hearing

At a hearing before the panel, the participating provider shall have the following rights:

1. To present all reasonably relevant information, as determined by the chairperson of the panel, regardless of the admissibility in a court of law;
2. To call witnesses on the provider's behalf and to examine and cross-examine witnesses called by any participant;
3. To be represented by a person or entity of the provider's choice, provided that the provider gives notice of the name of such representative to the chairperson of the panel at least five (5) business days prior to the hearing date; and
4. To make, at his or her discretion, opening and closing statements, and to submit a written statement at the close of the hearing or within such reasonable time period subsequent thereto as may be determined by the panel.

Conduct of Hearing

1. Anthem shall provide the panel with a record of Anthem's ground for the appealable action as soon as practicable after the panel is appointed. Anthem shall also designate a representative(s) to be present at the hearing, to answer questions from the panel or the participating provider regarding the appealable action. Such representative(s) shall have, on behalf of Anthem, the same rights as the participating provider as provided above.
2. The hearing shall be conducted fairly, but shall be informal and conducted strictly according to the judicial rules relating to the examination of witnesses or presentation of evidence. All reasonably relevant information, as determined at the discretion of the chairperson, shall be heard or accepted as exhibits. The chairperson of the panel shall preside over the hearing, rule upon matters of procedure, assure that all participants have a reasonable opportunity to present information and shall maintain decorum, and be responsible for the preservation of all documentation that is submitted.

Panel Decision

Within fifteen (15) days following the hearing, the panel shall render a written opinion on the matter. The participating provider shall be entitled to a copy of such written opinion. The panel shall determine solely whether Anthem fairly followed its policies and procedures in taking the appealable action and whether the information that Anthem relied upon in reaching the decision that was the basis of the appealable action was reasonably reliable.

If the decision of the panel is adverse to the Anthem, then Anthem shall rescind the termination for cause or the summary suspension for cause that was the subject of the appealable action.

Participating Provider Appeal of Audit Decisions Policy and Procedure

I. Purpose

The following identifies and describes the policy and procedure associated with a participating provider's appeal of any finding or decision resulting from an audit of the provider's record by Anthem. This policy and procedure applies only to participating providers under direct contract with Anthem. This policy and procedure shall not apply to (i) an audit decision if the participating provider's agreement specifies a different method of appeal; (ii) an audit decision with respect to which participating provider has surrendered any right of appeal in a written release, waive, settlement agreement or other agreement with Anthem; or (iii) preliminary audit results of findings that are not set forth in a final audit letter from Anthem to the participating provider.

II. Policy

It is the policy of Anthem to deal fairly with a participating provider. If an audit of the participating provider's records result in written finding or decision set forth in a final audit letter from Anthem to the provider, that is adverse to the participating provider, then the provider may appeal such finding or decision in accordance with the following procedure (the "appeal").

III. Procedure

Request for Hearing

If a participating provider is aggrieved by a written finding or decision set forth in a final audit letter, the participating provider may request in writing a hearing as described below. The request for a hearing ("Notice of Appeal") must be sent certified mail, return receipt requested, to Senior Manager, Anthem East Regional Special Investigation Units within thirty (30) days following the date of the final audit letter. Anthem's final audit letter to a participating provider shall include a copy of this policy and procedure. The provider's Notice of Appeal must describe with specificity the issues and amounts that are the subject of the provider's appeal.

The Senior Manager, Anthem East Regional Special Investigations Units or his/her designee shall schedule a hearing to occur not more than sixty (60) days after receipt of the participating provider's Notice of Appeal, unless the participating provider agrees to a hearing at a later date or unless a panel cannot reasonably be convened within such sixty (60) days through no fault of Anthem. Notice of the time and place of the hearing as well as a list of witnesses expected to testify on behalf of Anthem shall be given to the participating provider not less than fifteen (15) business days prior to the date scheduled for the hearing.

Within five (5) business days of the participating provider's receipt of Anthem's witness list, the provider shall provide Anthem the name, address and telephone number of any witnesses, including expert witness(es), that the provider expects to testify in his, her or its behalf, as well as the qualifications of any expert and a summary of any expert's opinion relating to the subject matter of the appeal.

If the participating provider fails to file a timely Notice of Appeal, or to provide the information concerning witnesses, or to appear at the hearing and to any subsequent appellate review of any and all matters set forth in the final audit letter; provided, however, that the panel may, for good cause, continue the hearing. Good cause shall not include any circumstances reasonably avoidable by the participating provider.

Composition of the Panel

The hearing panel (the "panel") shall consist of three (3) individuals who are appointed by the Senior Manager, Anthem East Regional Special Investigations Units or his/her designee. None of the individuals selected shall have participated directly in any audit decision or finding that is the subject of the appeal. At least one of the individuals shall be a member of the Anthem Medical Policy Council, or any specialty panel reporting to the Medical Policy Council, who is not in direct economic competition with the participating provider. The panel members shall designate one of them as a chairperson.

Provider's Rights at Hearing

At a hearing before the panel, the participating provider shall have the following rights:

1. To present all reasonably relevant information, as determined by the chairperson of the panel, regardless of its admissibility in a court of law.
2. To call witnesses on the provider's behalf and to examine and cross-examine witnesses called by any participant at the hearing.

3. To be represented by a person or entity of the provider's choice, provided that the provider give notice of the name of such representative to the chairperson of the panel at least ten (10) business days prior to the hearing date: and
4. To make, at his or her discretion, opening and closing statements, and to submit a written statement as the close of the hearing or within such reasonable time period subsequent thereto as may be determined by the panel.

Conduct of Hearing

1. Anthem shall provide the panel with substantiation of the findings and decisions set forth in the final audit letter that are the subject of the participating provider's appeal as soon as practicable after the panel is appointed. Anthem shall also designate a representative(s) to be present at the hearing, to answer questions from the panel or the participating provider regarding the issues that are subject to the appeal. Such representative(s) shall have, on behalf of Anthem, the same rights as the participating provider as provided above.
2. The hearing shall be conducted fairly, but shall be informal and need not be conducted strictly according to judicial rules relating to the examination of witnesses or presentation of evidence. All reasonable relevant information, as determined at the discretion of the chairperson, shall be heard or accepted as exhibits. The chairperson of the panel shall preside over the hearing, rule upon matters or procedure assure that all participants have a reasonable opportunity to present information, maintain decorum, and be responsible for the preservation of all documentation submitted.

Panel Decision

Within fifteen (15) business days following the hearing, or following the receipt of any materials the panel requested or allowed to be submitted after the hearing, the panel shall render a written opinion on the matter. The participating provider shall be entitled to a copy of such written opinion. The panel shall determine whether there was substantial information to support the findings of Anthem.

Based on this determination, the panel may uphold Anthem's findings and decisions in whole or in part or it may reverse Anthem's findings and decisions in whole or in part. The panel's written opinion shall also specify the amount of money, if any, that the participating provider owes to Anthem or that Anthem owes to the participating provider on account of the provider services either rendered to Anthem members or billed by the participating provider to Anthem.

If the decision of the panel is adverse to Anthem in any respect, then Anthem agrees to abide by the decision of the panel pending any further review, in a court of law or otherwise, that Anthem may elect to pursue.

Physician and Health Care Professional Audit Process

In an effort to enhance the partnership among physicians, health care providers, employer clients, members and the plan, Anthem routinely conducts physician and health care provider audits. It is the responsibility of Anthem to ensure that claims correctly reflect performed services, that the services are billed accurately, and that participating physicians or health care providers comply with provisions of their contracts with Anthem.

It is our goal to conduct audits with minimal inconvenience to physicians and health care providers. However, the process requires that physicians and health care professional provide medical and financial records for the members we request. To assist in this process, we will photocopy/microfilm these materials at your location and review records at our corporate headquarters. In all cases, confidentiality will be maintained. The following is a general overview of the process:

- An Anthem auditor will contact your office by telephone to set a mutually agreeable date and time within two weeks of the call for a physician/provider audit.
- Anthem auditors are thoroughly trained and experienced professionals, with a broad knowledge of CPT® and ICD-9 coding, Anthem policies and procedures, and Connecticut State statutes.
- You will receive written confirmation of the appointment from the auditor.
- The auditors will bring all necessary equipment to photocopy and/or microfilm the required information from your files.
- You will be given a list of members for whom medical record information is needed, based on claim information that you have submitted. You will be asked to provide the member's applicable medical records for the period specified by the auditor. This would include, but is not limited to, all offices and progress notes, travel cards, laboratory test results, referrals, requisitions, x-rays, patient sign-in sheets, the office appointment book and accounts-receivable data.
- Claim information and documentation obtained during the visit will be taken back by Anthem corporate headquarters and reviewed by the auditor and Anthem medical professionals.
- Upon completion of the audit, a preliminary audit letter will be sent to you. You will then be given the opportunity to respond to any items indicated as areas of concern.
- Any further information you provide in response to our preliminary audit letter will be considered in conjunction with the original information gathered. The results of this final review will be communicated to you in a final audit letter. If you disagree with the final audit letter, you will be afforded the opportunity to appeal the audit decision via Anthem's formal audit appeal process (See the Appeal/Grievance section of this manual).

Questions regarding the audit process may be addressed to your Anthem Behavioral Health Provider Relations Consultant.

Corrective Action Process

Purpose

Anthem is committed to promoting services to members by participating physicians and health care providers that are in accordance with the plan's participation agreements, credentialing/recredentialing criteria, utilization, and clinical quality guidelines, and administrative policies and procedures. To this end, the corrective action process provides consistent means for the plan to identify deficiencies or problems to the participating physician or health care provider so that he/she may adopt corrective measures. Anthem is not obligated to follow this process in every circumstance, nor does the adoption of this process enlarge or expand any obligations of the company under its participating physician and provider agreements. Likewise, this process does not enlarge the rights of any participating physicians or providers and does not reduce or eliminate any rights of Anthem.

General Description

When an issue is identified that appears to be in conflict with plan policies or guidelines, Anthem may institute the corrective action process to positively impact practice patterns and/or to effect compliance with contract requirements or administrative guidelines. Physicians and health care providers are afforded the opportunity to submit responsive input as part of this process. Once Anthem initiates the corrective action process, data is monitored to assure the issue has been successfully resolved.

Investigational Phase

The first level of the process is called the investigational phase. When Anthem identifies an issue that appears to be in conflict with company requirements, policies or guidelines, the company investigates the issue(s) and any related circumstances. If the investigation indicates that correction should occur, Anthem notifies the physician or health care provider of the issue(s) or concern(s) by letter, phone call or visit.

The physician or health care provider is afforded the opportunity to respond to this notification and, when specifically identified, must reply in writing to Anthem with thirty (30) days of the company's notice to the provider. If the plan finds that the response satisfactorily addresses the concern(s), the corrective action process is closed. If the plan does not receive a response from the physician or health care provider, or if the response does not satisfactorily address the issue(s) or concern(s), the company may initiate level I of this corrective action process.

Level I

Level I of the corrective action process is an educational stage which may include notification, monitoring and tracking of issue(s). At this level, the plan identifies the improvements required and provides a timeline for resolution, typically from three months to six months.

Anthem continues to monitor and review the issue(s) or concern(s) for the designated time period to determine if the provider corrects the problem(s). If the issue(s) is successfully resolved, the physician or health care provider is removed from the corrective action process and will receive notice to that effect. The company will periodically review the physician or health care provider to verify that the provider's correction continues.

If improvement is not shown during level I, the company notifies the physician or health care provider who may respond in writing to the company within thirty (30) days. If the plan finds that the response satisfactorily addresses the concern(s), the corrective action process is closed. If the plan does not receive a response from the physician or health care provider, or if the response does not satisfactorily address the issue(s), the company may initiate level II of the corrective action process.

Level II

At level II of the corrective action process, the Quality Steering Committee reviews the issues and recommends actions to be taken. The Quality Steering Committee consists of Anthem personnel at the manager level or above, and includes a medical director. The plan may initiate level II of the corrective action process when there is no response or an inadequate response to a level I notice to the provider, or when the provider fails to comply with the corrective action plan. In these circumstances, the plan notifies the physician or health care provider, who has the opportunity to respond in writing to Anthem within ten (10) business days of the plan's notice. If the plan finds that the response satisfactorily addresses the concern(s), the corrective action process is closed. If the plan does not receive a response from the provider, or if the response does not satisfactorily address the issue(s), the plan may initiate level III of this corrective action process.

Level III

At level III of the corrective action process, the case is presented to the Anthem Contracting Committee for the final determination and action. The contracting committee may take any action permitted under the applicable Anthem participation agreement, including termination of the agreement.

Where applicable, the physician or health care professional may appeal an adverse decision of the contracting committee according to the company's appeal processes, outlined in the *Anthem Policies and Procedures Manual*.

SECTION 4

Provider Responsibilities

- Act in accordance with the terms of the participating provider/ facility/ clinic agreement.
- Provide services at locations acceptable to Anthem Behavioral Health.
- Notify Anthem Behavioral Health of practice changes at least thirty days in advance.
- Make services available and accessible to members 24 hours per day, seven (7) days per week, and 365 days per year and in a manner that assures continuity of care.
- Meet Anthem Behavioral Health 's access standards for emergent, urgent and routine appointments.
- Notify Anthem Behavioral Health immediately of any sanction or limitation on practice or privileges.
- Notify Anthem Behavioral Health of quality of care concerns or critical incidents.
- Adhere to administrative policies and procedures.
- Participate in the Credentialing and Recredentialing Program.
- Follow Anthem Behavioral Health 's care management procedures.
- Adhere to Member Rights and Responsibilities. (Included in the Member Rights and Responsibilities Section)
- Comply with all State/Federal laws and Anthem Behavioral Health policies protecting patient privacy and handling of confidential treatment information.
- Cooperate with Anthem Behavioral Health 's quality improvement activities.
- Distribute member educational materials provided by Anthem Behavioral Health.
- Comply with record standards, reviews, and site visits.

(Please note: This listing is a reference and is not exclusive. Items are described in detail throughout this manual and in your provider agreement.)

Provider Coverage

In the event that you use the services of other providers for coverage purposes, covering arrangements must be made with another participating provider except in unusual and unanticipated circumstances when approved in advance by Anthem Behavioral Health. In all cases, you should arrange with the covering provider that he/she would accept payment from Anthem Behavioral Health as payment in full, except for any applicable member cost shares.

Required Reporting/Notification

In accordance with your participating provider agreement* (group or solo), participating providers are required to notify Anthem in writing within seven (7) days of the following:

- Any change of business address, including relocation or elimination of a location.
- Any action taken to restrict, suspend or revoke the provider's or group's license, accreditation or certification.
- Any action to restrict, suspend or revoke the provider's medical staff privileges.
- Any action brought against the group or provider for malpractice and the final disposition of such action by settlement or adjudication.
- The termination, reduction or cancellation of the insurance coverage required under the Agreement.
- Any criminal action against the group or individual provider.
- Any action to suspend, sanction, expel or disbar the group or individual provider under Title XVIII or Title XIX of the Social Security Act.
- Any situation which might materially affect the group's or solo provider's ability to carry out the duties under their agreement, or to meet any credentialing/recredentialing criteria.

- For group agreements only: Any material changes in the group's ownership, to the extent that the ownership or control of the group changes by 20% or more.

This information can be faxed to Anthem Behavioral Health Provider Relations at **203-654-3307** or mailed to P.O. Box 651, North Haven, CT 06473.

* See section E. "Notice of Changes" in your Solo or Group Participating Provider Agreement.

Use of Name

As a participating provider, your name, address, and other relevant practice-related information is included in literature distributed to current and potential members, payors, and other participating providers. It is important that you advise Anthem Behavioral Health of any office or practice changes within seven (7) business days.

Site Visits

To promote the provision of care to members in safe, clean, confidential environments, Anthem Behavioral Health conducts selected on-site inspections of providers' offices. The physical space, appointment scheduling, and record keeping practices are evaluated.

High-volume sites are selected for visits. Site visits are conducted at the time of initial credentialing for potential high-volume providers.

Expectations are outlined below. Please review these requirements with your office personnel to ensure compliance. Multi-site practices will require visits at each separate location. Anthem Behavioral Health will contact selected offices to arrange for a mutually convenient time for each visit. Following the site-visit, you will receive a written finding and report. A detailed corrective action plan may be included to assist you in meeting compliance.

1. Physical accessibility
2. Physical appearance
3. Adequacy of waiting and examination room space
4. Informed consent document and release of information forms are available
5. Availability of appointments
6. Adequacy of treatment record keeping
7. 24-hour on-call coverage
8. Non-life threatening emergency appointments available within standard
9. Urgent appointments available within standard
10. Routine appointments available within standard
11. Medical records stored in locked file cabinets
12. System in place for old record storage and retrieval
13. Medication and prescription pads are secured

SECTION 5

Claims Procedures

Participating Provider Payment Policy

The participating provider agreement includes relevant fee schedules. Compensation for covered services is at the contracted rate, less amounts of member cost shares payable by the member. Member eligibility and member cost shares may be verified through the Anthem Behavioral Health Provider Call Center at **800-934-0331**. If it is found that a member was not actively covered at the time services were delivered, the member is responsible for all fees, not Anthem Behavioral Health.

Members Held Harmless

The participating provider agreement requires that members be held harmless for any incurred charges for services that are covered under the member's health benefit plan. This includes services that are denied under the Utilization Management Program. Members may contract with their provider to self-pay for services not covered under their health benefit plan or for services not meeting medical necessity criteria. Providers must be able to evidence the member's consent to the specific self-pay services prior to the services being rendered, along with the member's knowledge that the services are not eligible for coverage under the member's health plan. A general financial responsibility acknowledgement will not satisfy this requirement.

Patient Balance Billing Prohibited

Balance billing members for amounts above contracted rates is strictly prohibited. Providers may collect applicable deductibles, coinsurance and / or copay amounts from the member at the time of service.

Missed Appointment Policy

Providers may charge members for missed appointments **only** if the provider's written policy is acknowledged by the member in writing before the start of treatment.

Maximum Visits Per Day

Behavioral health benefits are limited to one professional service per day except for the following:

1. Outpatient psychotherapy with a non-psychiatrist and medication management with a psychiatrist provided on the same day.
2. Outpatient psychotherapy and prior authorized psychological testing provided on the same day.
3. Comprehensive outpatient services, including group therapy.

Please note that account-specific variations may exist. Please call Anthem Behavioral Health for verification of possible exceptions.

Incomplete Claims

Claims will be returned due to invalid or incomplete required fields. The provider will be notified either on the EOB or via letter outlining the fields requiring completion or correction. To receive compensation, the provider must resubmit the claim with the fields corrected or completed within the original timely filing limits.

Coding Guidelines

Please see Attachment E for a listing of current professional CPT codes and Institutional UB-92 revenue codes accepted by Anthem Behavioral Health. Claims submitted using other codes will be rejected. Please feel free to call the Anthem Behavioral Health Provider Call Center at **800-934-0331** if you have any questions.

Claim Submission Guidelines – Paper Claims

All *BlueCare Health Plan*, *Century Preferred*, *Century 90* and *BlueCard* claims are processed and paid by Anthem. Please mail all claims to:

Anthem Blue Cross and Blue Shield
PO Box 533
North Haven, CT 06473

(*FEP*, *New England Health Plans*, *National Account* and claims for Anthem employees should be submitted as outlined on the *Behavioral Health Quick Reference Guide*.)

Claims for traditional outpatient services, including comprehensive outpatient must be submitted on the National Industry Standard Claim Form, CMS-1500, for professional and clinic providers. Uniform Billing Form, UB-92 must be used for **all** services provided at hospitals and facilities.


1. A separate claim form must be submitted for each patient containing all of the required elements.
2. Each line item can include no more than two dates of service for the same procedure code.
3. All claims must be submitted in a timely fashion, consistent with the participating provider agreement. Claims that are not submitted within the contracted filing limits may not be considered for compensation.

Claim Submission Guidelines – Electronic Submission

By electronically submitting claims for members, you can:

- Rely on weekly claims remittances;
- Profit from quick, accurate claims processing that will increase your cash flow;
- Access members' coverage and eligibility status data quickly and easily;
- Take advantage of electronically transmitted files and reduce the time-consuming process of posting payments to patient accounts; and
- Shorten waiting periods between claim submission and remittance, and improve overall efficiency.

If you would like to inquire about how you can submit your claims electronically, contact:

 EDI Support Unit: (800) 334-8262

Timely Filing Limits

Claims should be submitted to Anthem consistently, accurately and within timely filing limits to ensure the quickest turnaround time for compensation. This section will assist you with the requirements and guidelines for submitting claims.

In order to receive timely, direct compensation from Anthem for services you render as a participating physician or health care provider, the following claims filing limits apply:

<i>Blue Care Health Plan:</i>	180 days from date of service
<i>Century Preferred:</i>	180 days from date of service
<i>Century 90</i> (and its various riders):	180 days from date of service
<i>FEP:</i>	Submit claim by December 31 of the calendar year after the year in which the care or service was provided.

NOTE: Claims submitted after the filing limit will not be eligible for processing. When benefits are coordinated, the timely filing is 90 days from the date of payment by the primary payor. See below for the coordination of benefits.

Coordination of Benefits

The Birthday Rule

This rule applies when non-separated and non-divorced parents have different health plans, both of which cover children as dependents. The plan benefits of the parent whose birthday falls earlier in the calendar year (month and day) are determined first. If both parents have the same birthday, the plan which has been in effect longer is considered primary.

Separated or Divorced Parents

If two or more plans cover dependent children of separated or divorced parents who do not have joint custody of their children, the children's benefits are determined in this order (unless specified otherwise in a court decree):

- The plan of custodial parent.
- The plan of the spouse of the custodial parent (if the parent is remarried).
- The plan of the parent without custody.
- In cases of joint custody, the birthday rule applies.

Active Employees

When an active employee has a plan with his/her present employer and is still covered by a former employer's plan as a retiree or a laid-off employee, the plan covering that person as an active employee is primary.

COB Claim Submission

- Always submit charges to the primary plan first.
- When an Anthem plan is primary, collect the copay. This copay is deducted from your claims payment.
- When an Anthem plan is secondary, do not collect a copay unless the primary plan does not cover the service, or if the member is satisfying a deductible for the primary plan.
- When a claim is paid or rejected by the primary plan, an explanation of benefits (EOB) should accompany the check or denial notice. Bill charges for non-covered or unpaid service to the secondary plan, and attach the explanation of benefits.
- When Anthem is the secondary carrier, we will consider charges up to the negotiated allowed amount with the primary carrier. As the secondary carrier, Anthem will provide compensation for member cost sharing responsibilities for eligible covered services in accordance with the provisions of the member's coverage document.

Duplicate Coverage

When a family is covered by two Anthem programs, the following order of benefit determination is applied

- The plan that covers a person as the subscriber/employee is the primary plan.
- The plan that covers a person as a dependent is the secondary plan.
- The birthday rule applies for covered child dependents when two plans cover the same child as a dependent of different persons (i.e. parents).

When submitting such a claim, please do the following:

- Submit one claim under the membership identification number of the patient
- Indicate on lines 9 a-d of the CMS-1500 claim form the secondary information
- The appropriate Anthem program will make payments under both membership identification numbers as applicable.

SECTION 6

Attachments

- A. Sample PCP Coordination of Care Form
- B. Outpatient Treatment Report Form (revised)
- C. Psychological Testing Form
- D. CPT and Revenue Codes
- E. CMS-1500 (formerly called HCFA-1500), UB-92 Instructions
- F. Member's Rights and Responsibilities

PATIENT Name: _____

ID # _____ **DOB:** _____

PROVIDER:

Individual and/or Group

Address:

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

COORDINATION of CARE:

- I have communicated with patient's PCP or specialist: Yes No N/A
- I have communicated with patient's psychiatrist or therapist: Yes No N/A

ICD-9* DIAGNOSIS numeric + description (*DSM-IV codes typically correspond to ICD-9 codes) :

Axis I _____
 Axis II _____
 Axis III _____
 Axis IV _____
 Axis V (current) _____ (highest past year) _____

PSYCHOTROPIC MEDICATIONS: Prescribed by: PCP Psychiatrist APRN

1. _____
 2. _____
 3. _____
 If affective or psychotic disorder is present and no medications are prescribed, please explain:

RISK ASSESSMENT:

- Suicidal: Ideation Planned Imminent Intent History of self-harming behavior
- Homicidal: Ideation Planned Imminent Intent History of behavior harming others

SYMPTOMS - if present, check degree (✓)

	Mild	Mod.	Severe		Mild	Mod.	Severe
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Mood Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions/Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FUNCTIONAL IMPAIRMENT

ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family/Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance of Abuse:	<input type="checkbox"/> ETOH	<input type="checkbox"/> Rx Drug	<input type="checkbox"/> Other: _____

DEFINITION OF SUCCESSFUL TREATMENT

Desired observable outcomes #1.

Desired observable outcomes #2

LEVEL of IMPROVEMENT to DATE: # Sessions provided to date: _____

- Minor Moderate Major No progress to date Maintenance tx of chronic condition
- Start date for new auth** _____

PROVIDER'S CONTINUED TREATMENT PLAN (requested services):

MODALITIES	FREQUENCY	ANTICIPATED COMPLETION
<input type="checkbox"/> Individual	<input type="checkbox"/> weekly	<input type="checkbox"/> less than 1 month
<input type="checkbox"/> Family/Couple	<input type="checkbox"/> twice per month	<input type="checkbox"/> 1 to 2 months
<input type="checkbox"/> Group	<input type="checkbox"/> monthly	<input type="checkbox"/> 2 to 4 months
<input type="checkbox"/> Medication Management	<input type="checkbox"/> less than monthly	<input type="checkbox"/> more than 4 months

Request for Psychological Testing

Patient Information (must be completed):

Patient Name: _____ Date of Birth: _____

ID #: _____ Subscriber Name: _____

Provider Information:

Provider Requesting Testing: _____ Relationship to Patient: _____

Provider/Facility Identification Number: _____

Address: _____ Phone: _____

_____ Fax: _____

Provider to Administer Testing: _____

Provider/Facility Identification Number: _____

Address: _____ Phone: _____

_____ Fax: _____

Clinical Information:

Current Diagnosis (DSM IV) : Axis I _____ Description _____

Axis II _____ Description _____

Axis III _____

Axis IV _____

Current GAF _____ Highest Past Year _____

Has patient recently been in treatment? _____ How long and with whom? _____

Current psychotropic medications: _____

Previous psychotropic medications: _____

(Please proceed to next page)

Request for Psychological Testing continued...

What current symptoms or conditions suggest the need for testing? _____

Has the patient had any previous testing? (If so, please include dates, tests administered and results) _____

Specific questions to be answered by testing: _____

Please describe how the testing is necessary for diagnosing and treating the patient: _____

Test Proposed:

Name of Test	Purpose	Time Needed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Projected Date of Testing: _____

Signature of Provider (completing form): _____ Date: _____

Address/Phone/Fax (if different from providers on front): _____

BILLING CODES

<i>Revenue Code* / CPT Code</i>	<i>CPT Description</i>	<i>Anthem Behavioral Health Billing Guidelines</i>
	Outpatient Services	
914 / 90801	Psychiatric diagnostic interview examination	
914 / 90802	Interactive psychiatric exam using play equipment, etc.	Use for one hour psychiatric diagnostic interview - child under age 18
914 / 90804	Individual therapy, 20-30 min	
914 / 90805	Individual therapy, 20-30 min, w/ med mgmt	MD and APRN only
914 / 90806	Individual therapy, 45-50 min	
914 / 90807	Individual therapy, 45-50 min w/ med mgmt	MD and APRN only
914 / 90813	Individual therapy, 45-50 min, interactive w/ medication mgmt	Use for play therapy - child under 18 MD and APRN only
916 / 90846	Family psychotherapy w/o patient present	
916 / 90847	Family psychotherapy w/ patient present	
915 / 90853	Group psychotherapy, other	
914 / 90862	Pharmacological management	MD and APRN only
914 or 918 / 96101	Psychological testing, per hour	PhD only - requires prior authorization
914 or 918/ 96118	Neuropsychological testing, per hour	PhD only - requires prior authorization
914 / 99205	Office visit, new patient, 60 minutes	Use for emergency office evaluation - requires prior authorization
	CPT Inpatient/Facility Services	
	NOTE: These codes will be reimbursed only when services are provided during an authorized inpatient stay and only when the facility is one where Anthem Behavioral Health's contracted rate is not all-inclusive of	
90816	Individual therapy, 20-30 min, inpatient	
90817	Individual therapy, 20-30 min, inpatient w/ med mgmt	MD and APRN only
90818	Individual therapy, 45-50 min, inpatient	
90819	Individual therapy, 45-50 min, inpatient w/ med mgmt	MD and APRN only
90870	ECT, single seizure	MD only
99221	Initial hospital visit, per day, 30 min	MD only
99222	Initial hospital visit, per day, 50 min	MD only
99223	Initial hospital visit, per day, 70 min	MD only
Initial inpatient consultation, new or established patient, 40 min	MD only	MD only
Initial inpatient consultation, new or established patient, 55 min	MD only	MD only
99233	Subsequent hospital visit, per day, 35 min	MD only
99251	Initial inpatient consultation, new or established patient, 20 min	MD only
99254	Initial inpatient consultation, new or established patient, 80 min	MD only
99255	Initial inpatient consultation, new or established patient, 110 min	MD only
99261	Follow-up inpatient consultation, new or estab. patient, 10 min	MD only
99262	Follow-up inpatient consultation, new or estab. patient, 20 min	MD only
99263	Follow-up inpatient consultation, new or estab. patient, 30 min	MD only
99285	Emergency room visit, high severity and life-threatening	
	Other Services	
S4985	Home visit, 40 min	Use for mobile crisis intervention - clinics only -
S4980	Prolonged service in outpatient setting, first hour	Use for IOP for clinics only - requires prior authorization

<i>Revenue Code (and CPT/HCPCS Code when required)</i>	<i>Revenue Code Description Psychiatric</i>	<i>Anthem Behavioral Health Billing Guidelines</i>
914 / H0014	Prolonged service in outpatient setting	Use for ambulatory detox - requires prior authorization
124	Inpatient treatment	Requires prior authorization
190	Inpatient sub-acute	Requires prior authorization
762	23-hour observation bed	Requires prior authorization
912 or 913	Partial hospital	Requires prior authorization
905 / requires any HCPC	Intensive outpatient	Requires prior authorization
901/90870	ECT	Requires prior authorization
459 / 99281- 99285	Emergency room - crisis assessment and treatment	
551	Home care - skilled nursing	
126	Inpatient treatment	Requires prior authorization
190	Inpatient sub-acute	Requires prior authorization
762	23-hour observation bed	Requires prior authorization
912 or 913	Partial hospital	Requires prior authorization
906 / requires a HCPCS Code	Intensive outpatient	Requires prior authorization
459 / 99281- 99285	Emergency room - crisis assessment and treatment	
551	Home care - skilled nursing	Requires prior authorization

- A revenue code in conjunction with a CPT/HCPCS code is required when billing on a UB-04.

The following terms as used in the Member Bill of Rights and Responsibilities are defined for you here:

'We' and 'Our' refer to Anthem

'You' and 'Your' refer to the member

Member Bill of Rights and Responsibilities

We are committed to our responsibilities to:

- recognize and respect your needs;
- encourage your open discussions with all health care professionals and providers;
- help you become an informed health care consumer;
- assist you in receiving appropriate health care services;
- share our expectations of your responsibilities.

You have a right to:

- receive quality health care from your primary care provider in a timely manner and in a medically appropriate setting;
- participate with your health care professionals and providers in making decisions about your health care;
- select a participating primary care physician and change your selection at any time without the need for stating a reason;
- receive all benefits for which you have coverage;
- be treated with respect and recognition of your dignity and right to privacy, consistent with state and federal laws, and our policies;
- receive information about our organization and services, our participating health care professionals and providers, and your rights and responsibilities;
- a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;
- make recommendations regarding the organization's members' rights and responsibilities policies.
- voice complaints or appeals about:
 - our company,
 - about any decisions we (or our designated administrators) make,
 - your coverage, or
 - the quality of care provided;

You have the responsibility to:

- choose a primary care physician who will assess your individual needs;
- understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible;
- provide, to the extent possible, any information that we and/or our participating health care professionals and providers need so care can be provided to you;
- follow Anthems and instructions for care that you have agreed on with your health care professional and provider;
- tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- refuse treatment and be informed by your health care professional and provider of the medical consequences;
- know how and when to access care in routine, urgent and emergency situations;
- follow all plan procedures;
- let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- provide us with accurate and complete information needed to administer your benefit plan, including other health coverage and other insurance benefits you may have in addition to your coverage.

We are committed to providing quality service to our members and participating health care professionals. To further that goal, this Member Bill of Rights and Responsibilities will serve as an example of our commitment to you. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this statement.

Anthem Blue Cross and Blue Shield is committed to developing partnerships with members, physicians and health care providers. To further that goal, this *Member Bill of Rights and Responsibilities* will serve as testimony to our commitment. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this statement.