Anthem
And Its Affiliate HealthKeepers, Inc.

P.O. Box 27401
Richmond, VA 23279

July 15, 2019

Subject:

1) **Changes to timely filing requirements for Commercial and Medicare Advantage Plans for all claims submitted to plan on or after November 1, 2019.**
2) **Changes to participation requirements for Virginia HMO Medicaid effective December 1, 2019.**

Dear Provider:

As required by the Ethics and Fairness in Carrier Business Practices Act, all health insurance companies licensed to do business in Virginia making material changes to existing agreements or exhibits must do so by way of a formal amendment process. Consistent with that requirement, we are providing the enclosed amendment for your review. Please note that the specific amendments may or may not be applicable depending upon your current network affiliation(s) with us.

Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. (collectively "Anthem") continue to look for ways to improve our processes and align with industry standards. Timely receipt of medical claims for your patients —our members— helps our chronic condition care management programs work most effectively and also plays a crucial role in our ability to share information to help you coordinate patient care. In an effort to simplify processes, improve efficiencies, and better support coordination of care, we are changing all professional agreements to adopt a common time frame for you to submit claims.

Effective **for all claims submitted to Anthem on or after November 1, 2019**, your Anthem Provider Agreement(s) will be amended to require the submission of all professional claims for Commercial and Medicare Advantage within 90 days of the date of service. This means all claims **submitted on or after November 1, 2019**, will be subject to a 90-day timely filing requirement, and Anthem will refuse payment if submitted more than ninety (90) days after the date of service. [1]

For instance, for a claim with a date of service of August 5, 2019, the claim would be untimely if submitted more than 90 days after that date of service (i.e., the claim would deny if submitted on or after November 4, 2019).

NOTE: All claims with dates of service prior to November 1, 2019, that will be more than 90 days from the date of service on November 1, should be submitted prior to November 1, 2019, to avoid a timely filing denial.

Additionally, we are amending the Virginia HMO Medicaid Participation Attachment as required by the Federal 21st Century Cures Act. This federal law requires that all providers furnishing services to Medicaid members, including providers participating in a Managed Care Organization's provider network(s), are required to be screened and enrolled with the Department of Medical Assistance Services (DMAS) through The Provider Enrollment Wizard by **December 1, 2019.**

Please see the enclosed amendment to your Provider Agreement reflecting these changes.

To continue your current network participation, no action is required on your part. This amendment automatically becomes effective on the dates indicated above unless you supply Anthem with written notice of your intent to terminate the applicable

[1] If Anthem is the secondary payer, the 90-day period will not begin until Provider receives notification of primary payer's responsibility.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia. Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc., serving all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123, are independent licensees of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

provider agreement(s) within 40 calendar days of the postmark date of this amendment package. However, any time after the 40-calendar day period expires, you may terminate your agreement with a 120-day written notice of termination.

If you have questions regarding this amendment, please contact your Anthem network manager, or call one of the numbers below based on the location of your office. Thank you for your continued participation in the Anthem networks and the services you provide to our members.

Central Region – (804) 354-4126
Eastern Region – (757) 326-5158
Northern Region – (804) 354-4441
Western Region – (540) 853-5077
Ancillary Providers – (804) 354-2338

Sincerely,

Andrew A. Randazzo
Regional Vice President, Provider Solutions

Enclosure: [Amendment]

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AMENDMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROVIDER AGREEMENT

This is an Amendment to your current Anthem Blue Cross and Blue Shield Provider Agreement ("Agreement") and entered into between you, the "Provider" and Anthem Health Plans of Virginia, Inc. doing business as Anthem Blue Cross and Blue Shield (hereinafter referred to as "Anthem") and is incorporated into the Agreement as follows:

Virginia Provider Agreement

1. In the last sentence of Section 3.4 of the Agreement – Plan Access to and Requests for Provider Records - the word "retraction" is replaced with "retraction or recovery."

Commercial Business Participation Attachment

1. Section 2.3 - Submission and Adjudication of Commercial Business Claims of the Commercial Business Participation Attachment is deleted in its entirety and replaced with the following:

   Submission and Adjudication of Commercial Business Claims. Unless otherwise instructed or required by Regulatory Requirements, Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within ninety (90) days from the date the Health Services are rendered or Plan will refuse payment. If Plan is the secondary payor, the ninety (90) day period will not begin until Provider receives notification of primary payor's responsibility.**

2. Section 2.3.3 - Submission and Adjudication of Commercial Business Claims Sub 3 of the Commercial Business Participation Attachment is deleted in its entirety and replaced with the following:

   If Anthem or Plan asks for additional information so that Plan may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the ninety (90) day period referenced in section 2.3 above, whichever is longer.**

Medicare Advantage Participation Attachment

1. Section 6.1 - Submission and Adjudication of Medicare Advantage Claims of the Medicare Advantage Participation Attachment is deleted in its entirety and replaced with the following:

   6.1 - Submission and Adjudication of Medicare Advantage Claims. Unless otherwise instructed in the provider manual(s) or Policies applicable to Plan's Medicare Advantage Program, or unless required by Regulatory Requirements, Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within ninety (90) days from the date the Health Services are rendered or Plan will refuse payment. If Plan is the secondary payor, the ninety (90) day period will not begin until Provider receives notification of primary payor's responsibility.**

2. Section 6.1.3 - Submission and Adjudication of Medicare Advantage Claims Sub 3 of the Medicare Advantage Participation Attachment is deleted in its entirety and replaced with the following:

   6.1.3 - If Anthem or Plan asks for additional information so that Plan may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the ninety (90) day period referenced in section 6.1 above, whichever is longer.**

Plan Compensation Attachment

1. Virginia Reimbursement Policies of the Plan Compensation Attachment

   Reimbursement Policy 0053: Claims Requiring Additional Documentation: Subsection 4-B is changed to delete "retractions" and replace it with "retractions or recoveries."

Professional Provider Manual

1. Eligibility and Claims Submission (Professional Provider Billing Guidelines)

   The following row marked "WHEN" is deleted in its entirety:

WHEN	All Claims for Covered Services rendered to Anthem members must be submitted within **12 months of the date of service**, whether Anthem coverage is primary or secondary. In situations where Anthem is secondary but the primary payer takes over 12 months from the date of service to process their Claim, Anthem may waive this 12-month timely filing requirement on a case-by-case basis. In situations when the Anthem Claim is rejected and noted on the provider's "Claims Error Notification Report", the timely filing clock does not stop; therefore, even if the original Claim was submitted timely, the resubmission may deny for timely filing. When the provider submits Claims within 12 months and Anthem requests additional information, this information should be provided within 30 days or before the expiration of the 12 month period.

2. Federal Employees Health Benefits Program

   The following paragrah is deleted in its entirety:

   Submission of Claims under the Federal Employees Health Benefits Program

   All Claims under the FEHBP must be submitted to Plan for payment within three hundred sixty five (365) calendar days from the date of discharge or from the date of the primary payer's explanation of benefits. Providers agree to provide to Plan, at no cost to Anthem or Member, all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. If Plan is the secondary payer, the three hundred sixty five (365) calendar day period will not begin to run until Provider receives notification of primary payer's responsibility. Plan is not obligated to pay Claims received after this three hundred sixty five (365) calendar day period. Except where the Member did not provide Plan identification, Provider shall not bill, collect, or attempt to collect from Member for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.

   The above deleted paragraph is replaced with the following:

   Submission of Claims under the Federal Employees Health Benefits Program

   All Claims under the FEHBP must be submitted to Plan for payment within the timeframe listed in the Provider or Facility Agreement. This timeframe applies from the date of discharge or from the date of the primary payor's explanation of benefits.

   Providers and Facilities agree to provide to Plan, at no cost to Anthem or Member, all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a

medium approved by Plan. If Plan is the secondary payor, the timeframe will not begin to run until Provider or Facility receives notification of primary payor's responsibility. Plan is not obligated to pay Claims received after the timeframe indicated in the agreement. Except where the Member did not provide Plan identification, Provider and Facility shall not bill, collect or attempt to collect from Member for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.**

3. Utilization Management Program and Plan (the "Program")

   Section XV. Audit Activities: In the second sentence of Section A, the term "retract" is replaced with "retract or recover."

4. Audit

   A. Policy, Section 4-b, the terms "retractions" is replaced with "retractions or recoveries" (two instances)

   B. Audit Appeal Policy - Procedure - Section 1, the term "Retraction" is replaced with "Retraction or recovery")

Virginia HMO Medicaid Participation Attachment

1. The following new provision is added to Article V:

   5.15 - Provider shall be screened and enrolled with the Virginia Department of Medical Assistance Services and shall sign a DMAS provider participation agreement before this Agreement is effective as to Virginia Medicaid Members, pursuant to 42 CFR 438.602(b)(1) and (b)(2), 42 CFR § 438.608(b), 42 CFR § 455.100-106, 42 CFR § 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act.**

** The provisions, terms and conditions in these paragraphs shall apply to all Commercial and Medicare Claims submitted on or after November 1, 2019, with the exception of the Virginia HMO Medicaid Participation Attachment changes, which will apply to all Medicaid Claims submitted on or after December 1, 2019.

Except as expressly set forth herein, nothing contained herein shall be construed to modify the Agreement. To the extent this Amendment conflicts with any provision of the Agreement, this Amendment shall control.

THE EFFECTIVE DATE OF THIS AMENDMENT IS: November 1, 2019