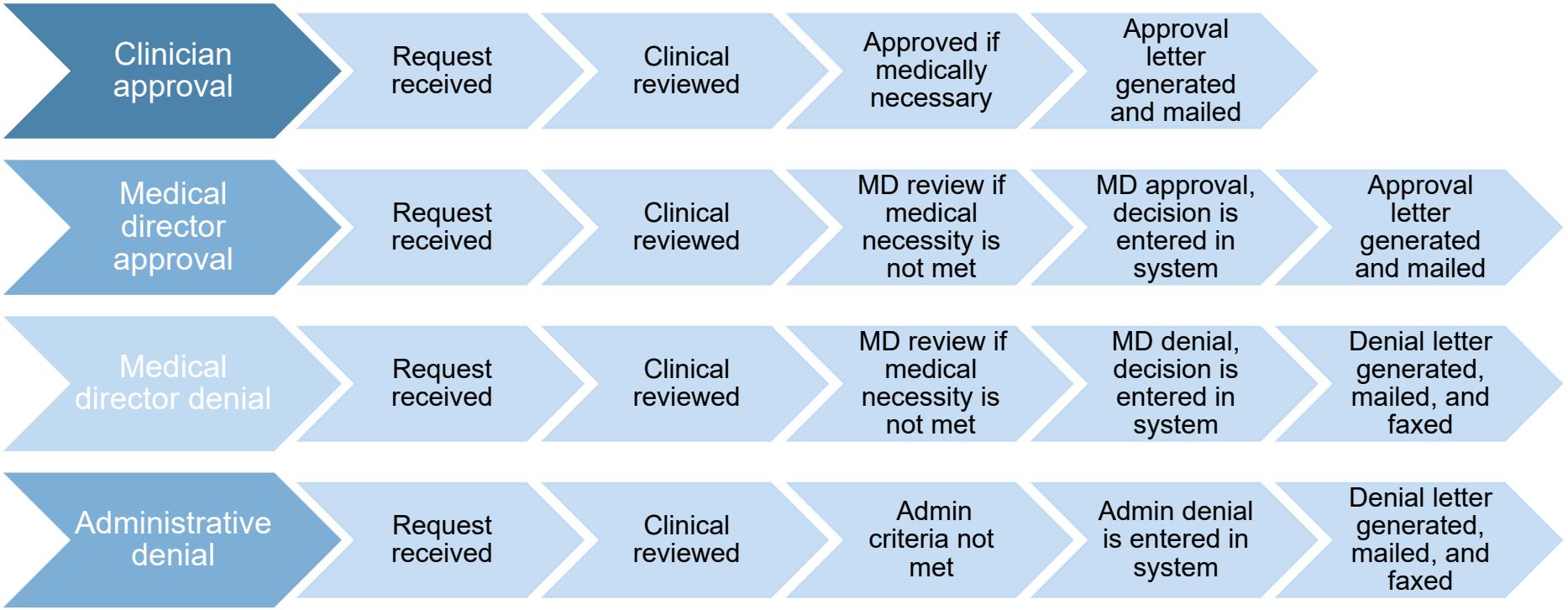
Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Anthem

Review Process and Clinical Requirements (PA) 201

2022 Indiana Health Coverage Programs (IHCP) works seminar

UM review pathways



Request for prior authorization review

Requests can be submitted via fax, phone, Interactive Care Reviewer (ICR), or Availity:*

- IHCP *Universal PA* form is required with fax requests
- Please send one member request per fax to avoid delays in processing and to prevent *HIPAA* violations

Upon receipt of the request, a case is created in our utilization management (UM) system and routed for clinician review

- Inpatient review clinicians are assigned by the facility
- Outpatient review clinicians are assigned according to CPT® codes

Clinician review process

1) Open supporting clinical documentation
2) Request reviewed for three *HIPAA* identifiers:
   - Any combination of:
     - Member name
     - Member DOB
     - Member address
     - State member ID (MID)

Clinician review process (cont.)

3) Request reviewed for meeting administrative parameters:

- **Eligibility:**
  - **Outpatient:** If ineligible, the fax will be returned to the provider, and/or Anthem Blue Cross and Blue Shield (Anthem) will notify the provider via phone that the member is no longer an active member, and the case is not eligible for review
  - **Inpatient:** If ineligible on the date of admission, the medical necessity review of the inpatient stay facility should be performed by the covering managed care entity through the date of discharge:
    - A case will be created in our system to allow for individual provider payment (not the facility) by Anthem for the dates the member is eligible with us
    - An administrative denial for ineligibility on the date of service will be issued to the requesting facility

Clinician review process (cont.)

Timely notification:

- **Outpatient:**
  - If the service was rendered prior to the request, a failure to prior authorize administrative denial would be issued:
    - Requests must be submitted at least 7 calendar days prior to a non-urgent, elective service
    - Requests for urgent, elective services must be submitted at least 3 calendar days prior to the date of service
- **Inpatient:**
  - Requests for emergent inpatient admissions must be submitted within 2 business days:
    - If not submitted within 2 business days, a late notification administrative denial will be issued
  - Requests for admission to post-acute levels of care require notification prior to admission:
    - Requests should be submitted at least 3 calendar days prior to admission
    - Anthem prioritizes the initial admission request to post-acute care as urgent requests and completes these reviews within 3 calendar days of receipt

Clinician review process (cont.)

PA requirements:

- **Outpatient:** If the requested procedure codes do not require PA and the rendering provider is in-network, the fax is returned to the provider with notification that no PA is required:
  - Providers are encouraged to utilize the Provider Look Up Tool (PLUTO) to identify PA requirements
  - All outpatient out-of-network requests require a PA
- **Inpatient:** An elective, pre-planned, inpatient stay requires a PA:
  - If no PA was obtained prior to a non-emergent, planned admission, a failure to PA administrative denial will be issued
  - If an emergent inpatient admission results from a planned outpatient procedure that has been approved or did not require a PA, the emergent inpatient admission would be reviewed for medical necessity

Clinician review process (cont.)

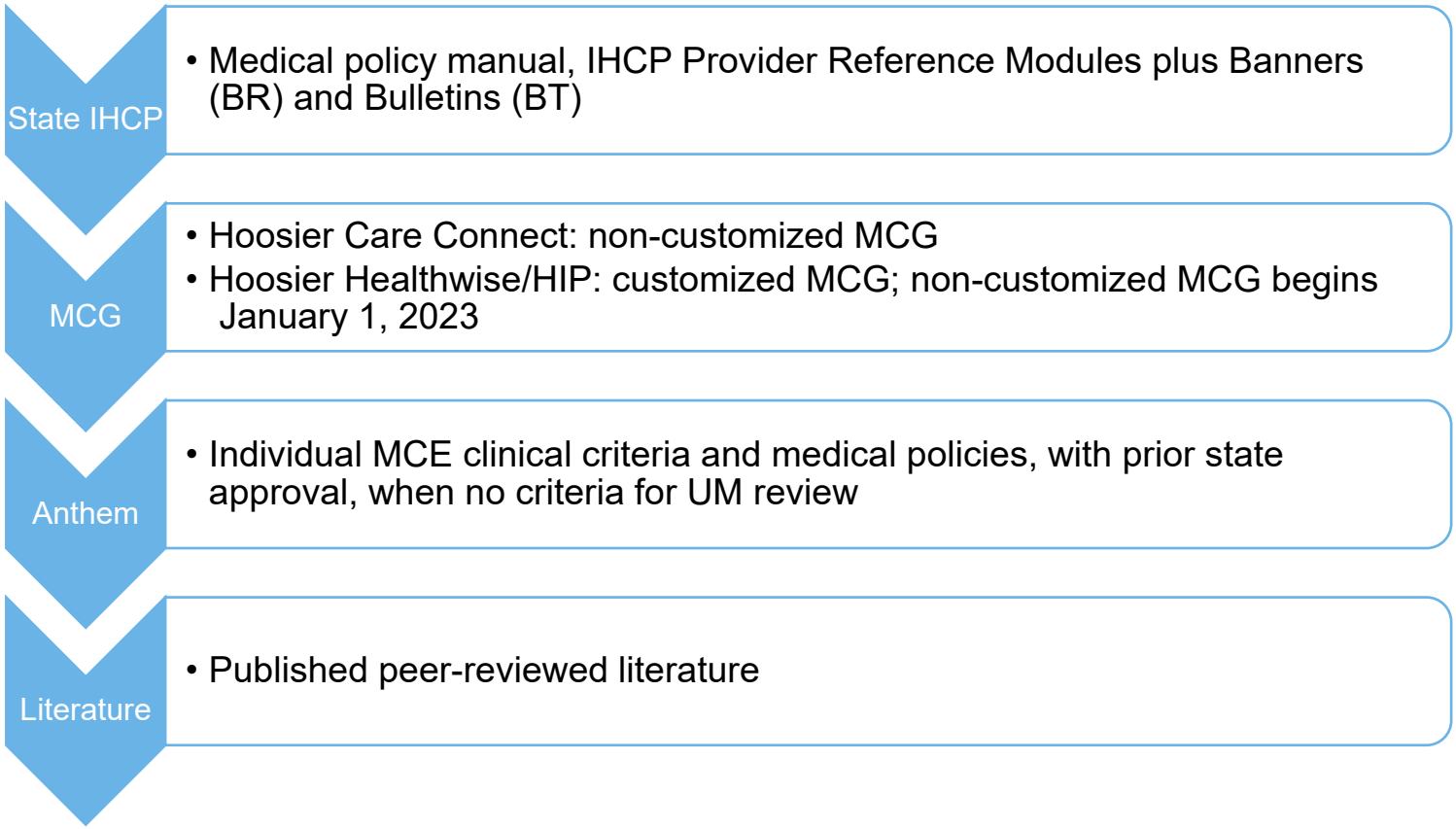
Benefit availability:

- **Outpatient/Inpatient:**
  - The requested procedure/service is reviewed with consideration of the services and units allowable by the member's plan (Healthy Indiana Plan HIP , Hoosier Healthwise, Hoosier Care Connect)
  - An administrative denial may be issued for services requested that are non-covered, with the exception of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
  - An administrative denial for benefit exhaustion may be issued for members in a post-acute care setting who have reached their max benefit limit

If all administrative parameters are met, the clinician will review the request for medical necessity.

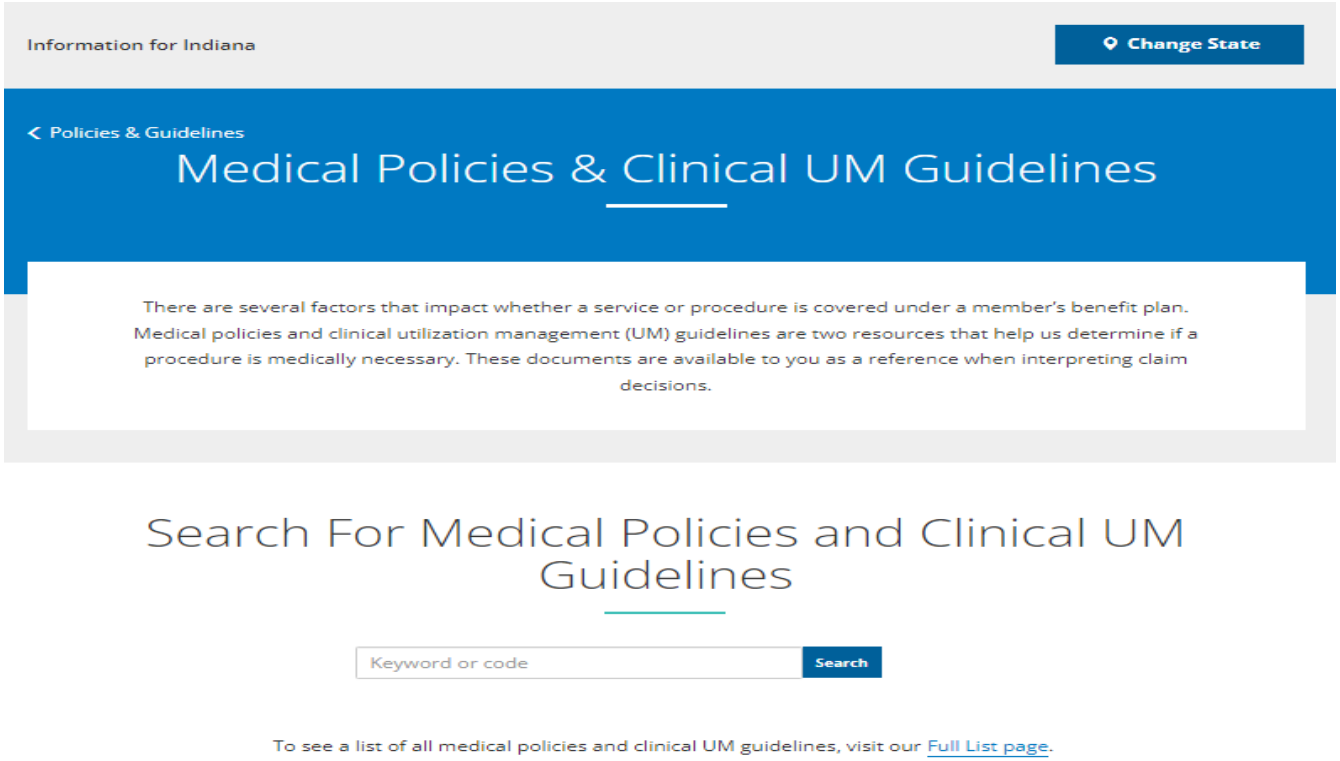
Clinician review process (cont.)

4) Application of appropriate medical necessity guidelines based on the hierarchy below:



Clinician review process (cont.)

Anthem's medical and clinical guidelines are available on our provider website:
https://www.anthem.com/provider/policies/clinical-guidelines/?cnslocale=en_US_in



Clinical requirements – physical health outpatient

- **Durable medical equipment (DME) request:**
  - *Clinical Criteria* or medical policy is dependent on the code type for outpatient services
  - Precertification Lookup Tool (PLUTO) will guide the provider to the clinical guideline or medical policy that is used to review the code
    - Example:
      - E0466 Home ventilator, any type, used with a non-invasive interface, (for example, mask, chest shell):
        - Anthem clinical guidelines can be CG-DME-26 or CG-DME-47
      - E2510 Speech generating device, synthesized speech, permitting multiple methods:
        - State guideline which is IHCP Provider Reference Module: Durable Medical Equipment and Supplies, Section on Augmentative and Alternative Communication Devices
  - State BT201723 / BT202221 face-to-face criteria:
    - Visit must occur and be recorded no more than 6 months before the start of services
    - A new face-to-face visit is not required for the continuation of an existing service

Clinical requirements – physical health outpatient

- **Home health (HH):**
  - Follows a similar pathway as DME for criteria
  - Utilize PLUTO to see which guideline is used
    - Example:
      - 99600 Unlisted home visit service/procedure:
        - Anthem clinical guidelines can be CG-MED-23 and or CG-MED-71
      - S9501 Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours:
        - Anthem clinical guidelines can be CG-MED-23 and or MED.00013
  - State BT201723 / BT202221 face-to-face criteria:
    - Home health services, documentation of a face-to-face encounter in accordance with *42 CFR 440.70(f)* is required
    - To initiate home health services, the face-to-face encounter must occur no more than 90 days before or 30 days after the start of services
    - A new face-to-face visit is not required for the continuation of an existing service

Clinical requirements – physical health outpatient

- **Home health continued:**
  - Anthem allows a 4 day grace period to submit the HH PA request
    - Example:
      - HH admission completed on Friday
      - Anthem OP UM would need to have the HH PA request by Tuesday:
        - This allows for weekend and holiday home admissions
      - Anthem will also accept a copy of the plan of care (485) that is pending the MD's signature:
        - This will prevent any delay in care
        - MD signature is required within 30 days
  - **IHCP home health module V5.0 home health PA documentation:**
    - The following documentation must be submitted with the PA request for **all** home health services: a copy of the written plan of treatment that was developed by the attending physician, home health agency personnel, and (if applicable) therapists, and has been signed by the attending physician and is current through the date of request
    - The signed 485 (POC) must be sent to Anthem within 30 calendar days from the date of approval

Clinical requirements

- **Elective surgical procedures (outpatient and inpatient):**
  - Follow PLUTO to determine which guideline or medical policy applies to the code
  - All inpatient levels of care for pre-service elective procedures must have a PA in the UM system:
    - The procedure code may not require PA; however, the inpatient level of care does require a PA to be submitted
    - The 2 potential pathways for an elective inpatient admission are:
      1) Notification only for inpatient only codes (IPO) per the state fee schedule
      2) For codes that are not on the IPO list, a medical necessity review will be conducted

Clinical requirements – physical health inpatient

- **Emergent inpatient admission:**
  - Minimum of 24 hours of clinical data providing the following: diagnosis, symptoms, history, treatment, and response to initial treatment

- **Obstetric deliveries:**
  - Newborn notification of delivery form:
    - Found on our provider site: https://providers.anthem.com/docs/gpp/IN_CAID_MCSNotificationofDeliveryForm.pdf?v=202106041459
  - Date of admission
  - Discharge date, if known
  - If additional days are required outside of federal mandate, clinical should include a reason for overstay including the diagnosis, symptoms, history, treatment, and response to initial treatment

Clinical requirements – physical health inpatient (cont.)

- **Post-acute care requests** (Skilled nursing facility, long-term acute care hospital, acute inpatient rehab):
  - Therapy notes pertinent to the member (speech, physical, occupational) to include:
    - Activities of daily living
    - Baseline and current abilities
  - Discharge planning/ barriers to discharge:
    - Home/caregiver support
    - Durable medical equipment/home health needs
  - Medical interventions:
    - IV therapy, wound care notes, feeding, etc.
  - Preadmission screening and resident review (PASRR) submission is required for every skilled nursing facility admission
  - The level of care (LOC) is required by day 30 for Hoosier Care Connect members pending transition to traditional Medicaid/FFS in a skilled nursing facility

Clinical requirements – Behavioral health

- **Initial requests for acute inpatient psychiatric and detox cases:**
  - PA form with requested information
  - Intake assessment
  - Diagnosis
  - Medications
  - MD notes
  - Estimated length of stay
  - Clinical Institute Withdrawal Assessment (CIWA)/Clinical Opiate Withdrawal Scale (COWS) scores (if applicable)
  - Urine drug screen (UDS) results
- **Concurrent review requests for acute inpatient psychiatric and detox cases:**
  - PA form with requested information
  - Updated diagnosis
  - Medications and medication changes
  - MD notes (daily prescriber notes)
  - Progress notes
  - Estimated length of stay
  - Updated CIWA/COWS scores (if applicable)

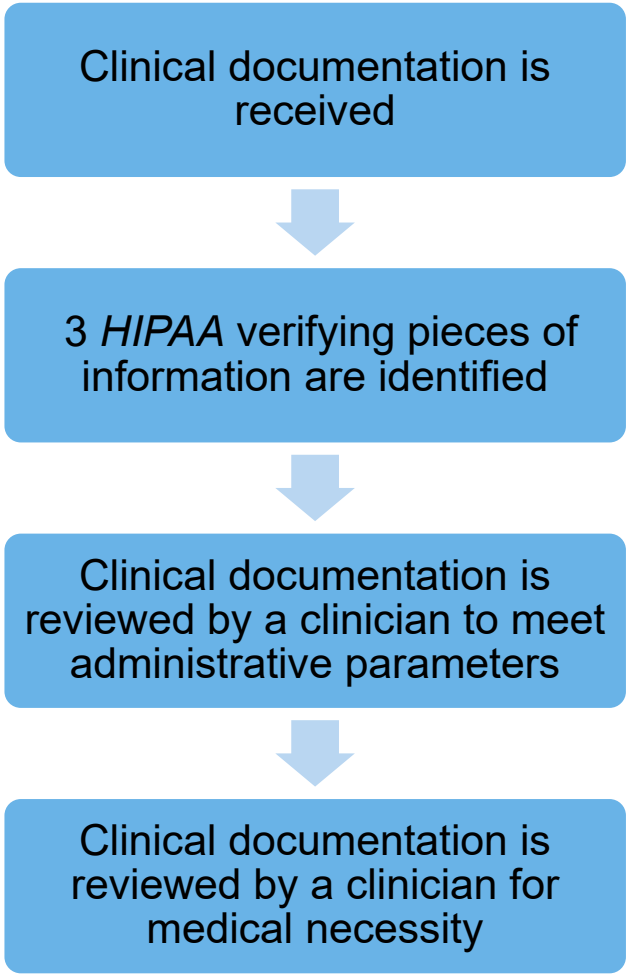
Clinical requirements – Behavioral health (cont.)

- **Initial requests for Residential Treatment Center (RTC), Intensive Outpatient Program (IOP), and Partial Hospitalization Program (PHP) levels of care:**
  - PA form with requested information
  - Intake assessment
  - Treatment plan
  - Diagnosis
  - Medications
  - Estimated length of stay
  - *ASAM (American Society for Addiction Medicine) Forms* (RTC only)
- **Concurrent review requests for RTC, IOP, and PHP levels of care:**
  - Fax cover sheet that contains “Concurrent Review Request for Reference # XXX”
  - PA form with requested information
  - Medications and medication changes (if applicable)
  - MD notes (weekly prescriber notes)
  - Progress notes
  - Group notes
  - Discharge planning
  - *ASAM Forms* (RTC only)

Clinical requirements – Behavioral health (cont.)

- **Initial requests for traditional outpatient, Electroconvulsive Therapy (ECT), Opioid Treatment Program (OTP), Transcranial Magnetic Stimulation (TMS):**
  - PA form with requested information.
  - PA is only needed for out-of-network requests (traditional outpatient, ECT, OTP).
  - PA requests for ECT and/or TMS require detail of medication failure and treatment failure to justify this level of care.
  - Diagnosis, assessment, treatment plan, medications.
- **Initial requests for applied behavioral analysis (ABA):**
  - PA form with requested information
  - Autism diagnosis (F84.0) is required
  - Any applicable testing results
  - Intake assessment (including the level of functioning, severity, social skills, life skills, etc.)
  - Treatment plan
  - Daily schedule
- **Initial requests for psychiatric/neuropsychiatric testing:**
  - PA form with requested information
  - Assessments
  - Diagnosis
  - Justifications for testing requests

Clinical review process recap



Clinician review process (cont.)

Decision and notification:

- If the case meets medical necessity criteria using the appropriate guideline from the decision hierarchy, the clinician will approve the case in the UM system, and a letter will be sent by mail to the provider and member
- If the case does not meet medical necessity criteria, the clinician will route the case to a medical director for further review
- Once the medical director renders a decision, the case is then routed back to the clinician to enter the decision in the UM system:
  - If approved, a letter will be sent by mail to the provider and member
  - If denied, a letter will be sent by mail to the provider and member
    - A copy of the letter will be faxed to the provider including information about their option for reconsideration, peer-to-peer, and appeal

Post-denial options

Reconsideration

- Request within 7 business days of the denial date
- Submit additional clinical information to the health plan and indicate **Reconsideration** on the fax cover sheet
- A decision will be rendered within 7 business days of the reconsideration request

Peer-to-Peer

- Request within 7 business days of a denial date (initial or reconsideration)
- Call **866-902-4628** , option 1 to set up the peer-to-peer
- A decision will be rendered following the peer-to-peer discussion

Appeal

- Request within 60 calendar days of the denial date
- Fax clinical to **855-535-7445**
- A decision will be rendered within 30 days unless the request is expedited in which decision will be rendered within 48 hours

Questions about UM

If you have questions about UM decisions or the UM process:

- Call our Provider Helpline at the numbers below Monday through Friday 8 a.m. to 8 p.m. ET:
  - Hoosier Healthwise: **866-408-6132**
  - Healthy Indiana Plan: **844-533-1995**
  - Hoosier Care Connect: **844-284-1798**
- If you have additional questions, contact your Provider Experience representative

Provider Experience Physical Health Zone Map

Physical health Provider Experience managers

Zone 1/Beacon Health Systems

Jessi Earls
Jessica.Wilkerson-Earls@anthem.com
317-452-2568

Zone 2/Ascension St. Vincent

Angelique Jones
Angelique.Jones@anthem.com
317-619-9241

Zone 3

Jamaal Wade
Jamaal.WadeSr@anthem.com
317-409-7209

Zone 4/Deaconess

Jonathan Hedrick
Jonathan.Hedrick@anthem.com
317-601-9474

Zone 5/Parkview

David Tudor
David.Tudor@anthem.com
317-447-7008

Zone 6/IU Health; St. Joseph Regional Medical Health Center; Home Health and Hospice

Matt Swingendorf
Matthew.Swingendorf@anthem.com
317-306-0077

Zone 7/Baptist Health

Sophia Brown
Sophia.Brown@anthem.com
317-775-9528

Zone 8/Eskenazi

Marvin Davis
Marvin.Davis@anthem.com
317-501-7251

Zone 9/Out-of-state providers, Franciscan, Community Health Network

Nicole Bouye
Nicole.Bouye@anthem.com
317-517-8862

Dir, Provider Experience
Jacquie Marsalis
Jacqueline.Marsalis@anthem.com

https://providers.anthem.com/docs/gpp/IN_CAID_PU_NetworkRelationsMap.pdf?v=202110061311

Provider Experience Behavioral Health Subject Matter Experts

Statewide behavioral health (BH) subject matter experts (SME)

Acute hospitals
Tish Jones, Provider Experience Manager
Latisha.Willoughby@anthem.com
317-617-9481

Community mental health centers/federally qualified health centers/rural health clinics
Matthew McGarry, Provider Experience Manager
Matthew.McGarry@anthem.com
463-202-3579

Substance use disorder (SUD)/Opioid treatment program (OTP)
Alisa Phillips, Provider Experience Manager, Sr.
Alisa.Phillips@anthem.com
317-517-1008

SME – SUD/OTP
Michele Weaver, Provider Experience Manager
Michele.Weaver@anthem.com
317-601-3031

Solo BH and applied behavior analysis providers

Zones 1, 2, 5, 6
Ashley Holmes
Ashley.Holmes@anthem.com
317-315-0623

Zones 3, 4, 7, 8
Whit'ney McTush
Whitney.McTush@anthem.com
317-519-1089

UM contacts for Anthem

- **Physical health UM:**
  - Inpatient/Continued Stay Review:
    - Tara Wallace, RN Manager:
      - tara.wallace@anthem.com
    - Kasey Reisman, RN Manager:
      - kasey.reisman@anthem.com
  - Outpatient:
    - Terrie Sproat RN Manager:
      - terrie.sproat@anthem.com
- **Behavioral health UM:**
  - Inpatient/Continued Stay Review/Outpatient:
    - Amy McConnell, LCSW Manager:
      - amy.mcconnell2@anthem.com
    - Holly Gregory, LCSW Manager:
      - holly.gregory@anthem.com

Questions

Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

* Availity LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

https://providers.anthem.com/in

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

INBCBS-CD-006967-22 September 2022