

Indiana | Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care
Connect, and Indiana PathWays for Aging

Prior Authorizations

2026 Indiana Health Coverage
Programs (IHCP) Works Annual
Seminar



Agenda

- Anthem's Indiana Medicaid programs
- Indiana PathWays for Aging Dual Care
- Turnaround Times
- Types of Case Denials for Medical Benefits
- How to Reduce Risk of Denial
- Post-Denial Options
- New: Peer-to-Peer Self-Scheduling in Availity
- Clinical Criteria Hierarchy by Department
- Prior Authorization Look Up Tool (PLUTO)
- Availity Usage for Increasing Efficiency
- Face-to-Face Requirements

Anthem Indiana Medicaid Programs

- Healthy Indiana Plan:
 - Available to low-income adults ages 19 to 64, this program provides health coverage that encourages active participation in health management through cost-sharing and preventive care benefits
- Hoosier Healthwise:
 - Provides health coverage for Indiana children up to age 19 and pregnant women in low-income families
- Hoosier Care Connect:
 - Tailored for Indiana residents who are aged 59 years and younger, blind, or disabled, and who are also not eligible for Medicare
- Indiana PathWays for Aging:
 - Designed for aging Indiana residents aged 60 and over, eligible for a full coverage aged, blind, or disability category (with or without Medicare), can be receiving long-term support services such as long-term care facility or are approved for a PathWays waiver, can be on the Behavioral and Primary Health Coordination program. This program offers access to resources and health services that promote independence and enhance quality of life

Indiana PathWays for Aging Dual Care

- PathWays Dual Care: Member has both Medicare and Medicaid benefits:
 - Example: Medicare through Anthem and Medicaid PathWays through Anthem
- Utilization Management (UM) Reviews
 - One member identification number
 - Medicare will review for both Medicare and Medicaid
 - Single UM decision letter



Turnaround Times

Turnaround time (TAT) requirements improve transparency and provide clear timelines for prior authorization decisions.

Prior Authorization TAT:

- Standard pre-service (non-urgent): 48 hours from the received date and time
- Urgent/expedited pre-service: 24 hours from the received date and time
- Concurrent review: 48 hours from the received date and time
- Retrospective review: 30 calendar days from the received date
 - This applies to requests for admission that are received on or after the date the member has been discharged from inpatient care

All TATs exclude weekends and state and federal holidays.

Types of Case Denials for Medical Benefits

- Medical necessity denials:
 - Anthem's Policy or MCG Criteria not met
- Administrative denial reasons:
 - Late notification
 - Benefit exhaustion
 - Failure to obtain prior authorization
 - Non-covered service
 - Ineligible on date of service



How to Reduce Risk of Denial

- Submit clinical documentation with a fully completed [IHCP Prior Authorization Request Form](#) to avoid delays that may result in late notification denials.
- Clear and concise clinical documentation helps minimize medical necessity denials by ensuring reviewers have the information needed to make a determination.
- Verify member eligibility prior to submitting a prior authorization request. The IHCP Provider Healthcare Portal is an excellent resource: [Indiana Medicaid Provider Healthcare Portal](#).
- Double-check member eligibility and that there is an approved prior authorization before elective inpatient admissions.
- Post acute providers should plan ahead to avoid benefit exhaustion denials.

Post-Denial Options: Reconsideration

- Reconsideration:
 - Request within 7 business days of the denial date via fax or online on the [Availity Essentials website](#).
 - Submit additional clinical information to the health plan and indicate “reconsideration” on the fax coversheet or in the Availity Essential note.
 - A decision will be rendered within 7 calendar days of the reconsideration request.
 - Fax to specific department:
 - Physical Health Inpatient UM: 844-765-5156
 - Physical Health Outpatient UM: 844-765-5157
 - Behavioral Health Inpatient UM: 844-452-8074
 - Behavioral Health Outpatient UM: 844-456-2698
 - Reconsideration determinations are sent via surface mail notification letters with fax confirmation.

Post-Denial Options: Peer-to-Peer and Appeal

- Peer-to-Peer:

- Request within 7 business days of denial date (initial or reconsideration) for Healthy Indiana Plan, Hoosier Healthwise, and Hoosier Care Connect.
- Request within 15 business days of denial date (initial or reconsideration) for Indiana PathWays for Aging.
- Call 866-902-4628 > option 1 for IN > subsequent option 1 for physical health, option 2 for behavioral health.
- Peer-to-peer determinations are sent via notification letter with fax confirmation.
- Peer-to-peer reviews are completed within 48 hours of the request.

- Appeal:

- Request within 60 calendar days of the denial date.
- Fax appeal request and clinical to 855-516-1083, for oral or written instructions, see [Anthem's provider manual](#) > grievances and appeals chapter.
- A decision will be rendered within 30 calendar days unless the request is expedited, in which case the request will be responded to within 48 business hours.

New: Peer-to-Peer Self-Scheduling in Availity

Available now for Anthem's Indiana Medicaid providers
Launched July 2026

What's new:

- Providers can schedule, reschedule, or cancel peer-to-peer reviews 24/7 through [Availity Essentials](#).

Benefits:

- Faster appointment confirmation and real-time visibility
- Easy online rescheduling and cancellation
- Less administrative work for provider staff

Important to know:

- The existing peer-to-peer call-in line remains available.
- Self-scheduling is not available for administrative denials or third-party vendors at this time.
- Reviews must be verbal discussions between a physician and another physician, nurse practitioner, or physician assistant.

Clinical Criteria Hierarchy by Department

Physical Health:

- Outpatient services:
 - State-approved criteria are used to determine that the member is receiving medical necessity treatment and at an appropriate level of care.
- Inpatient services:
 - Non-customized MCG are utilized to make medical necessity decisions.
 - Exception: inhaled nitric oxide is reviewed using a state-approved Anthem guideline.

Behavioral Health:

- Non-customized MCG criteria are utilized to make medical necessity decisions for psychiatric requests.
- Non-customized MCG and American Society of Addiction Medicine (ASAM) criteria are utilized to make medical necessity decisions for substance use disorder requests.
- State-approved Anthem clinical UM guidelines and Medical Policies.

Prior Authorization Lookup Tool (PLUTO)

- Allows providers to search procedure codes to determine whether prior authorization is required.
- Search by the specific line of business (Medicaid/SCHIP/Family Care, Medicaid Hoosier Care Connect, Medicaid - PathWays).

Line of Business

Select Line of Business
Medicaid/SCHIP/Family Care
Medicaid Hoosier Care Connect
Medicaid - PathWays
Medicare

- Identifies which clinical guideline will be used for the case review.
- Prior authorization lookup tool is available at the Anthem provider website ([Precertification lookup tool](#)).

Availity Essentials Usage for Increasing Efficiency

- Benefits of using Availity Essentials:
 - Real-time prior authorization submission
 - Easy access to determination letters
 - Easy upload of clinical documentation
- For training on how to use Availity Essentials: <https://www.availity.com/customer-support/>
- For other ways to submit UM requests, refer to the most up-to-date [Anthem Medicaid Provider Manual](#).

Face-to-Face Requirements

What is a face-to-face?

- Documentation of a face-to-face encounter in accordance with 42 CFR 440.70(f) is required.
- The face-to-face encounter must occur no more than 90 calendar days before or 30 calendar days after the start of services.

When is a face-to-face needed?

- Initial start of care
- Increase in home health hours due to a change in the member's condition
- Break in service, which is defined as an interruption in service of 60 calendar days or more from the end of the last authorization period
- Annually on a rolling 12-month basis that is within 90 calendar days prior or 30 calendar days after the previous year's face-to-face date

Face-to-Face Requirements Additional Information

- The functional assessment must support the need for home health from the physician or nurse practitioner.
- The documentation must include:
 - The date the practitioner saw the patient.
 - Detailed clinical findings from the visits.
 - Clear connections between clinical findings and home healthcare needs.
- The face-to-face encounter must be documented by the provider; home health agencies cannot create the documentation for the provider's signature.
- For all face-to-face requirements, refer to *IHCP Bulletin* [BT2025104](#).

UM Contacts for Anthem

Physical health UM:

- Director:
 - Samantha Mummert, MSN, RN samantha.mummert@anthem.com
- Inpatient/Continued Stay Review:
 - Kasey Reisman, RN Manager kasey.reisman@anthem.com
 - Daniel Peters, RN Manager daniel.peters@anthem.com
- Outpatient:
 - Terrie Sproat, RN Manager terrie.sproat@anthem.com

Behavioral health UM:

- Inpatient/Outpatient/Continued Stay:
 - Amy Kountz, DBH, LCSW Manager amy.kountz@carelon.com

Questions



Thank you

- We'd like to know how this presentation helped you, and if there is any additional information or clarification we could offer.
- Please take a moment to complete the survey by scanning the QR code or following [this link](#).





Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging 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. Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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