Prior authorization (PA) 201

2021 Indiana Health Coverage Programs (IHCP) Works virtual seminar
Terms

- **PA** — Prior authorization
- **UM** — Utilization management
- **HIP** — Healthy Indiana Plan
- **IHCP** — Indiana Health Coverage Programs
- **ICR** — Interactive Care Reviewer
Retroactive eligibility

Frequent questions from providers:

• How do I obtain a retro review request for a member who was ineligible upon inpatient admission and is now showing eligible?
• How do I obtain a retro review request for a Healthy Indiana Plan (HIP) Fast Track member?
• How do I submit a request for newborns who have no Medicaid ID?
How do I obtain a retro review request for a member who was ineligible upon inpatient admission and is now showing eligible?
Retroactive eligibility occurs when a member’s effective date of coverage is back-dated by the state. This can happen for various reasons for example:

- Member was on presumptive eligibility then moved to HIP, and their coverage was back dated.
- Member made their Fast Track payment, and eligibility was back dated to the first of the month of the payment.
Retroactive eligibility can result in administrative denials (denials for reasons other than medical necessity), such as:

- Claims filed past the filing limit.
- Failure to obtain prior authorization (PA).
- Failure to notify utilization management (UM) in a timely manner.
For patients believed to have retroactive eligibility and the patient has not been discharged (has an active case):

- If PA is required but was not performed timely, submit the request to UM as soon as eligibility is confirmed:
  - Include documentation to identify the reason the notification was not submitted in a timely manner (for example, member became retro-eligible).
  - If retro-eligibility is confirmed, the services will be reviewed for medical necessity back to the first day of eligibility.
For patients believed to have retroactive eligibility and the patient has already been discharged from inpatient care or the outpatient service has already been rendered:

- If PA is required and the request is outside of timely notification requirements:
  - File the claim normally.
  - When the claim is administratively denied for failure to obtain PA, you may dispute the claim, providing support and documentation of retroactive eligibility.
  - If the original administrative determination (denial) is overturned as a result of the dispute, the claim will be reviewed for medical necessity.
  - If medical necessity criteria are met, the claim will be reprocessed, or the provider will be notified of any actions they need to take to obtain reimbursement.
Provider claims disputes:

- The claims dispute form can be submitted:
  - Through Availity* at: [https://www.availity.com](https://www.availity.com)
  - Access the [Provider Dispute Resolution Request Form](https://www.providers.anthem.com/in) on our provider website at [https://providers.anthem.com/in](https://providers.anthem.com/in):
    - Submit via mail:
      Provider Disputes and Appeals
      Anthem Blue Cross and Blue Shield
      PO Box 61599
      Virginia Beach, VA 23466
    - Verbally (claim reconsideration only)
      - Hoosier Healthwise: **866-408-6132**
      - Healthy Indiana Plan: **844-533-1995**
      - Hoosier Care Connect: **844-284-1798**
Retroactive eligibility — Fast Track for HIP members

How do I obtain a retro review request for a HIP Fast Track member?
Retroactive eligibility — Fast Track for HIP members (cont.)

- This applies only to individuals ages 19 to 64, whom you have assisted with submitting an IHCP application with a Fast Track prepayment.

- **This process must be completed within five days of the date of inpatient admission:**
  - You must help your patient complete an application for health coverage using the *IHCP Fast Track Application*.
  - You must assist your patient with submitting the Fast Track prepayment of $10 as part of the application process.
  - After assisting with the application for health coverage, you must complete an *IHCP Fast Track Notification Form*, which is located on our provider website at https://providers.anthem.com/in > Resources > Forms > Other Forms. For your patients who have chosen Anthem Blue Cross and Blue Shield (Anthem) as their managed care organization, fax the form to **855-841-5669**.
Retroactive eligibility — Fast Track for HIP members (cont.)

- Anthem will check every week to see if the member has become HIP eligible. After eligibility has been established, Anthem will send the completed *IHCP Full Eligibility Notification Form* to your office via fax at the fax number supplied at the time of admission. Anthem will notify your office within seven days of verifying eligibility.

- Once Anthem has confirmed enrollment, you may submit PA requests via Interactive Care Reviewer (ICR) or fax for services rendered beginning the first day of the month the Fast Track payment was made. Before submitting your PA requests, you must verify eligibility using the IHCP Provider Healthcare Portal available at [https://www.in.gov/Medicaid/providers/723.htm](https://www.in.gov/Medicaid/providers/723.htm).
You must submit the **PA request and the completed *IHCP Full Eligibility Notification Form* within 60 days of receiving the form.** Failure to submit the form with PA requests will result in a denial.

These requests, when submitted timely, will be reviewed for medical necessity, regardless of discharge status.
Retroactive eligibility — Fast Track for HIP members (cont.)

Submitting a prior authorization request and clinical:

- Providers may request prior authorization and submit clinical through the Interactive Care Reviewer (ICR) portal. ICR is accessible via Availity at [https://www.availity.com](https://www.availity.com).

- Providers may call Anthem to request prior authorization for inpatient health services using the following phone numbers:
  - Hoosier Healthwise: **866-408-6132**
  - Healthy Indiana Plan: **844-533-1995**
  - Hoosier Care Connect: **844-284-1798**

- Fax *IHCP PA Form* and physical health inpatient clinical information to:
  - UM intake team: **866-406-2803**
  - Health plan inpatient: **844-765-5156**
Retroactive eligibility — Fast Track for HIP members (cont.)
How do I submit a request for newborns who have no Medicaid ID?
Newborns are assigned to the same managed care entity as the mother, retroactive to the date of birth:

- Hospitals should report all Medicaid newborns to the state as quickly as possible so a permanent Medicaid member ID can be assigned.
- Providers should report these births to Anthem UM within three days.
- Providers may contact Provider/Member Services to request a temporary ID number:
  - Hoosier Healthwise: 866-408-6132
  - Healthy Indiana Plan: 844-533-1995
  - Hoosier Care Connect: 844-284-1798
- The temporary ID will allow providers to request PA and submit newborn claims until a permanent ID is assigned.
Retroactive eligibility

For the full provider notifications:

• **Retroactive eligibility — prior authorization/utilization management and claims processing**
• **Prior authorization process for Fast Track prepayment**
• **Temporary newborn cases**
• For other provider notifications, visit the provider website at https://providers.anthem.com/in.
If you have questions, providers may contact Provider/Member Services Monday to Friday, 8 a.m. to 8 p.m. ET at:

• Hoosier Healthwise: 866-408-6132
• Healthy Indiana Plan: 844-533-1995
• Hoosier Care Connect: 844-284-1798
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
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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.
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