Important Utilization Management Information

Where to Find Medical Policies and Utilization Management Clinical Guidelines

To learn more about our medical policies, please visit our website at www.anthem.com/ca. Choose Information for: Providers on the bottom right, and under Learn More, click on State Sponsored Plans. On the left side of the screen, click Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements. Then, in the middle of the screen, click on Medical Policies and Clinical UM Guidelines (for Local Plan members). You now have the ability to search through all documents pertaining to this subject.

These criteria are available to members, physicians, and other health care providers upon request by contacting the Utilization Management (UM) department at 1-888-831-2246, 8 a.m. to 5 p.m., Monday through Friday, excluding holidays.

More Information Available Regarding Utilization Management

Anthem Blue Cross makes a variety of information regarding Utilization Management available on our provider resources website. This includes detailed information outlined in our Provider Operations Manual. To find this information, go to http://www.anthem.com/ca and follow these web steps:

> Select INFORMATION FOR: Providers
> under Learn More, click State Sponsored Plans
> under Provider Communications, choose the link Provider Operation Manuals and Important Updates
> at the top of the page, open Provider Operations Manual for Medi-Cal.

Within the Utilization Management chapter of the Provider Operations Manual, you will find the following information:

- Affirmative Statement
- How to reach a physician reviewer
- How to reach utilization management staff
- Staff response time and hours of operation of the Utilization Management department
- How to reach us by fax and phone, including TTY and our ability to communicate using telephone interpreters in a variety of languages, including all threshold languages required by the state of California.
- How to obtain Utilization Management criteria

Within the case management chapter, we make information available on how to refer your patients enrolled in state sponsored programs into our complex case management programs.

Urgent Request

Please note that we define an urgent request as the following:

Urgent Request: Any request for coverage of medical care or treatment with respect to which the application of the periods for making non-urgent care determinations could result in the following circumstances:

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• Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
• In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be managed adequately without the care or treatment that is the subject of the request.

Medical Necessity Determination of Coverage

When requesting a determination of coverage based on medical necessity, it is important you provide the clinical reviewer with sufficient clinical information, including but not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Patient's psychosocial history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitative evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members
- Information from responsible caregiver

Actions Taken to Increase Provider Satisfaction

Anthem Blue Cross is committed to continuously improving provider satisfaction. Here are just some of the upgrades we’ve made:

- Several UM initiatives have taken place to simplify work processes and transition functions to non-clinical staff, where appropriate. The ultimate goal is to improve customer satisfaction through quicker decisions and lower overall administrative costs of reviews. Some examples:
  - Revised authorization indicator and network tools to enable more authorization approvals at time of intake.
  - Increased use of non-clinical staff to assist with decision notifications.
  - Integrated Case Management and Network Services to streamline authorization for out-of-network requests and improve communication gap between UM and Contracting.
  - Implemented RightFax FileNet to simplify the process of receiving faxes within UM.
- Initiated use of the full spectrum of Milliman guidelines to increase the number of cases that could be managed by a nurse versus a medical director.
- Implemented procedure for concurrent stay review staff to assess DRG-based facilities differently than per diem-based facilities. Staff may now authorize seven days stay at one time, once a case meets initial Milliman admission guidelines.
- Implemented new peer-to-peer reconsideration workflow. This allows the physician clinical reviewer permission to overturn an adverse determination within 30 days of a denial, when we receive new clinical information. The appeal process would be required after the 30 days.
• Implemented new Primary Health Management Model within Medical Management. We realigned staff within this Model to allow them to focus their attention on specific regions to strengthen relations with our providers and improve continuity of care and improvements in reporting and documentation consistency. This includes selected UM and CM staff who are now dedicated to only California member cases for state sponsored programs. Within this Model, case managers will perform concurrent stay review and prior authorization functions for members with complex care, to decrease the number of handoffs. The new Model has allowed case managers more involvement with our hospitalized members as they now work more closely with concurrent stay review nurses and assume the discharge planning responsibilities for the more complex hospitalized patients.

• Implemented reduced prior authorization list that provides consistency for our providers throughout multiple lines of business in California, as well as eases the authorization process.

• Transitioned to a new claims system. Migrating to the new environment enhances the quality of our operations and creates greater efficiencies for state partners, members and providers. This transition continues our efforts to achieve parity with nationally accepted coding guidelines and industry standards and practices, as well as to enhance accurate, efficient claims processing.