

Anthem Blue Cross and Blue Shield in Connecticut Precertification/Prior Authorization Guidelines

The following guidelines apply to Anthem Blue Cross and Blue Shield (“Anthem”) products issued and delivered by Anthem in Connecticut. For information on precertification/prior authorization requirements for those members of National Accounts please call the number on the member’s card. To verify member eligibility, benefits and account information please call the telephone number listed on the back of the member’s identification card.

Precertification/Prior authorization is the determination by Anthem that selected inpatient and outpatient medical services (including surgeries, major diagnostic procedures and referrals) are medically necessary. For the member to receive maximum benefits, Anthem must authorize the services for which precertification/prior authorization is required prior to being rendered. Precertification/prior authorization can help avoid unnecessary charges or penalties by helping to ensure that the member's care is medically necessary and administered at an appropriate network facility and by a network provider.

Precertification/Prior authorization includes:

- a review of both the service and the setting.
- Care will be covered according to the member's benefits for the number of days authorized unless our concurrent review determines that additional days qualify for coverage.
- Certain services may require the member to use a provider designated by Anthem's Utilization Management staff.
- A copy of the approval will be provided to the member and the physician or provider of service.
- For benefits to be paid, the member must be eligible for benefits and the service must be a covered benefit under the contract at the time the services are rendered and the member must not have exceeded any benefit limitations under their plan.

Responsibility for Precertification/Prior authorization:

For HMO type health plans: Under our HMO plans and products:

It is the participating physician’s or provider’s responsibility to contact Anthem’s Utilization Management Department at (800) 238-2227, or such other number indicated below for specific services, to obtain precertification/prior authorization.

The request must come from the provider or facility rendering the service, not the referring physician, except where described below for specific services.

If precertification/prior authorization is not obtained, the claim payment may be

reduced or denied by the Plan and the member must be held harmless.

For PPO type health plans: Under our PPO plans and products:

Services provided by a network provider: The provider is responsible for Precertification/Prior authorization Services provided by a BlueCard® or non-participating provider: The member is responsible for Precertification/Prior authorization

The member is financially responsible for services and/or settings that are not covered under the certificate based on an adverse determination of medical necessity or experimental or investigational services.

Contact Anthem's Utilization Management Department to obtain precertification at: (800) 238-2227, or such other number indicated below for specific services.

The precertification number is listed on the back of the member's Anthem ID card.

Inpatient Surgical/Inpatient Medical Admission: Precertification is required for the following services:

- Elective admissions
- Emergency admissions - Anthem must be notified within 48 hours or two business days
- Gastric bypass surgery
- Human organ and bone marrow/stem cell transplants
- Inpatient hospice
- Inpatient rehabilitation admissions
- Inpatient skilled nursing facility admission
- OB (obstetrical) related medical stay, excludes childbirth

Services listed above are effective and current as of July 1 2019. For benefits to be paid, the member must be eligible on the date of service and the service must be a covered benefit under the policy. This list is subject to change and is not all inclusive

No Precertification for Emergencies

Precertification is not required for emergency admissions. However, to ensure that members receive the maximum coverage possible, Anthem must be notified about the admission within 48 hours or as soon as reasonably possible. Failure to notify Anthem may result in denial of claims for services that we determine are not medically necessary under the benefits contract.

Precertification/Prior Authorization is required for the following services:

- Ablative techniques for treating Barrett's esophagus
- ALCAT
- Blepharoplasty, blepharoptosis repair, and brow lift
- Breast surgery (female and male excluding breast biopsy)
- Cochlear implant and auditory brain stem implant

Cranial/facial surgery
 Genetic testing – see below
 Hyperbaric oxygen therapy (systemic/topical)
 Implantable infusion pumps
 Intraocular implant/shunt
 Locally ablative techniques for treating primary and metastatic liver malignancies
 Lung volume reduction surgery
 Maze procedure
 Nasal/sinus surgery
 Out of network referrals/services
 Physical therapy, occupational therapy and speech therapy
 Potential cosmetic/reconstructive procedures of the skin, head/neck, upper extremity, or lower extremity
 Sclerotherapy
 Selected diagnostic testing: e.g. sleep disorders
 Selected injectable therapy- e.g. Synagis,
 Selected surgery: e.g. TMJ, varicose veins, total ankle replacement, gender reassignment, transcatheter uterine artery embolization
 Selected outpatient diagnostic imaging – see below
 Specialized durable medical equipment– customized equipment
 Stem cell/bone marrow transplant (with or without myeloablative therapy) and donor leukocyte infusion
 Testicular/penile prosthesis
 Treatment of hyperhidrosis
 Uvulopalatopharyngoplasty (UPPP)
 Ventriculectomy/cardiomyoplasty
 Wearable cardioverter-defibrillators

Precertification/Prior Authorization is recommended for the following services

Air and water ambulance
 Ambulatory EEG
 Cooling Devices and Combined Cooling/Heating Devices
 Electrical bone growth stimulator
 Hysterectomy
 Infertility treatment
 Myocardial sympathetic innervations imaging with or without SPECT
 Neuromuscular stimulator
 Private duty nursing
 Select specialty pharmacy drugs - e.g., ESA (erythropoiesis stimulating agents)
 Epogen, Procrit, Aranesp, IVIG, Remicade
 Skilled nursing services in the home (fully insured only)
 Spinal surgery
 Therapeutic Apheresis
 Total Hip Arthroplasty
 Total Knee Arthroplasty

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Prior authorization/preservice clinical review for medical non-oncology specialty drugs regardless of service date, may be submitted by contacting Anthem's medical specialty drug review team:

- by phone at 833-293-0659 or
- by fax at 888-223-0550 or
- online access at availity.com available 24

Prior authorization/Preservice clinical review is required through AIM for the following non-emergent outpatient services for members of most of our commercial plans and products:

Arterial Ultrasound
Cardiac Catherization
CT
Coronary Angiography
Echo cardiology [stress echocardiography (SE), transesophageal echocardiography (TEE), and resting transthoracic echocardiography (TTE)]
Genetic Testing
Medical oncology drugs
MLST (multi-level Sleep Study)
MRA/MRI
Non Invasive Diagnostic Vascular Studies
Nuclear cardiology
PET
Percutaneous Coronary Intervention (PCI)
Polysomnography, home sleep study and home portable monitors
Radiation therapy (IMRT, proton beam, brachytherapy, SRS, SBRT)
Upper Gastrointestinal Endoscopy (EGD) in adults

Providers may contact AIM for prior authorization/preservice clinical review medical necessity reviews of the services listed above through the following options:

Access AIM *ProviderPortal*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.

Access AIM via the Availity Web Portal at availity.com

Call the AIM Contact Center toll-free number: 866-714-1107, Monday – Friday, 8:00 am - 5:00 pm.

Services listed above are effective and current as of July 1 2019. For benefits to be paid, the member must be eligible on the date of service and the service must be a covered benefit under the policy and administered in the appropriate setting. This list is subject to change and is not all inclusive

Mental Health/Substance Abuse Services

Anthem's mental health and substance abuse benefits in Connecticut are administered by professionals who are specially trained to handle referrals and coordinate care for mental health and substance abuse. Call (800) 934-0331 for:

Inpatient behavioral health and substance abuse admissions

- Partial hospital program (PHP)
- Intensive outpatient programs (IOP)
- Intensive in-home services
- Transcranial magnetic stimulation (TMS)
- Applied behavior analysis (ABA)
- Extended Day Treatment

Pre-certification for psychological testing and outpatient services varies by products and plan, please contact the appropriate state's customer service number for requirement or when verifying eligibility. Professionals are available 24 hours a day, seven days a week.

Services listed above are effective and current as of July 1 2019. For benefits to be paid, the member must be eligible on the date of service and the service must be a covered benefit under the policy. This list is subject to change and is not all inclusive.

UM Decisions- Appropriateness of Care and Services

As part of our goal to improve the health of the members we serve, we are committed to promoting appropriate utilization of medical services. Please note the following:

Individuals who make utilization management decisions do not receive compensation or incentives to deny care. This also applies to individuals who supervise them, including management, medical directors, utilization management managers and licensed staff. Utilization management decisions are based only on appropriateness of care and services and existence of coverage. The plan does not specifically reward for denial of services, or offer incentives to encourage denial of services.

UM Criteria is Available to Physicians/Providers

Physicians and health care providers may request that we provide the specific criteria utilized to render a medical necessity determination. If a treating physician or provider would like to request a copy of specific UM criteria, they may call the Utilization Management Department at: (800) 437-7162.

Physician Reviewers are Available to Discuss Utilization Management Decisions

Our physician reviewers are involved in utilization management determinations that result in a denial of benefits and are available to discuss the determinations by calling (800) 437-7162.

For details on Pharmacy Precertification Requirements please visit our pharmacy website. (link available on the Provider Home page)