CHAPTER 7: UTILIZATION MANAGEMENT

OVERVIEW

The Plan’s Utilization Management (UM) program is collaboration with providers to promote and document the appropriate use of health care resources. The program reflects the most current utilization management standards from the National Committee for Quality Assurance (NCQA).

The UM department takes a multidisciplinary approach to provide health care services in the setting best suited for the medical and psychosocial needs of the member based on benefit coverage, established criteria, and the community standards of care.

Role of Utilization Management

In conjunction with providers, UM assists in providing the right care to the right member, at the right time, in the appropriate setting.

Service Reviews

The UM department provides precertification, concurrent, and post-service reviews using clinical criteria based on sound clinical evidence. These criteria are available to members, physicians, and other health care providers upon request by contacting the UM department at 866-398-1922.
Availability of UM Staff

The Plan ensures availability of UM staff at least eight hours a day on normal business days to answer UM-related calls. Member or provider UM-related calls received through the Member Customer Service/Provider Inquiry phone number are triaged to, and handled by, UM staff. Utilization Management can be reached at 866-398-1922.

After normal business hours, an answering service is available to take UM-related messages. A UM staff member will return the call the next business day. Eligibility verification, benefits and network information may be available after normal business hours through our protected website.

Decision Making

The Plan makes UM decisions affecting the health care of members in a fair, impartial, consistent, and timely manner. We do not reward practitioners and other individuals conducting utilization review for issuing denials of coverage or care. There are no financial incentives for UM decision makers that encourage decisions that result in under-utilization.

The Utilization Management Committee (UMC) meets at least every other month and supports the Quality Operations Committee (QOC) in appropriate provisions of medical services and provides recommendations for utilization management activities.

Decision and Screening Criteria

Decision and notification time frames for approval, modification, deferral, and denial are in alignment with the National Committee for Quality Assurance (NCQA), contracts and other applicable legislation.

The UM department applies Milliman Care Guidelines and Clinical Guidelines for utilization management screening and decisions. UM does not rely solely on these guidelines, but also gives consideration to the clinical information that is provided, as well as the individual health care needs of the member.
Decision criteria incorporates nationally recognized standards of care and practice from sources such as the American College of Cardiology, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Orthopedic Surgeons, current professional literature, and cumulative professional expertise and experience. The decision criteria used by the clinical reviewers are evidenced-based and consensus-driven. We periodically update criteria as standards of practice and technology change. We also involve actively practicing physicians in the development and adoption of the review criteria.

These criteria are available to members, physicians, and other health care providers upon request by contacting the UM department at 866-398-1922.
### PRECERTIFICATION REVIEW

The services listed below require precertification review by Anthem Blue Cross and Blue Shield for all Healthy Indiana Plan members. This list will be updated as needed.

All providers are responsible for verifying eligibility and authorization for non-emergent services prior to rendering services to a Plan member. For benefits to be paid, the member must be eligible on the date of service and the service must be a covered benefit. Except in an emergency, failure to obtain prior authorization for the designated services below may result in a denial for reimbursement.

<table>
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<tr>
<th>Prior Authorization</th>
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<tbody>
<tr>
<td><strong>Inpatient Admission:</strong></td>
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<tr>
<td>Electrolyte Admissions</td>
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<td>Emergency Admissions (Anthem requires Plan notification within 24 hours)</td>
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<tr>
<td>Inpatient Skilled Nursing Facility (SNF)</td>
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<td>Long Term Care Facility (LTAC)</td>
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<td>Rehabilitation Facility admissions</td>
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<td>Inpatient Hospice Respite Care</td>
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<td>Bariatric Surgery</td>
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<tr>
<th>Outpatient Services:</th>
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<tr>
<td>Bariatric Surgery</td>
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<tr>
<th>Radiology Services:</th>
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<tr>
<td><strong>NOTE THE SEPARATE RADIOLOGY PRECERTIFICATION PHONE NUMBER</strong></td>
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<tr>
<td>Nuclear Cardiology</td>
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<td>CT Scan</td>
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Human Organ and Bone Marrow/Stem Cell Transplants (Predetermination of Benefits is Required)

- Inpatient Admits for ALL solid organ and bone marrow/stem cell transplants
- All outpatient services for the following:
  - Stem Cell/Bone Marrow Transplant (with or without myeloablative therapy)
  - Donor Leukocyte Infusion

Out-of-Network Referrals

Out-of-Network Referrals (may be preauthorized based on network availability and/or medical necessity). Out-of-Network services must be rendered by an IHCP provider.

Mental Health/Substance Abuse (MHSA)

- All facility based care:
  - Inpatient admissions
  - Intensive outpatient program (IOP)
  - Partial Hospitalization program (PHP)
  - Residential Care

If precertification is late** or not obtained for any of the Blue products, Anthem’s reimbursement will be reduced for medically necessary services, including the facility, inpatient medical visits and the surgeon, as follows:

- 30 percent for elective inpatient admissions (including skilled nursing facility stays, rehabilitation admissions, hospice)
- 100 percent (no payment) for outpatient procedures
- Providers may not balance bill the member for any such reduction in payment.

**Late is defined as one business day after date of service. Late call penalties are not assessed for emergency admissions.
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For details about pharmacy precertification requirements, visit www.anthem.com or call pharmacy prior authorization at 800-338-6180.

What to Have Ready When Calling Utilization Management

To request precertification review or report medical admission, call the Utilization Management (UM) department at 866-398-1922.

To help the process be as quick as possible, have the following information ready when calling:

- Member name and ID number including YRK prefix
- Diagnosis with the International Classification of Diseases, 9th Revision, (ICD-9) code
- Date of injury/date of hospital admission and third-party liability information (if applicable)
- Facility name (if applicable)
- Primary Care Physician (PCP) name
- Specialist or attending physician name
- Clinical justification for the request
- Level of care
- Results of lab tests, radiology and pathology results
- Medications
- Treatment plan with time frames
- Prognosis
- Psychosocial status
- Exceptional or special needs issues
• Ability to perform activities of daily living
• Discharge plans

Physicians, hospitals and ancillary providers are required to provide information and documentation to UM. Physicians are also encouraged to review their utilization and referral patterns.

Precertification Review Time Frame

For routine non-urgent requests, the UM department will complete a precertification review within 14 calendar days from request. We will send requests that do not meet medical policy guidelines to our physician or medical director for review. We will notify providers by phone or fax within 14 calendar days from the receipt of the request of the UM decision, and will send the member and requesting provider a written notification by mail within 14 calendar days from the receipt of the request of any denial or deferral decision.

Requests with Insufficient Clinical Information

For precertification requests with insufficient clinical information, the Plan contacts the provider with a request for the clinical information reasonably necessary to determine medical necessity. We make one or two attempts to contact the requesting provider to obtain the additional necessary clinical information. If we do not obtain a response, we will send a Deferral—Lack of Medical Information letter to the member and provider.

This deferral letter includes specific information that we need to make a decision. If we do not receive the information, we send a denial letter to the member and provider within 14 calendar days from receipt of the request. We extend the deferral time frame for another 14 calendar days if the member or the provider requests an extension.

For urgent requests, the UM department completes precertification review within 72 hours (3 days) from receipt of the clinical information necessary to render a decision.
Generally speaking, the provider is responsible for contacting the Plan to request precertification review for both professional and institutional services. However, the hospital or ancillary provider should always contact the Plan to verify precertification review status on all non-urgent services before rendering services.

**Radiology Utilization Program**

Please note that the Radiology Utilization Program has a separate precertification phone number: **888-730-2817**

For a complete listing of the Radiology Pre-Certification CPT Codes the document is located on [www.anthem.com](http://www.anthem.com) under the Answers@Anthem section. We recommend checking this document periodically for updates.

Outpatient diagnostic imaging services performed in the emergency room, at an urgent care, at an ambulatory surgery center, or during an inpatient or observation stay will not require pre-certification.

Pre-certification requests must be submitted by the ordering providers using the online tool or by calling **888-730-2817**. If the requested service meets medical necessity criteria, the web technology has the ability to render an immediate approval decision. If your request is urgent medical nature please call the Radiology Call Center at **888-730-2817**.

We are committed to working with providers to help ensure that members receive high quality, appropriate services and are able to utilize the highest level of benefit from their health plan.

If you have any questions please contact your local Network Management representative or Provider Inquiry.
Emergency Medical Conditions and Services

The Plan does not require prior authorization for treatment of emergency medical conditions. In the event of an emergency, members can access emergency services 24 hours a day, 7 days a week. In the event an emergency room visit results in the member being admitted to the hospital, Anthem must be contacted within 24 hours of the admission.

Members who call their PCP’s office reporting a medical emergency (whether during or after office hours) are directed to dial 911 or told to go directly to the nearest hospital emergency department. All non-emergent conditions should be triaged by the PCP or treating physician with appropriate care instructions given to the member.

Referrals to Specialists

The UM department is available to assist providers in identifying a network specialist and/or arranging for specialist care. Here are some other items to keep in mind when referring members:

- Authorization from UM is not required if referring a member to an in-network specialist
- Authorization from UM is required when referring to an out-of-network specialist

Provider responsibilities include documenting referrals in the member’s chart and requesting that the specialist provide updates as to the diagnosis and treatment plan.
CONCURRENT REVIEW

Admission and Continued Stay Reviews

When continued stay is expected to exceed the number of days authorized during precertification review or when the inpatient stay did not have precertification review, the hospital must contact the Plan for concurrent review. In such cases, we require clinical reviews on all members admitted as inpatients in an acute care hospital, intermediate facility, or skilled nursing facility. We perform the reviews to assess that the medical care rendered is medically necessary, and that the facility and level of care are appropriate. The Plan identifies members admitted to the inpatient setting through:

- Facilities reporting admissions
- Providers reporting admissions
- Members or their representatives reporting admissions
- Claims submissions for services rendered without authorization
- Precertification authorization requests for inpatient care

The Utilization Management (UM) department will complete concurrent inpatient reviews within 24 hours of receipt of clinical information, or sooner consistent with the member’s medical condition. UM nurses will request clinical information from the hospital on the same day they are notified of the member’s admission/continued stay. If the information provided meets medical necessity review criteria, we will approve the request within 24 hours from the time the information is received. We will send requests that do not meet medical policy guidelines to the physician advisor or medical director for review.
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We will notify providers within 24 hours of the decision. We will send a written notification to the member and requesting provider within two business days of any denial decision.

**Inpatient Admission Notification**

The Plan identifies members admitted to the inpatient setting (acute care hospital, acute rehabilitation hospital, intermediate facility or skilled nursing facility) through:

- Facilities reporting admissions within 24 hours of admission or the first business day after a weekend
- Providers reporting admissions
- Members or their representatives reporting admissions
- Precertification authorization requests for inpatient care for **elective** admissions

For medical admissions, call **866-398-1922**.

For mental health or substance abuse admissions, notify Anthem Behavioral Health at **866-398-1922 option #3**.

Once the Plan receives admission notification, a request is made for clinical information to support the medical necessity. Evidence-based criteria are used in determining medical necessity and appropriate level of care.

**Clinical Information for Concurrent Review**

Facilities are required to provide clinical information within 24 hours of the admission notification in order to facilitate concurrent review, certify approved inpatient days, expedite discharge planning and authorizations and ensure proper claims payment. Decisions are made within 24 hours of the receipt of the clinical information needed to make a decision.

The UM nurse or case manager performs ongoing, follow-up, concurrent reviews in collaboration with hospital UM staff and provides assistance with discharge planning, as needed, to facilitate and coordinate the timely transition of care when medically indicated.
Denial of Service

Only a medical or behavioral health physician who possesses an active professional license or certification can deny a service (procedure, hospitalization, or equipment) for lack of medical necessity. When a determination is made that a request is not medically necessary, a physician reviewer calls the requesting provider for peer-to-peer discussion of the case. The physician reviewer also informs the provider of the opportunity for an appeal should the final determination result in a denial.

The UM department has utilization management policies and procedures that address the availability of physician reviewers to discuss by telephone adverse determinations based on medical necessity. Providers may contact the physician clinical reviewers to discuss any UM decision by calling the UM department at 866-398-1922.

Post-Service/Retrospective Review

Post-service review determines the medical necessity and/or level of care for services that were rendered without obtaining concurrent review, and therefore, no inpatient days certified. For inpatient admissions where no notification was received, facilities are required to submit a copy of the medical record with the claim.
SECOND OPINIONS

There is no cost to members for second opinions. A second opinion must be given by an appropriately qualified health care professional. When the request is regarding care from a specialist, a provider of the same specialty must give the second opinion. This specialist must be within the Plan’s network and may be selected by the member.

For cases in which there is no provider within the network who meets the specified qualification, the Plan may authorize a second opinion by a qualified provider outside of the network, upon request by the member or provider.
ADDITIONAL SERVICES

Mental Health and Substance Abuse

Contact Anthem Behavioral Health Services at 866-398-1922, option #3 for precertification of all mental health and substance abuse services.

The following mental health and substance abuse services require prior authorization:

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Cross-References

- Important Contact Information
- Claims and Billing Guidelines
- Member Grievances and Appeals
- Provider Grievances and Appeals
- Outpatient Treatment Review Form