Anthem Blue Cross and Blue Shield in New Hampshire
Precertification/Prior Authorization Guidelines

The following guidelines apply to Anthem Blue Cross and Blue Shield (“Anthem”) products issued and delivered by Anthem in New Hampshire. For information on precertification 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 prior authorization is required prior to being rendered. Prior authorization/precertification 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.

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) 531-4450, 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/prior authorization at: (800) 531-4450, or such other number indicated below for specific services.

The Precertification/Prior authorization 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 (see additional information below)
- 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 2017. 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:

- Breast surgery (female and male excluding breast biopsy)
- Cochlear implant and auditory brain stem implant
- Genetic testing
- Nasal/sinus surgery
- Out of network referrals/services
- Physical therapy and occupational therapy - see below
- Some outpatient diagnostic imaging - see below
- Stem cell/bone marrow transplant (with or without myeloablative therapy) and donor leukocyte infusion
- Uvulopalatopharyngoplasty (UPPP)

Precertification/Prior authorization is recommended for the following services:

- Ablative techniques for treating Barrett's esophagus
- Air and water ambulance
- ALCAT
- Ambulatory EEG
- Blepharoplasty, blepharoptosis repair, and browlift
- Cooling Devices and Combined Cooling/Heating Devices
- Cosmetic/reconstructive procedures - e.g., rhinoplasty, panniculectomy, lipectomy
- Electrical bone growth stimulator
- Genetic testing – see below
- Home hospice care
- Hysterectomy
- Hyperbaric oxygen therapy (systemic/topical)
- Implantable infusion pumps
- Infertility treatment
- Intraocular implant/shunt
- Locally ablative techniques for treating primary and metastatic liver malignancies
- Lung volume reduction surgery
- Maze procedure
- Myocardial sympathetic innervations imaging with or without SPECT
- Neuromuscular stimulator
- Selected diagnostic testing: e.g. sleep disorders – see below
- Selected durable medical equipment - customized equipment
- Selected injectable therapy - e.g., Synagis
- Selected outpatient surgery: e.g. TMJ, varicose veins, total ankle replacement, gender reassignment, transcatheter uterine artery embolization
- Spinal surgery
- Testicular/penile prosthesis
- Therapeutic Apheresis
- Tonsillectomies in children
- Total Hip Arthroplasty
- Total Knee Arthroplasty
• Treatment of hyperhidrosis
• Venticulectomy/cardiomyoplasty
• Wearable cardioverter-defibrillators

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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
• MLST (multi-level Sleep Study)
• MRA/MRI
• Non Invasive Diagnostic Vascular Studies
• Nuclear cardiology
• PET
• Percutaneous Coronary Intervention (PCI)
• Polysomnoigraphy, home sleep study and home portable monitors
• Radiation therapy (IMRT, proton beam, brachytherapy, SRS, SBRT)
• Select specialty pharmacy drugs - e.g., ESA (erythropoiesis stimulating agents)
  Epogen, Procrit, Aranesp, IVIG, Remicade
  **Arterial duplex imaging of the extremities will only be reviewed retrospectively

Effective 7/1/17 Genetic Testing medical necessity reviews for all local fully insured members will be managed by AIM Specialty Health® "

Providers may contact AIM for prior authorization of the services listed above through the following options:

• Access AIM ProviderPortalSM 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 2017. 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.
Physical Therapy and Occupational Therapy through Orthonet

Precertification is required through Orthonet for outpatient physical and occupational therapy following the initial evaluation, for members of most of our commercial plans and products.

The program consists of a utilization management program and a consultation management program. Under the utilization management program, all outpatient physical and occupational therapy services following the initial evaluation will require prior authorization through Orthonet. The consultation management program will focus on providing our network providers with clinical consulting services to help support decisions regarding the clinical effectiveness of physical and occupational services. For both programs, the rendering physical or occupational therapy provider/facility should contact Orthonet since they will have the clinical details and information needed for the review. Please note that the initial evaluation does not require prior authorization.

Please contact Orthonet to obtain precertification for these services at 888-788-0807. 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.

Mental Health/Substance Abuse Services

Anthem's mental health and substance abuse benefits in New Hampshire are administered by professionals who are specially trained to handle referrals and coordinate care for mental health and substance abuse. Call 800-228-5975 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)

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

Services listed above are effective and current as of March 2017. 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 on anthem.com)