Overview

Providers and Facilities agree to abide by the following Utilization Management ("UM") Program requirements in accordance with the terms of the Agreement and the Covered Individual’s Health Benefit Plan. Providers and Facilities agree to cooperate with Anthem in the development and implementation of action plans arising under these programs. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined below, including, but not limited to:

Pre-service and Continued Stay Review

A. Provider or Facility shall ensure that non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Plan are submitted for review as soon as possible before the service occurs. Information provided to the Plan shall include demographic and clinical information including, but not limited to, primary diagnosis.

B. Provider or Facility shall provide confirmation to Anthem UM with the demographic information and primary diagnosis within twenty-four (24) hours or next Business Day of a Covered Individual’s admission for scheduled procedures.

C. If an Emergency admission has occurred, Provider or Facility shall notify Anthem UM within twenty-four (24) hours or the first Business Day following admission. Information provided to the Plan shall include demographic and clinical information including, but not limited to, primary diagnosis.

D. Provider or Facility shall verify that the Covered Individual’s primary care physician has provided a referral as required by certain Health Benefit Plans.

E. Provider or Facility shall comply with all requests for medical information for Continued Stay Review required to complete Plan’s review and discharge planning coordination. To facilitate the review process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.

F. Anthem specific Pre-certification/Pre-authorization Requirements may be confirmed on the Anthem web site or by contacting customer service.

Medical Policies and Clinical Guidelines

Please refer to the Medical Policies and Clinical Utilization Management (UM) Guidelines section of this manual for additional information about Medical Policy and Clinical UM Guidelines.

On-Site Review

If Plan maintains an on-site Initial Request/Continued Stay Review program, the Facility’s UM program staff is responsible for following the Covered Individual’s stay and documenting the prescribed plan of treatment, promoting the efficient use of services and resources, and facilitating available alternative outpatient treatment options. Facility agrees to cooperate with Anthem and provide Anthem with access to Covered Individuals medical records, as well as, access to the Covered Individuals in performing on-site Initial
Request/Continued Stay Review and discharge planning related to, but not limited to, the following:

- Emergency and/or maternity admissions
- Ambulatory surgery
- Case management
- Pre-admission testing (“PAT”)
- Inpatient Services, including Neo-natal Intensive Care Unit (“NICU”)
- Focused procedure review

### Discharge Planning

Discharge planning includes the coordination of medical services and supplies, medical personnel and family to facilitate the Covered Individual’s timely discharge to a more appropriate level of care following an inpatient admission.

### Observation Bed Policy

Please refer to the “Observation Services Policy” located in the Billing and Reimbursement Guidelines section of the Manual.

### Retrospective Utilization Management

Retrospective UM is designed to review post service Claims for Health Services in accordance with the Covered Individual’s Health Benefit Plan and Anthem medical policy and clinical guidelines. Medical records and pertinent information regarding the Covered Individual's care may be reviewed by health care professionals with review by peer clinical reviewers when necessary to determine the level of coverage for the Claim, if any. This review may consider such factors as the Medical Necessity of services provided, whether the Claim involves cosmetic or experimental/investigative procedures, or coverage for new technology treatment.

### Failure to Comply With Utilization Management Program

Provider and Facility acknowledge that the Plan may apply monetary penalties such as a reduction in payment, as a result of Provider's or Facility’s failure to provide notice of admission or obtain Pre-service Review on specified outpatient procedures, as required under this Agreement or for Provider's or Facility’s failure to fully comply with and participate in any cost management programs and/or UM programs.

### Case Management

Case Management is a voluntary Covered Individual Health Benefit Plan management program designed to support the use of cost effective alternatives to inpatient treatment, such as home health or skilled nursing facility care, while maintaining or improving the quality of care delivered. The nurse case manager in Anthem’s case management program works with the treating physician(s), the Covered Individual and/or the Covered Individual’s Authorized Representative, and appropriate Facility personnel to both identify candidates for case management, and to help coordinate benefits for appropriate alternative treatment settings. The program requires the consent and cooperation of the Covered Individual or Covered Individual’s Authorized Representative, as well as collaboration with the treating physicians.
A Covered Individual (or Covered Individual’s Authorized Representative) may self-refer or a Provider or Facility may refer a Covered Individual to Anthem’s Case Management program by calling the Customer Service number on the back of the member’s ID card.

**Utilization Statistics Information**

On occasion, Anthem may request utilization statistics for disease management purposes using Coded Services Identifiers. These may include, but are not limited to:

- Covered Individual name
- Covered Individual identification number
- Date of service or date specimen collected
- Physician name and/or identification number
- Value of test requested or any other pertinent information Anthem deems necessary

This information will be provided by Provider or Facility to Anthem at no charge to Anthem.

**Electronic Data Exchange**

Facility will support Anthem by providing electronic data exchange including, but not limited to, ADT (Admissions, Discharge and Transfer), daily census, confirmed discharge date and other relevant clinical data.

**Reversals**

Utilization Management determinations may be reversed if:

1. New information is received that is relevant to an adverse determination which was not available at the time of the determination, or;
2. The original information provided to support a favorable determination was incorrect, fraudulent, or misleading.

**Peer to Peer Review Process**

Upon the Providers request from an attending, treating or ordering physician, Anthem provides a clinical peer-to-peer review process where our internal peer clinical reviewers re-examine cases when an adverse medical necessity determination will be made or has been made regarding health care services for Covered Individuals. The attending, treating or ordering physician may offer additional information and/or further discuss his/her cases with our peer clinical reviewers who made the initial adverse determination.

**Initiating a Peer-to-Peer Request:** Providers can initiate a peer-to-peer request IF he/she is the attending, treating or ordering physician, Nurse Practitioner, or Physician Assistant who provides the care for which any adverse medical necessity determination is made. In compliance with nationally recognized guidelines from the National Committee for Quality Assurance (NCQA) and URAC, Provider or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.
Quality of Care Incident

Providers and Facilities will notify Anthem in the event there is a quality of care incident that involves a Covered Individual.

Audits/Records Requests

At any time Anthem may request on-site, electronic or hard copy medical records, utilization review sheets and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

UM Definitions

1. **Pre-service Review.** Review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Covered Individual.
2. **Initial Request/Continued Stay Review** (continuation of services). Review for Medical Necessity during initial/ongoing inpatient stay in a facility or a course of treatment, including review for transitions of care and discharge planning.
3. **Pre-certification/Pre-authorization Request.** For Anthem UM team to perform Pre-service Review, the provider submits the pertinent information as soon as possible to Anthem UM prior to service delivery.
4. **Pre-certification/Pre-authorization Requirements.** List of procedures that require Pre-service Review by Anthem UM prior to service delivery.
5. **Business Day.** Monday through Friday, excluding designated company holidays.
6. **Notification.** The telephonic and/or written/electronic communication to the applicable health care Providers, Facility and the Covered Individual documenting the decision, and informing the health care Providers, Facility and Covered Individual of their rights if they disagree with the decision.