Anthem Blue Cross and Blue Shield & Its Affiliated HMOs Professional Provider
Utilization Management Program and Plan

This document constitutes the utilization review plan required by Section 32.1-137.10 of the Code of Virginia for all Anthem companies that conduct utilization review as defined in Section 32.1-137.7 of the Code of Virginia. For the purposes of this Utilization Management Program, the Affiliates identified in Exhibit A of the Southeast Services, Inc. Agreement and HealthKeepers, Inc., Peninsula Health Care, Inc., and Priority Health Care, Inc., are collectively referred to herein as “Health Plan” unless otherwise noted. HealthKeepers, Inc., Peninsula Health Care, Inc., and Priority Health Care, Inc. may also be referred to herein as the “HMOs” or collectively as the “HMO.”

This document describes the prospective and concurrent Utilization Management activities of the Health Plan (and their designees) with Providers of health care. Providers agree to participate in this Program as it may be amended, modified or updated from time to time. By participating in this Program, the Provider agrees to strictly adhere to and comply with all of the terms, requirements, and guidelines of this document.

I. Introduction

Because the escalation of health care costs is a national and local issue, the Health Plan considers effective medical management an essential process, strategically directed at maintaining quality health care while curtailing unnecessary costs associated with inappropriate consumption of health care resources.

The Utilization Management Program affords the following opportunities to Hospitals, Providers and Covered Persons:

A. It limits the potential for and/or the number of retroactive denials.
B. If adhered to, it significantly reduces the need for requesting additional medical information to evaluate and justify health care coverage.
C. It promotes compliance with policy benefit provisions, resulting in sound health care delivery with appropriate compensation for services rendered.

Contact Information:
Website – http://www.Anthem.com
Telephone Numbers:
1-800-533-1120 Anthem Blue Cross and Blue Shield Provider Data Touch Interactive Voice Response System (see attached “Data Touch Interactive Voice Response (IVR)” brochure on page 0)
Group Plan Services Operations
Pharmacy Management
Behavioral Health
Medical Management

1-800-321-8318 Anthem Blue Cross and Blue Shield Individual or Government business

1-800-421-1883 HealthKeepers, Inc. and Peninsula Health Care, Inc.

1-757-326-5270 Priority Health Care, Inc.

1-800-991-6045 Behavioral Health

The Health Plan’s Point of Care system - available to initiate or check status of a Health Services Review, Admission Review or Referral. Instructions on how to register for Point of Care is available at www.Anthem.com or through your Provider consultant. (Not available for Medicare Advantage)
In addition to checking claims status, eligibility and benefits, the features below are available on Point of Care:

- Primary care physicians can submit requests for Referrals and fax Referral information to specialists and hospitals.
- Hospitals and specialists can view Referrals for their patients.
- Hospitals and Attending Providers can submit requests for Admission Reviews.
- Utilization Review/Case Management Departments and Attending Providers can update clinical information and ask for extension of hospital stays.
- View Health Services Reviews (authorizations of outpatient procedures).

II. Definitions

A. The following terms, as used in this document, shall have the meanings defined in the Agreement:

1. Covered Person/Member – (referred to herein as “Covered Person”).
3. Medically Necessary or “Medical Necessity”
4. Provider/Specialist/Primary Care Physician/Center – (referred to herein as “Provider”).
5. Covered Service
6. Non-Covered Service

B. The following terms, as used in this document, shall have the meanings shown below:

1. Admission Review shall mean a review that determines whether inpatient services and inpatient transfers from one hospital to another are Covered Services and are Medically Necessary.
2. Attending Provider shall mean the Provider ordering tests and/or procedures for a Covered Person as an outpatient or a Provider having the primary responsibility for the care of the major condition or diagnosis of a Covered Person in an inpatient setting.
3. Concurrent Review shall mean a review conducted during a Covered Person's hospital stay or course of treatment that determines whether services are a Covered Service and are Medically Necessary.
4. Emergency or Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.
5. Health Services Review shall mean a review that determines whether outpatient services are a Covered Service and are Medically Necessary.
6. Referral shall mean an Attending Provider’s recommendation for a patient to receive outpatient services from another in-network Provider (provider or facility).
7. Utilization Management Program (“UMP” or “Program”) shall mean the Health Plan or its designees who perform the utilization management services described in this document.

III. General Requirements of the Provider

The Provider shall fully and diligently cooperate with and abide by all elements of the Utilization Management Program, including but not limited to the following components of the Program: Referrals, Admission Review, telephonic and/or onsite Concurrent Review, and Health Services Review. The Provider agrees to provide medical information in a timely manner to the Utilization Management Program for the purpose of determining the Medical Necessity of the Covered Person’s care. Each element of the UMP is described in more detail in the remainder of this document.

Elements:
- Referrals - see Article V
- Admission Review - see Article VI
- Concurrent Review - see Article VII
- Medical/Surgical Outpatient Health Services Review - see Article VIII
- Behavioral Health Care Outpatient Health Services Review - see Article IX
- Prescription Drug Health Services Review - see Article X
The Covered Person and the Health Plan are not responsible for medical services that are delivered in violation of the requirements of this Utilization Management Program and Plan.

IV. General Information

A. To obtain general patient eligibility and coverage information and patient-specific requirements for Referrals, Admission Reviews and Health Services Reviews, the Provider may call Service Operations at the numbers listed in the Contact Information in Article I.

B. To have a particular service reviewed for Medically Necessity, the Provider may submit a request through the Health Plan's Point of Care system or call Medical Management at the number listed in the Contact Information in Article I. These phone lines are operational Monday through Friday during normal business hours with the exception of the Health Plan's designated holidays.

C. The UMP applies to Medical Necessity review as described. It applies in entirety to all Covered Persons unless otherwise noted. Admission Reviews, Concurrent Reviews, Health Services Reviews and retrospective audits are for the purpose of confirming Medical Necessity. All other provisions of any Contracts, including but not limited to the other coverage exclusions, limitations on days, and appropriate waiting periods, shall continue to be enforced and are not subject to the UMP.

D. If services rendered to a Covered Person are:

- determined by the Health Plan to be not Medically Necessary or,
- in the case of an HMO Covered Person, not covered for any reason,

then Provider shall make no charge and render no bill to the Covered Person for such services, and neither the Health Plan nor any Covered Person shall have any payment responsibility for those services except as otherwise provided in (a) and (b), below.

a. Covered Persons may only be held responsible for payment of the Non-Covered Services referenced above if, before the services are rendered, the Covered Person signs an acknowledgment and consent form as specified in the Agreement.

b. Further, the Health Plan may cover certain of the Non-Covered Services referenced above in connection with Covered Persons enrolled under fully-insured Contracts and under certain self-insured or at-risk Contracts that adopt into their health plan, in writing, the exception described in this subsection IV, D. Specifically, if a Covered Person receives the above referenced Non-Covered Services, the following physician services rendered to that Covered Person will not be denied by the Health Plan in spite of the denial of coverage for the overall services:

Services rendered in (i) an inpatient hospital; (ii) inpatient psychiatric facility setting; or (iii) a psychiatric partial inpatient facility setting:

- by physicians who do not control whether the Covered Person was treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians, and
- by the Attending Provider, other than inpatient evaluation and management services provided to the Covered Person.

- Inpatient evaluation and management services include routine visits by the Attending Provider for purposes such as reviewing patient status, test results, and patient medical records.
- Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by the Attending Provider.

Services rendered in an (i) outpatient hospital setting (ii) Emergency room or (iii) ambulatory surgery setting by pathologists, radiologists or anesthesiologists. (However, this exception, does not apply if and when any such pathologists, radiologists or anesthesiologists assumes the role of Attending Provider.)

E. Under this Utilization Management Program, audit activity may include a review of any or all of the following: Medical Necessity, charges, diagnosis and other coding, and documentation of services rendered. See Article XI for additional details.
F. Any references made in this document to UMP will include any review agents engaged by the UMP to perform Medical Necessity and audit reviews of services rendered by Providers and their staff. Therefore, the same cooperation afforded the UMP will also be expected for any of its agents.

G. The UMP shall have reasonable access to medical records of Covered Persons as needed for the purposes of utilization management or quality improvement activities. Photocopies of Provider records or review of such records requested by the UMP shall be supplied without charge by the Provider. Any services ordered and not documented as having been performed in the medical record or in ancillary departmental records will not be reimbursed. Documentation should reflect who rendered what service, why, when and to whom. See Attachment A for Documentation Guidelines for Physician Office Medical Records and Medical/Surgical Record Documentation Standards for Inpatient and Outpatient Hospital Records and Attachment B for Behavioral Health Documentation Guidelines. Photographs submitted as part of the Admission Review or Health Services Review process will not be returned to the Provider.

H. To ensure the patient receives the highest level of benefits or any benefit for Covered Persons, Providers should refer patients to network Providers. The UMP may authorize Medically Necessary specialized Covered Services that are not available in the Provider network and that can only be rendered by a non-network Provider (inpatient or outpatient), provided that these services are approved in advance through the UMP. However, any service available in the network must be rendered by a network Provider in order to receive the highest level of benefits, with the exception of Emergency services as defined by the UMP and, for HMO Covered Persons, out of area urgent care services which will be certified at the in-network benefit level wherever they are rendered.

Urgent care situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury. Examples of an urgent care situation may be a high fever or sprain.

I. The Health Plan ensures the confidentiality of patient-specific medical records and information in accordance with applicable state and federal laws and regulations. A breach of confidentiality by Health Plan associates may result in disciplinary action up to and including termination of employment. Information requested during the review process is limited to patient-specific information necessary for proper adjudication of the claim and used solely for the purposes of medical management activities. It is shared only with those individuals and entities that have authority to receive such information. All medical record information submitted to the Health Plan will be maintained for a period of five years.

V. Attending Provider Rights & Responsibilities for Referrals

If a referral is required by the Covered Person’s contract, then it shall be made by the Attending Provider telephonically or electronically. Upon receipt, the UMP will perform an eligibility review of the services specified in the Referral.

A Referral is not a review for Medical Necessity or coverage, therefore, it is not a guarantee of payment. To help ensure correct claims payment, Attending Providers must notify the Health Plan of Referrals before services are rendered or, in Emergencies, as soon as possible. The Referral covers a number of visits or span of time for the care to take place.

For Medicare Advantage, the UMP does not require Attending Provider to contact the Health Plan for referrals to Providers in the Medicare Advantage network; however, the Attending Provider must document such referral in the Covered Person’s medical records maintained by the Attending Provider.

VI. Attending Provider Rights & Responsibilities for Admission Review

A. While the Hospital may complete the Admission Review process as a courtesy to the Attending Provider, it is the responsibility of the Attending Provider to ensure that the Admission Review requirements are completed prior to services being rendered.

B. The Attending Provider should notify the UMP at least three (3) business days in advance of an elective or maternity admission. This Admission Review process should occur during the Utilization Management Program’s normal business hours. At the time of the notification, the Attending Provider must furnish the relevant clinical information to substantiate the need for inpatient care, as required by the UMP reviewer or the Health Plan’s Point of Care System, and obtain Admission Review from the UMP prior to any elective or planned admission of a Covered Person.
C. For Emergency medical, surgical or behavioral health admissions, an Admission Review must be requested by the end of the first business day following the admission or within 48 hours of the admission, whichever is later.

D. Direct inpatient transfers made from one Hospital to another will require Admission Review. Procedures are the same as for any Admission Review request. If the transfer is approved, the Affiliate will reimburse for ambulance transfer services.

E. Except in the case of an Emergency, failure to obtain an Admission Review for a Hospital admission may result in denial of coverage for services provided to an HMO Covered Person and partial or full denial of coverage if, in retrospect, the services provided to a non-HMO Covered Person are determined not to be Medically Necessary.

F. The following information is required for the UMP to complete an Admission Review:
   1. Covered Person's identification number and Covered Person's name,
   2. Attending Provider's or health care Provider's name, address and phone number,
   3. Hospital name and address,
   4. Admission date and anticipated length of stay, frequency and duration of previous outpatient service(s) and medical information pertinent to determining Medical Necessity of planned care. This includes presenting clinical symptoms, relevant medical history and previous treatment, lab/radiological results, treatment plan orders, patient response to treatment and discharge needs.

VII. Attending Provider Rights & Responsibilities for Concurrent Review

A. The Attending Provider is responsible for requesting and obtaining an extension of the original approved duration of inpatient care if needed. At the time of the Admission Review, the Attending Provider will be notified of the frequency of the need for updated clinical information to certify an extension. The Attending Provider agrees to supply medical information in a timely manner to the UMP for the purpose of determining the Medical Necessity of the Covered Person's continued care received at the Hospital. This process may be coordinated with the Hospital. Approval of benefits for continued hospitalization is subject to care continuing to be Medically Necessary. If the discharge of a Covered Person occurs after the last day covered by the Admission Review or if all inpatient days are not certified, there may be a partial or full denial of coverage if, in retrospect, the services are determined not to be Medically Necessary.

B. The following information is needed for the UMP to complete a Concurrent Review:
   1. Covered Person's identification number or Covered Person's name,
   2. Current medical status of the patient including any lab/radiological results, current clinical symptoms, treatment plan and patient response to the treatment, discharge plans and progress toward implementation of those plans and anticipated length of stay.

C. Discharge Planning is an integral part of the Admission and Concurrent Review programs. The focus is to assess Covered Person's care needs during and after hospitalization in order to effect an appropriate and timely discharge and to promote appropriate alternative settings of care such as the home, skilled nursing facility or outpatient department. The Attending Provider will work with the UMP nurse reviewers to facilitate the discharge needs of the patient. A Health Services Review may be required for home, outpatient or skilled nursing facility care. The agency/nursing home should obtain the appropriate review. Discharge services can include but are not limited to: home health nursing including physical, speech and occupational therapies provided by a home health agency; private duty nursing; and skilled nursing facility services. Contracting home health agencies are required to provide skilled services as needed 24 hours a day, 365 days per year.

VIII. Attending Provider Rights & Responsibilities for Medical/Surgical Outpatient Health Services Review

It is the responsibility of the Attending Provider to obtain a Health Services Review during the UMP's normal business hours prior to the outpatient services being rendered except in Emergency situations. The latest list of services requiring a Referral or Health Services Review is available to Providers online at www.Anthem.com, through the Health Plan's Point of Care system or by calling Medical Management at the number listed in the Contact Information in Article I.
A. During the Health Services Review process, the UMP reviewer will need information regarding the Covered Person's diagnosis, medical history and medical information pertinent to establish the Medical Necessity of planned care.

B. The intended frequency and duration of services along with a detailed treatment plan is required to establish a certified period of time.

C. Once the medical information is received, the UMP will determine if the proposed services meet Medical Necessity guidelines and, therefore, can be certified for reimbursement. The Provider of the service is notified as soon as the decision is made.

IX. Attending Provider Rights & Responsibilities for Behavioral Health Care Outpatient Health Services Review

Some Contracts require a Health Services Review for outpatient psychiatric therapeutic procedures (CPT 90801-90899, and appropriate E&M codes). Coverage for outpatient behavioral services is certified when the patient's condition or symptoms and the appropriateness of treatment are determined to be in accordance with the UMP's Behavioral Health Medical Necessity Criteria. Care may be certified by a Health Plan's Behavioral Healthcare case manager, Health Plan's Behavioral Healthcare Medical or Clinical Directors or a psychiatric consultant representing the UMP.

A. The Attending Provider shall certify any non-emergent outpatient behavioral services. Health Services Reviews can be obtained during normal UMP business hours.

B. Outpatient behavioral services Health Services Review requests will not be reviewed retrospectively for more than sixty (60) days after the service is rendered, except in cases of Emergency services. If a Health Services Review is not obtained within sixty (60) days after a non-emergent outpatient behavioral service is rendered, then, notwithstanding any provision to the contrary contained herein or in any Provider agreement, the Health Plan and Covered Persons are not responsible for making any payment to the Attending Provider.

C. The initial Health Services Review decision will cover a specified number of outpatient sessions. Any additional services must be certified and a treatment plan must be sent to the Health Plan's Behavioral Health Department prior to services being rendered.

X. Provider Rights & Responsibilities for Prescription Drug Health Services Review

A. The Prescription Drug Health Services Review Program is required for certain drugs obtained at a pharmacy or administered in the physician's office. To find out if a drug requires a Health Services Review, the Provider may call the number listed in the Contact Information in Article I.

B. The Prescription Drug Health Services Review list may also be accessed by visiting our website www.Anthem.com.

C. The Prescription Drug Health Services Review Program is designed to promote drug use according to FDA, USP and/or recognized standards of care. Drugs considered for a Health Services Review require review due to their therapeutic indications, safety profile, potential for inappropriate or “off-label” use, role in therapy, or cost.

D. Some Prescription drugs may be subject to quantity limits. Quantity limits are considered when the drug labeling indicates a specific number of days or an amount of drug that is considered a “duration of therapy” for most conditions. They may also be based on generally accepted standards of practice or, drug label/literature, or recommended average therapy needs for a particular condition. Providers may request the criteria by calling the number listed in the Contact Information in Article I.

E. Prescription Drug Health Services Review requests from the Provider may be mailed to:
Prior Authorization Department
1351 William Howard Taft
Floor 2 West
Cincinnati, Ohio 45206
or faxed to: (800) 601-4829
Phone number to call-in Prior Authorization requests (800) 338-6180
F. Requests may be called, faxed or mailed on the appropriate forms when applicable. Providers can get authorization forms by calling the number listed in the Contact Information in Article I or by accessing the Health Plan's website at http://www.Anthem.com. Requests should include patient name, Member ID number, drug and quantity requested. Appropriate clinical information must also be provided to support the use of the medication requested. Requests without this information can not be processed and will be returned to the Provider for completion.

G. Once complete, the request is reviewed and processed. Requests for prescription drugs that do not meet Medical Necessity criteria may be forwarded to the clinical pharmacist for review. The clinical pharmacist either approves the request or consults with a Medical Director or physician consultant for a decision.

H. Initial drug Health Services Review decisions are made within two business days of receipt of all necessary information. Approval letters are mailed or faxed to the Provider within two business days of the decision. Denial letters are mailed or faxed to both Covered Person and Provider within two business days of the decision. Denial letters include information on the reconsideration and appeal process and action steps required. To request an appeal, contact 1-866-568-2374.

I. Requests for a peer to peer or an expedited appeal may be initiated by calling Pharmacy Management at the number listed in the Contact Information in Article I.

J. In the event of an adverse decision, the appeals process described in Article XIII is available.

XI. Provider Rights & Responsibilities for Audit Activities

A. Under the UMP, the Provider agrees to allow on-site reviews by the UMP review staff to examine the medical records and/or itemized bills related to claims under the Program. The UMP reserves the right to make benefit determinations based on these reviews and retract any reimbursement made based on false, misleading or incomplete information. The method of review and selection of cases will be determined by the UMP.

B. Periodically the UMP will perform retrospective audits of cases receiving inpatient or outpatient care. While the focus of each audit differs, the combined purposes of these audits are to confirm documented Medical Necessity of care received, relevance of pre-procedure diagnostic testing, validation of the appropriate setting, quality of care and accuracy in coding and billing for services received. These reviews are conducted on inpatient admissions or outpatient services (Retrospective Audits); outpatient surgical services received in ambulatory surgery or free standing ambulatory surgery centers (Ambulatory Surgery Audits); or Provider bills (Bill Audits).

C. General Audit Guidelines

- Prior to a review, the UMP provides the Provider with a list of the cases it wishes to review. The Provider will have these case records available when the UMP reviewer arrives. Occasionally, a single request for a bill audit will be received. Medical documentation would then be requested for a review at the UMP location.

- At the end of each review, the UMP reviewer will discuss his/her findings with designated Provider representatives. A reconciliation of findings will be made at the completion of the audit.

XII. Utilization Management Program Responsibilities

A. In making Medical Necessity and other coverage determinations, the Health Plan may give consideration, (to the extent that, and for as long as, the Health Plan deems appropriate) to nationally recognized, consensus-based and/or published medical literature and guidelines or to criteria that are based on these (or to any portion thereof). Examples of such guidelines and/or literature that may be utilized or considered, in whole or in part, include, without limitation, Milliman Care Guidelines. * Guidelines and/or literature (or any portion thereof) developed by other national or specialty organizations may also be utilized and/or given consideration (to the extent that, and for as long as, the Health Plan deems appropriate). Information about any guidelines and/or literature currently being used by the Health Plan can be obtained by calling the UMP.

* Milliman Care Guidelines are a set of optimal clinical practice benchmarks for treating uncomplicated patients with common conditions. To obtain information about Milliman, Inc. or to obtain a copy of the Guidelines, visit its web site at www.mnr.com or call 1-888-464-4746. Due to licensing restrictions, the
B. The Health Plan’s Behavioral Health Department uses mental health and substance abuse Medical Necessity criteria for the purpose of determining benefit coverage and assisting behavioral health care professionals in understanding the basis of our level of care and continuation of care decisions. The criteria are primarily symptom and behavior-based, and were originally developed “in-house” by our staff of behavioral health professionals with input from behavioral healthcare practitioners throughout Virginia, including practitioners at academic institutions.

C. The Health Plan’s Behavioral Health Medical Necessity criteria are reviewed at least annually. The Behavioral Health medical director leads this annual review process and is responsible for synthesizing input from the various sources, including relevant scientific literature and a consideration for other published criteria sets, and making appropriate revisions to the criteria. A number of persons, both internal and external to the Health Plan, are asked to review the criteria annually, including the Health Plan’s Behavioral Health case management staff, Behavioral Health psychiatric consultants, and a sample of network Providers, including Providers specializing in treatment of children, adolescents, adults, substance abuse and dependency. The criteria are also reviewed annually by the Health Plan’s Behavioral Health Quality Improvement Committee, which has network Provider representation. The Health Plan’s Medical Management and Quality Improvement Committees review the criteria also. Final endorsement is obtained from the Health Plan’s Managed Care Advisory Panel. The latest version of the Behavioral Health Care Medical Necessity Criteria is made available to Providers and Covered Persons at their request by calling Medical Management at the number listed in the Contact Information in Article I. and available at www.Anthem.com.

D. All utilization review standards and criteria used by the UMP are objective, clinically valid and compatible with established principles of health care. They are also sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.

E. The UMP arranges the services of physician consultants who are board certified specialists in all major specialty categories of health care on an “as needed” basis in conducting utilization review.

F. Review staff include licensed registered nurses, licensed clinical social workers, licensed professional counselors, or clinical nurse specialists with at least 3 years of clinical experience who conduct the first level review under the direction of the Medical Director or Clinical Director for Behavioral Health Care. The Medical Director and Physician staff members have current unrestricted licenses to practice medicine. In addition, the physician staff members have unencumbered DEA licenses, and if in active practice, evidence of Board certification and malpractice coverage.

G. All Medical Necessity adverse decisions are made in the first instance by a Medical Director, Clinical Director or physician consultant. The UMP will make a good faith attempt to obtain information from the Provider prior to rendering an adverse decision. If an Admission Review or Health Services Review is questioned on the basis of Medical Necessity, at any time before the UMP renders a decision, the treating Provider is entitled to review the issue of Medical Necessity with a physician consultant or peer of the Provider who represents the UMP.

H. If the UMP approves the admission as Medically Necessary, a length of stay will be certified. Instructions on the method for Concurrent Review - whether onsite or telephonic - will be provided when the original length of stay is certified. A certification number is generated on each initial review and is a reference number only and not a confirmation that the service is approved.

I. The UMP will orally or electronically communicate any review decision to the treating Provider no later than two business days after receipt by the UMP of all information necessary to complete the review. As used herein, an “adverse decision” means a decision by the UMP that a health care service rendered or proposed to be rendered was or is not Medically Necessary. In the case of an adverse decision for concurrent care, the UMP will orally or electronically notify the treating Provider within 24 hours and follow up in writing within two business days of the decision (14 days for Medicare Advantage). The notification will include instructions on how the Provider, on behalf of the Covered Person, may seek a reconsideration of the adverse decision, including the name, address, and telephone number of a contact at the UMP. To request reconsideration, the Provider must submit it by telephone to the contact information listed in Article 1.

J. The Health Plan’s Behavioral Health Department uses regionally-based Provider profiling data that it generates to help determine the number of sessions or days that the Health Plan will initially authorize for coverage when a Health Services Review is requested by mental health Providers. Specific information regarding this process is available by contacting the Behavioral Health Medical Director, Clinical Director, or Provider Network Manager at 800-991-6045.
XIII. Utilization Management Program Appeals

A. A Provider may file an appeal as outlined in Exhibit J, Provider Appeal Policy and Procedure. The appeal policy is also available on http://www.anthem.com.

To request a verbal appeal contact 800-533-1120

Send written request for an appeal to:
Anthem Blue Cross and Blue Shield
Attn: Corporate Appeals Unit
P.O. Box 27401
Richmond, VA 23279
Physician Office
Medical Record Documentation Criteria

The medical record is a written account of all significant clinical information pertaining to a patient. It is a critical tool for continuity and coordination of patient care over time, often among several Providers. Complete and thorough documentation of the patient’s care, therefore, is synonymous with providing good care, since the conditions that encourage the first also contribute to the second. All medical record documentation must be maintained for 5 years for audit purposes. Standards for documentation are:

1. Each patient has an individual confidential medical record.
2. Each page contains patient ID.
3. Provider is identified on each entry.
4. Medical record is legible.
5. All entries are dated.
6. Medical records are readily accessible to the physician during normal office hours.
7. Specific allergies or drug reactions are documented prominently on the medical record.
8. For each patient there is documentation of the following:
   - Pertinent history and physical examination
   - Personal and biographical data
   - Completed problem list is documented and recurrent or chronic illnesses or diseases are listed on the problem list
   - Previous visit problems are addressed
   - Current therapies
   - Copies of written reports for diagnostic and therapeutic ancillary services utilized by the patient
   - Follow-up plan and/or return visit is documented for each encounter
   - Consultations with or Referrals to other physicians and Providers, including information on any medical intervention as a result of these Referrals
   - Consultant, lab and imaging studies reflect physician review
   - Periodic screening appropriate to patient age and conditions
   - Immunization record is complete (for pediatric Covered Persons only - below age 16)
   - Health guidance/counseling is appropriately provided to Covered Persons

9. For each visit, there is documentation of the following:
   - Reason for visit and chief complaint
   - Working diagnosis
   - Treatment plan, including prescribed medications
   - Patient education

Medical/Surgical Record Documentation Standards Inpatient And Outpatient Hospital

Sufficient documentation in the medical record is required to enable the UMP review staff to determine Medical Necessity, quality of care, and appropriateness of treatment and to verify services performed for the purpose of determining coverage and reimbursement.

Covered Persons receiving services in a hospital setting must be under the medical supervision of a physician. The physician maintains responsibility for total care of the Covered Person. Signatures and credentials are required documentation. Although members of other disciplines write notes, the Provider has the responsibility of documenting the Medical Necessity for the prescribed care.
I. Documentation Criteria

A. All hospital services rendered must be appropriately documented in the Covered Person’s medical record. The medical record should be complete, legible and signed by the person providing the service. To be deemed complete, documentation of inpatient services must:

1. Describe the Covered Person’s clinical signs and symptoms (including specific examples) that necessitate admission including failed response to outpatient management.

2. Document an accurate and complete chronological picture of the Covered Person’s clinical course with accessibility to past and present diagnoses, and relevant health risk factors.

3. Support the intensity of the Covered Person’s evaluation and/or treatment, including Provider’s thought processes and the complexity of medical decision-making.

4. Document the implementation of a treatment and discharge plan specifically designed for the Covered Person, detailing frequency and type of treatment/medication and dosage; any Referrals/consultations, and Covered Person/family education follow up needs.

5. Document Covered Person’s progress, including response to treatment, change in treatment, change in diagnosis/condition, and Covered Person’s non-compliance (if relevant).

6. Document continuous skilled observation and intervention by trained personnel consultants.

7. Document reasons for and results of x-rays, lab tests, invasive procedures, and other ancillary services.

8. Document extenuating circumstances that necessitate short periods (less than 3 hours) of absence from the Hospital (i.e., court appearance, medical/surgical treatment).

9. All entries to the medical records should be dated and authenticated.

B. All professional Provider services must adhere to the following guidelines:

1. Documentation in the medical record must verify each individual charge submitted to the Health Plan.

2. Documentation must specify date of service, time of service, type of service rendered, and the name and title of the health care professional who rendered the service. "Summary" notes, regardless of time periods summarized, will not be acceptable as verification of individual therapies or services provided.

3. The CPT/ICD-9 codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

C. Discharge planning should begin at the time of admission. The initial assessment and other intervention should be documented in the medical record.
Behavioral Health Documentation Guidelines
Inpatient And Outpatient

These documentation guidelines were developed by the Health Plan’s behavioral health specialists in conjunction with behavioral health professionals across the state, and may be used for the review of behavioral health services for applicable Contracts. The determination of reimbursement requires adequate documentation of patient acuity and services provided. The Provider must maintain adequate and accurate clinical records.

Documentation must be legible and signed by the person providing the service. Legible documentation is required to substantiate reimbursement for services. The Health Plan reserves the right to retract or recover any payments made when there is absence of documentation, illegible documentation, or if documentation is insufficient to justify services billed, subject to all restrictions of applicable law.

Documentation should be complete, including positive as well as negative findings, and should be recorded in a timely manner. A progress note is generated and documented after each patient contact. The CPT/ICD-9 codes reported on the health insurance claim form should reflect the documentation in the medical record. All medical record documentation must be maintained for 5 years for audit purposes.

Documentation must reflect who rendered what service, why, when and to whom.

Inpatient Documentation Guidelines

Sufficient documentation in the medical record is required to enable Utilization Review staff to determine medical necessity, quality of care and appropriateness of treatment and to verify services performed for the purpose of determining coverage and reimbursement.

Patients within a hospital setting must be under the medical supervision of a physician. The Attending Provider maintains responsibility for the total care of the patient. Although members of other disciplines write psychotherapy notes, the physician of record has the responsibility to document the medical necessity for the prescribed psychotherapy and the total treatment program.

Evaluations, assessments, and other services shall be made by credentialled and/or licensed professional staff according to hospital policy and professional standards.

I. Admission Note

A. Within 24 hours of a patient’s admission, the Attending Provider and the nurse performing the initial assessments must personally document their findings in the medical record. Documentation must include the time the assessment was performed by the Attending Provider.

1. Documentation of the severity of the presenting problem must support the Medical Necessity of admission for inpatient hospitalization.
   a. The primary DSM-IV Axis I and Axis II diagnosis must be documented by the physician and must be consistent with the presenting problem.

2. The patient’s potential for danger to self, others and/or property must be clearly documented. Documentation must indicate the following:
   a. presenting thoughts
   b. intent
   c. plan
   d. method

3. An initial diagnostic evaluation must be documented and include the following:
   a. date of exam
   b. presenting problem - supporting signs and symptoms
c. history of present illness
d. previous treatment and outcome
e. medical history, (including medications & allergies)
f. social history/family history
g. history of alcohol and drug use
h. mental status exam
i. diagnosis

4. Initial treatment plan, including the goals for hospitalization, must be documented, providing the following information:
   a. an estimated Length of Stay (LOS)
   b. initial Discharge Plan

5. Signatures and credentials are required documentation for the following:
   a. Attending Provider
   b. all licensed staff

II. History And Physical

Within 24 hours of admission, a history and physical (H&P) must be completed by a licensed physician and documented in the medical record. The H&P must evaluate the patient’s physical and medical stability for treatment in an inpatient setting. An explanation of exceptions for any H&P component must be documented.

A. H&P documentation is to include an evaluation of the following:
   1. general appearance and nutritional status
   2. skin and lymph
   3. head and neck
   4. eyes/vision
   5. ears/hearing
   6. nose
   7. mouth and throat
   8. chest and lungs
   9. breast
   10. heart
   11. abdomen
   12. genitalia
   13. rectal
   14. bones, joints and muscles
   15. neurological; to include the following:
      - motor
      - sensory
      - cranial nerves
      - deep tendon reflexes
      - strength
      - cerebrum
      - posture, gait
   16. clinical impression, to include activity level

B. Signature and credentials of the physician are required.

C. Laboratory results must be documented in a timely manner.

III. Consultation Services

A. A consultation is the rendering of an expert opinion, in relation to the diagnosis or treatment of an illness or injury by a Provider other than the Attending Provider. The Provider must be qualified by training and experience to render an expert opinion in a given specialty.

B. The Attending Provider must order the consultation, and the Provider who renders it must include a written report in the medical record.
C. All consultations must be performed by the Provider billing for the service. Contracts do not provide benefits for telephone consultations.

IV. Master Treatment Plan

A. A master treatment plan that addresses measurable goals and objectives relating to the presenting problems and defines realistic goals for discharge must be documented in the medical record within 3 days.

1. All therapies and disciplines involved must be addressed in the master treatment plan.
   a. The patient’s strengths and weaknesses and the ability to reach realistic goals must also be documented.
   b. The master treatment plan must be current and updated at least every 7 days.

2. Discharge planning must be documented in the master treatment plan.

3. Specific follow-up plans for post discharge must be documented.

B. Psychological testing required for differential diagnosis and the development of a master treatment plan should be ordered within 3 days of admission and results documented in the medical record within 3 days of completed testing.

V. Progress Notes

A. Documentation in the patient’s progress notes is required to address the patient’s response to treatment.

1. After significant patient contact, all disciplines must record their assessment in the medical record. All entries must be dated and signed by each professional, noting their credentials.
   a. Interventions, goals of the master treatment plan and coordination of services must be substantiated.
   b. An explanation of positive or negative change in the patient’s condition is required.
   c. Deterioration or complication following initiation or change of medication must be documented.
   d. Ongoing documentation of the patient’s mental, functional and medical stress is required.
   e. Patient’s response to treatment must be documented.
   f. A record of the use of any physical and/or chemical restraints or seclusion must be documented.

B. The medical record must reflect daily medical and nursing documentation of the severity of illness and intensity of services rendered, and a daily progress note documented by the psychiatrist.

VI. Psychotherapy

A. Documentation, written or dictated by the Provider, of psychotherapy sessions is required in the medical record to determine that the services were rendered and Medically Necessary.

B. The Provider must personally render all psychotherapy billed to the Health Plan. It is recognized that there are useful milieu therapy groups run by other personnel, but these milieu therapy groups are included in the hospital charge and will not be reimbursed separately by the Health Plan.

1. Patient interactions of less than 20 minutes in duration may be documented as medication evaluation, but may not be documented as psychotherapy sessions.

2. For utilization review purposes and to qualify for reimbursement, one note for each psychotherapy session is required. The psychotherapy note must indicate the following information:
   a. date of service
   b. length of session
   c. statement of therapeutic focus, including the therapist’s intervention(s)
   d. periodic reference to the patient’s progress
   e. individuals present at the session
   f. a separate note must be written in the hospital record for each patient in group therapy, indicating the nature of the participation at each session
Outpatient Documentation Guidelines

A clinical record is required for all office psychotherapeutic services. Sufficient documentation is required to determine medical necessity, quality of care, appropriateness of treatment and to verify service performed for the purpose of determining coverage and reimbursement. The Provider must personally render all psychotherapy billed to the Health Plan.

I. Clinical Evaluation

A. A clinical evaluation must be documented in the medical record:

1. The presenting problem:
   a. history of present illness
   b. evidence of personal distress
   c. impairment of functioning

2. Medical history including medication and allergy history; current medications prescribed with dosages noted
3. Previous treatment and outcome
4. Social history/family history
5. History of alcohol and drug use
6. Mental status exam
7. Appropriate diagnosis
8. The treatment plan with goals of treatment including the estimated number of treatment sessions to achieve goals
9. Signature and credentials of treating Provider

II. Psychotherapy Notes

A. Patient interactions of less than 20 minutes in duration may be documented as medication evaluation, but may not be documented as psychotherapy sessions.

B. Clinical notes must be documented in a timely manner and include:

1. Patient’s name
2. Date of service
3. Type and length of session
4. Individuals present at the session
5. Current symptoms
6. Current level of functioning
7. Focus of session, including the therapist’s intervention(s)
8. Future directions including revisions in goals, if indicated
9. Next scheduled appointment
10. Summary of treatment outcome upon termination
11. A separate note is written in the medical record for each patient in group therapy, indicating the nature of the participation at each session.
12. Signature and credentials of treating Provider after each session, including progress toward the individual’s goals