Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Anthem

Utilization management discussion

2023 Indiana health coverage programs (IHCP) works seminar

Agenda topics

- Introduction of UM team
- Clinical hierarchy
- Turnaround times
- Case denials
- Post denial options
- Prior authorization look up tool
- Clinical documentation
- Discharge documentation

Utilization management hierarchy

- New clinical hierarchy effective April 1, 2023 :
  - IHCP guidelines
  - National guidelines
  - Anthem Blue Cross and Blue Shield (Anthem) is using non-customized MCG
  - Applicable to behavioral health and physical health
  - Discussion regarding the IHCP bulletin BT2022117
- **IHCP bulletin BT2022117**

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT2022117 DECEMBER 20, 2022

Managed care programs will follow the same utilization management hierarchy

Beginning April 1, 2023, Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise will follow the same utilization management (UM) medical criteria hierarchy for all managed care programs.

Therefore, managed care programs will retire all customized guidelines by April 1, 2023, and ensure that any authorization reviewed on or after April 1, 2023, will be reviewed with consideration to the outlined hierarchy.

For select items outlined in this bulletin, managed care entities (MCEs) must use Indiana Health Coverage Programs (IHCP) Policy. For all other items where the Office of Medicaid Policy and Planning (OMPP) has criteria or guidelines in place, the MCE cannot have criteria or UM policies that are more restrictive. The MCE must use the full suite of noncompany customized InterQual or Milliman Care Guidelines (MCG) clinical guidelines, inclusive of Medicare national coverage determinations (NCDs) and Medicare local coverage determinations (LCDs). For areas not addressed by IHCP Policy and MCG/InterQual, the MCE may develop their own UM policy and criteria, but they must be approved by the state and made available to the state. The hierarchy for clinical criteria and guidelines is outlined in this bulletin.

Medical review criteria hierarchy

Medical review criteria must adhere to the following hierarchy:

1. **Federal Law** – All review criteria must comply with federal law (if the *Code of Federal Regulations* has any Medicaid-specific requirements, the IHCP must comply).
2. **Indiana Code** – All review criteria must comply with Medicaid-specific provisions of the *Indiana Code*.
3. **State Plan** – Review criteria are subject to the terms of the state plan (which is the IHCP agreement with the Centers for Medicare & Medicaid Services [CMS] outlining the coverage and reimbursement of IHCP services).
4. **Indiana Administrative Code** – All review criteria must comply with Medicaid-specific provisions of the *Indiana Administrative Code* (which is given authority from the *Indiana Code*).
5. **IHCP Policy** – This includes IHCP provider reference modules, bulletins and banner pages. MCEs must follow IHCP Policy (fee-for-service criteria) exactly for the following items:
   - ABA Therapy: *IHCP Bulletins* BT201867, BT201953 and *Behavioral Health Services* provider reference module
   - Drug Testing: *IHCP Bulletins* BT201846, BT202183 and *Laboratory Services* provider reference module
   - EndoPredict-Breast Cancer: *IHCP Bulletin* BT202010 and *Genetic Testing* provider reference module
   - Hysterectomies: *IHCP Bulletin* BT201976 and *Obstetrical and Gynecological Services* provider reference module

   - ReliZorb (in-line cartridge containing digestive enzymes for enteral feeding): *IHCP Banner Page* BR202050 and *Durable and Home Medical Equipment and Supplies* provider reference module
   - Speech-Generating Devices: *IHCP Bulletin* BT202012 and *Durable and Home Medical Equipment and Supplies* provider reference module
   - Spinal Stenosis: *IHCP Bulletin* BT2020111 and *Surgical Services* provider reference module
   - Transplants: *IHCP Bulletin* BT202019 and *Surgical Services* provider reference module
   - Bariatric Procedures: *IHCP Bulletin* BT202240 and *Surgical Services* provider reference module
   - Oxygen Usage: *IHCP Bulletin* BT202242 and *Durable and Home Medical Equipment and Supplies* provider reference module
6. **Non-Customized National Clinical Guidelines** – The MCE may choose to use either InterQual or MCG but must use the full suite of review criteria in these platforms – ***including*** the Medicare NCDs and the Medicare LCDs.
   - If an item is covered by MCG or InterQual, the MCE must use the applicable MCG or InterQual guideline in lieu of an MCE-derived UM policy or criteria.
   - **The MCG and InterQual guideline hierarchy is as follows:**
     a. **Must use diagnosis or procedure-specific guidelines before more general guidelines.**
     b. **Use Medicare (MCR) guidelines in this order: NCDs, then LCDs for Indiana.**
7. **MCE-Derived UM Policy and Criteria** – Must be preapproved by the state.
8. **Professional Society Guidelines** – Guided by published peer-reviewed literature (can supersede national and MCE-derived UM policy and criteria if specifically called out to be used in the Scope of Work, such as the American Society of Addiction Medicine [ASAM]).
9. **Professional References/Subject-Matter Expert (SME)** – Guided by published peer-reviewed literature.
10. **Best Standards of Care** – Guided by published peer-reviewed literature.

The OMPP reserves the right to add additional or remove the fee-for-service criteria and will provide the MCEs with appropriate notice.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 800-457-4584.

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Utilization management hierarchy

IHCP policy – This includes IHCP provider reference modules, bulletins and banner pages. MCEs must follow:

- ABA therapy: *IHCP bulletins* ***BT201867, BT201953*** **and** ***behavioral health services*** provider reference module.
- Drug testing: *IHCP bulletins* ***BT201846, BT202183*** **and** ***laboratory services*** **provider reference module**
- EndoPredict-Breast cancer: *IHCP bulletin* ***BT202010*** **and** ***genetic testing*** **provider reference module**
- Hysterectomies: *IHCP bulletin* ***BT201976*** **and** ***obstetrical and gynecological services*** **provider reference module**
- ReliZorb (in-line cartridge containing digestive enzymes for enteral feeding): *IHCP banner page* ***BR202050*** **and** ***durable and home medical equipment and supplies*** **provider reference module**
- Speech-generating devices: *IHCP bulletin* ***BT202012***
- and ***durable and home medical equipment and supplies*** **provider reference module**
- Spinal stenosis: *IHCP bulletin* ***BT2020111*** **and** ***surgical services*** **provider reference module**
- Transplants: *IHCP bulletin* ***BT202019*** **and** ***surgical services*** **provider reference module**
- Bariatric procedures: *IHCP bulletin* ***BT202240*** **and** ***surgical services*** **provider reference module**
- Oxygen usage: *IHCP bulletin* ***BT202242*** **and** ***durable and home medical equipment and supplies*** **provider reference module**

Utilization management hierarchy (cont.)

Non-customized national clinical guidelines – The MCE may choose to use either InterQual or MCG but must use the full suite of review criteria in these platforms – ***including*** the Medicare NCDs and the Medicare LCDs.

- If an item is covered by MCG or InterQual, the MCE must use the applicable MCG or InterQual guideline in lieu of an MCE-derived UM policy or criteria.
- **The MCG and InterQual guideline hierarchy is as follows:**
- **Must use diagnosis or procedure-specific guidelines before more general guidelines.**
- **Use Medicare (MCR) guidelines in this order: NCDs, then LCDs for Indiana.**

Turnaround time (TAT)

- **Standard pre-service (non-urgent):** Effective July 1, 2023 , changed from seven calendar days to five business days from the received date
- **Urgent/expedite pre-service:** Effective July 1, 2023 , changed from three calendar days (72 hours) to 48 hours from the received date
- **Emergent admissions and concurrent review:** one business day from receipt of all clinical information necessary to make a decision:
  - Up to three calendar days when clinical is requested
- **Retrospective review:** 30 calendar days from the received date:
  - This applies to PA requests for admission that are received on or after the date the member has been discharged from inpatient care

Types of case denials

- Medical necessity denials for physical health and behavioral health:
  - MCG criteria utilized to make medical necessity decisions for each request
  - MCG/ASAM criteria utilized to make medical necessity decisions for substance use disorder requests
  - Criteria used to determine member is receiving active treatment and at an appropriate level of care
- Administrative:
  - Late notification
  - Benefit exhaust
  - Failure to prior authorize
  - Non-covered service
  - Ineligible on date of service

Post-denial options

- **Reconsideration:**
  - Request within seven business days of denial date via fax or portal
  - Submit additional clinical information to the health plan and indicate **Reconsideration** on the fax coversheet
  - A decision will be rendered within seven business days of the reconsideration request
  - Reconsideration determinations are sent via notification letters
- **Peer-to-peer:**
  - Request within seven business days of denial date (initial or reconsideration)
  - To request a peer-to-peer call **866-902-4628**, option 1
  - Peer-to-peer determinations are sent via notification letter with fax confirmation
- **Appeal:**
  - Request within 60 calendar days of the denial date
  - Fax clinical to **855-535-7445**
  - A decision will be rendered within 30 days unless the request is expedited, in which the request will be responded to within 48 hours

Prior authorization lookup tool

- Allows providers to search codes to determine if prior authorization (PA) is required.
- Search by the specific line of business (Medicaid, SCHIP, Family Care, or Hoosier Care Connect).
- Directs the user on which guideline is utilized for the case review.
- Prior authorization lookup tool is available at **https://providers.anthem.com/in** > claims > **Precertification lookup tool** .

Clinical documentation

- Behavioral health-initial and concurrent review requests:
  - PA form with requested information
  - Intake assessment
  - Diagnosis
  - Medications
  - MD notes
  - Estimated length of stay
  - CIWA/COWS scores (if applicable)
  - Urine drug screen (UDS) results

- Physical health/behavioral health emergent inpatient admission requests:
  - 24 hrs of clinical information is highly preferred to demonstrate care implemented and evaluate the effectiveness of that care

- Physical health post-acute requests:
  - Therapy notes (speech, physical, occupational) should be provided with each review
  - Discharge planning:
    - Level of care should be provided by day 30 for Hoosier Care Connect members who are transitioning to Medicaid/Fee for Service
    - Level of care should be provided by day 60 for Healthy Indiana Plan (HIP) members

Discharge documentation

- Importance of discharge information being submitted (BH and PH):
  - Discharge planning notes provide helpful information to aid in medical necessity reviews and case management referrals
  - Timely notification of discharge dates, within three business days is preferred
  - Timely follow-up with members is crucial to help prevent rapid readmissions
- Behavioral health-discharge information expected:
  - Discharge medications
  - Follow-Up appointments/level of care transitioning to
  - Discharge diagnosis
  - Updated contact information

Physical health Provider Relationship Account Managers

Zone 1/Beacon Health Systems, St. Joseph Regional Medical Center

Jessi Earls
Jessica.Wilkerson-Earls@anthem.com
317-452-2568

Zone 2

Whit'ney McTush
Whitney.McTush@anthem.com
317-519-1089

Zone 3/Lutheran

Ashley Holmes
Ashley.Holmes@anthem.com
317-315-0623

Zone 4

Jamaal Wade
Jamaal.WadeSr@anthem.com
317-409-7209

Zone 5/Eskenazi, Home Health and Hospice, Skilled Nursing Facilities

Matt Swingendorf
Matthew.Swingendorf@anthem.com
317-306-0077

Zone 6

Jonathan Hedrick
Jonathan.Hedrick@anthem.com
317-601-9474

Zone 7/Baptist Health, Cincinnati Children's Hospital Medical Center, Norton Healthcare

Sophia Brown
Sophia.Brown@anthem.com
317-775-9528

Zone 8/Out-of-state providers

Angelique Jones
Angelique.Jones@anthem.com
317-619-9241

Indiana University Health, Parkview Regional Health, Ascension	Community Health Network, Franciscan Health, Deaconess
David Tudor David.Tudor@anthem.com **317-447-7008**	Nicole Bouye Nicole.Bouye@anthem.com **317-517-8862**

Director, Provider Relationship Account Management

Jacquie Marsalis
Jacqueline.Marsalis@anthem.com
317-431-2439

Provider experience zone map

https://providers.anthem.com/docs/gpp/IN_CAID_PU_NetworkRelationsMap.pdf?v=202110061311

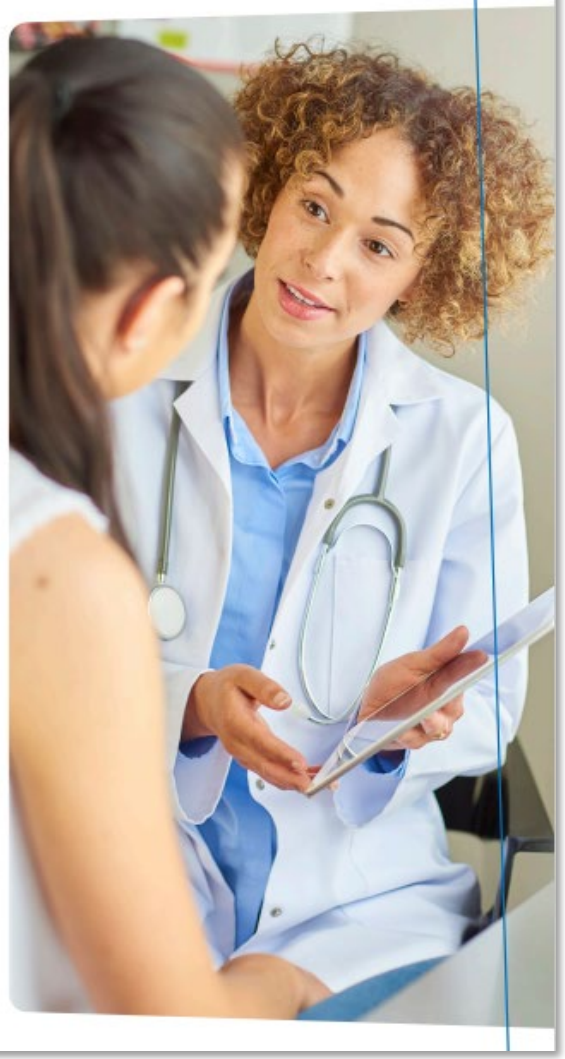
Statewide behavioral health (BH) subject matter experts (SME)

Acute care hospitals
Tish Jones, Provider Relationship Account Manager
Latisha.Willoughby@anthem.com
317-617-9481

Community mental health centers/Federally qualified health centers/Rural health clinics
Matthew McGarry, Provider Relationship Account Manager
Matthew.McGarry@anthem.com
463-202-3579

Substance use disorder (SUD)/Opioid treatment program (OTP)
Alisa Phillips, Provider Relationship Account Manager, Sr.
Alisa.Phillips@anthem.com
317-517-1008

Michele Weaver, Provider Relationship Account Manager
Michele.Weaver@anthem.com
317-601-3031



Provider experience BH subject matter experts

UM contacts for Anthem

- **Physical health UM:**
  - Inpatient/Continued Stay Review:
    - Tara Wallace, RN Manager
      - tara.wallace@anthem.com
    - Kasey Reisman, RN Manager
      - kasey.reisman@anthem.com
  - Outpatient:
    - Terrie Sproat, RN Manager
      - terrie.sproat@anthem.com

- **Behavioral health UM:**
  - Inpatient/Outpatient/Continued Stay:
    - Amy McConnell, LCSW Manager
      - amy.mcconnell@carelon.com
    - Ben Pfeiffer, LCSW Manager
      - benjamin.pfeiffer@carelon.com

https://providers.anthem.com/in

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INBCBS-CD-040232-23 October 2023