Kentucky
Medicaid • Medicare Advantage • Commercial

2025 Hospital Webinar

Becky George and Brian Richardson

January 14, 2025

Anthem

Agenda

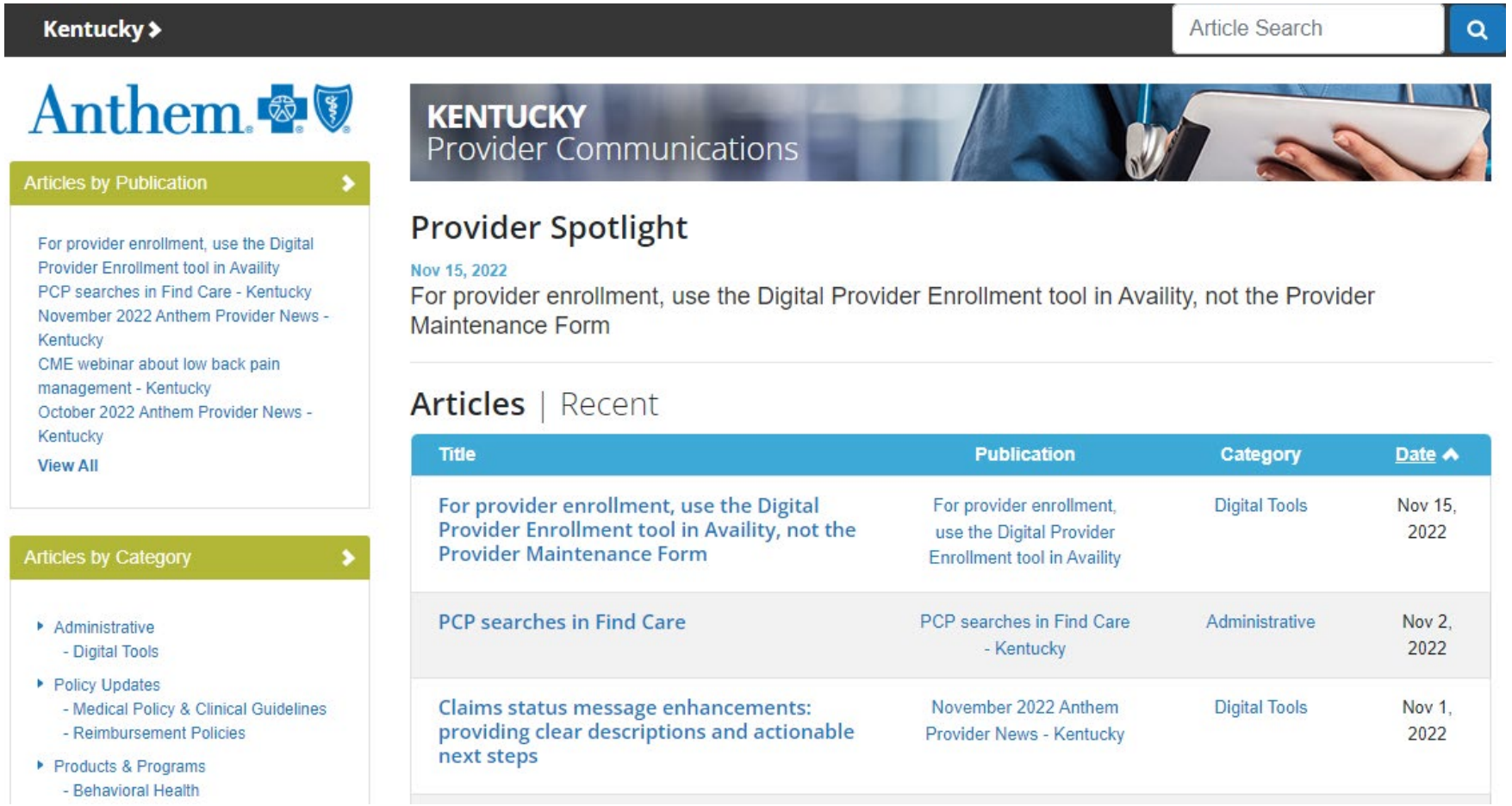
- Provider Relations contacts
- Policy and announcements
- Kentucky Commercial local utilization management
- Medicare Advantage
- Grievances and appeals
- Questions

Note: Discussion includes Commercial and Medicare Advantage provider services.

Anthem Provider Experience contacts

anthem.com/content/dam/digital/docs/provider/commercial/general/KYBCBS-CDCM-026466-23.pdf

Policy announcements — newsletters



https://providernews.anthem.com/kentucky

Use this link to sign up for email newsletters: Kentucky - Provider News

Policy announcements — Expansion of Carelon Medical Benefits Management, Inc. programs

When to use Anthem versus Carelon Medical Benefits Management for Commercial is located on our website and newsletter. Below link displays updates for providing the authorization based on service. Effective March 1, 2025.

Policy link:
https://providernews.anthem.com/kentucky/articles/expansion-of-carelon-medical-benefits-management-inc-program-23151

At a glance:

- Carelon Medical Benefits Management will expand programs to include cardiovascular, musculoskeletal, and surgical reviews beginning March 1, 2025.
- Additional outpatient UM will include transportation, fertility, and various other therapeutic and monitoring services.
- Providers must obtain online pre-service reviews for certain procedures starting February 24, 2025.

Policy announcements — Expansion of Carelon Medical Benefits Management, Inc. programs (cont.)

When to use Anthem versus Carelon Medical Benefits Management for MA is located on our website and newsletter. The link below displays updates for providing the authorization based on service. Effective March 1, 2025.

Website link: https://providernews.anthem.com/kentucky/articles/expansion-of-carelon-medical-benefits-management-inc-program-23022

This is a reminder that effective March 1, 2025, Carelon Medical Benefits Management will expand the cardiovascular program to perform medical necessity reviews for an additional procedure for Anthem members. Carelon Medical Benefits Management works to improve healthcare quality and manage costs for today's most complex and prevalent tests and treatments — helping to promote care that is appropriate, safe, and affordable.

Bulletins discussing the authorization process can be found at:
https://providernews.anthem.com/kentucky?s=ICR

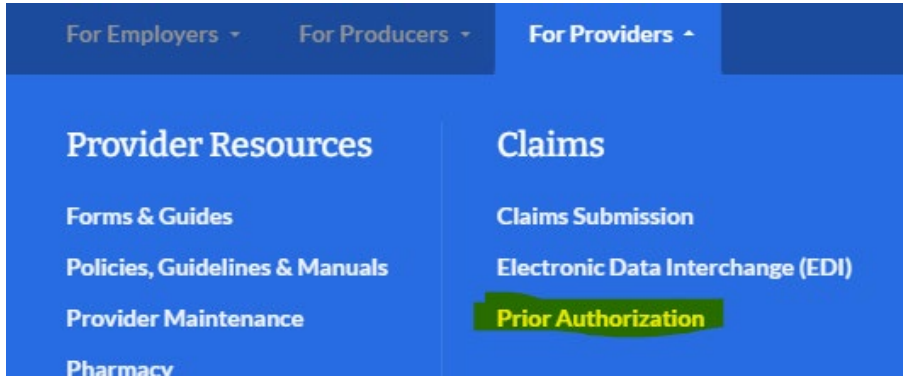
Medical Commercial hospital utilization management

Medical inpatient UM

All inpatient admissions require preapproval:

- Acute care hospital
- Inpatient rehabilitation
- Long term acute care
- Skilled nursing facility

Anthem UM authorization requirements can be found at anthem.com.



Core business hours:

- We are available for extended hours on Monday and Friday 8:30 a.m. to 6 p.m. ET.
- We are available Tuesday to Thursday 8:30 am to 5 p.m. ET.
- We also provide coverage on weekends and holidays.

Medical inpatient UM (cont.)

Authorization for acute initial admission or continued stay can be requested electronically via fax, the provider portal ICR (Interactive Care Reviewer), Availity Essentials, or by telephone.

Contact information:

- Fax: **800-730-6061**
- Phone: **877-814-4803** (please have the member ZIP code available for accurate call routing)

More about ICR:

- ICR allows providers to electronically submit authorization requests to Anthem at no cost to them, as well as to track the status of authorizations.
- If interested and not yet registered providers may register to use ICR at https://Availity.com.

For additional questions regarding the ICR tool, providers can contact their local network relations representative.

Authorization for post acute initial admission or continued stay are requested through Carelon Medical

Benefits Management:

- Skilled nursing facilities (including swing beds), inpatient rehabilitation facilities, and long-term acute care hospitals
- Requests accepted via portal or telephone only: https://portal.mynexuscare.com/

Medical inpatient UM (cont.)

Electronic medical record (EMR)
Anthem is pursuing partnerships with our Kentucky facilities to gain access to Anthem member's electronic medical records.

EMR access would:

- Decrease lack of Information denials.
- Decrease time spent by facilities to submit clinical information.
- Decrease the number of cases pended for clinical information.
- Allow information gathering to enhance collaboration with the facility for discharge planning for successful member outcomes.
- Leverage EMR access for case management services as well to assist with discharge planning.

If you are interested in partnering with us for access to your facilities EMR, please contact Tiffanie Merriman.

Medical inpatient UM (cont.)

Clinical review requests

When submitting information via fax always use a coversheet and include the authorization number if known. Also indicate on the coversheet what is being requested, (for example, continued stay with specific dates, discharge date).

Per *HIPAA* guidance, only send pertinent clinical information for the length of stay being requested, not the entire medical record. Sending the entire medical record or information that is not pertinent to the current request can potentially delay the decision.

Kentucky surgeries are always urgent. Authorization requests for surgeries should always be classified as urgent — never elective.

A request should only be classified as retrospective if the member has been discharged from the hospital at the time the request is submitted. Please do not classify the case as retrospective via the portal if the member has not been discharged.

When submitting clinical information via Availity, the question “Is the patient still in the hospital?” must be answered correctly. If it is answered No but the member is still in the hospital, Availity will not let you proceed without entering a discharge date. That will then automatically classify the case as retrospective and can potentially delay the decision.

Discharge planning begins upon admission. Provide the discharge plan as soon as it is available and update with any changes during the course of the hospital stay. This allows for the Anthem nurse to assist with any discharge planning needs as soon as they are known.

Notify Anthem of discharge dates, include the disposition and the time if known. The inability to close cases timely could result in issues with claim payments.

Medical inpatient UM (cont.)

Adverse determinations:

- One re-review and one peer-to-peer discussion are available per review.
- In the event of an adverse determination, a re-review may be requested. Submit additional clinical information and indicate that it is a request for re-review.
- A peer-to-peer discussion with an Anthem medical director is available. To schedule, call **888-870-9342** (for Carelon Medical Benefits Management, call **833-404-1682** for peer-to-peer call).
    - Choose OP or IP
    - Choose your state (KY)
    - Provide the following information:
        - Reference # in letter (starts with letters UM)
        - Member ID #
        - Member full name and spelling
        - Member date of birth
        - Physician name, spelling, and best callback number
        - Provide four weekday dates between 8 a.m. and 4 p.m. ET

Medical inpatient UM (cont.)

BlueCard

UM does not have any relationships with BlueCross BlueShield plans outside of Anthem's 14 plans. For questions/concerns related to authorization outside of Anthem, the provider must work with that plan directly as we do not have access to that information, nor do we have contacts from a UM perspective to those plans.

Medical inpatient UM (cont.)

Late call penalty:

- Penalty sanctions will apply to elective, urgent, and emergent IP late precertification requests.
- If the request is late, our system auto-applies the late call penalty.
- If submitting a late request with justification (exception), please **note this on the first page of the authorization**
- Exceptions to late call penalty:
  - Maternity (delivery) admissions
  - Insurance information was not available from the member at the time of admission or incorrect information was received from the member, due to illness, mental status, or language differences at the time of services. Including primary payer issues
  - Anthem system problems prevented authorization from being obtained Anthem provides erroneous information
  - Provider was given wrong information regarding an authorization or patient eligibility by an Anthem employee
  - Provider system outage (more than 48 hours beyond date of service requiring a preapproval)

Medical inpatient UM (cont.)

Appeals

Send written appeal to the address below.:

Anthem Blue Cross and Blue Shield

Grievance and Appeals

P.O. Box 105568

Atlanta, GA 30348-5568

Include:

- Member's name.
- Member's ID number.
- Name of the provider.
- Dates of service.
- Claim ID or reference number.
- Specific reasons for disagreeing with the decision.

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Medical inpatient UM (cont.)

Case management:

Case management is a service provided to all members at no additional cost.

Case management is a collaborative process of member support that evaluates, develops, implements, and coordinates options, resources, and services. It includes working one-on-one with members, their families, and other members of the interdisciplinary care team.

Case managers educate and support members to empower self-reliance in best managing their health. Through case management, members understand their options, access available services, and participate in managing their healthcare needs.

Anthem case managers can begin to contact the member and introduce the case management program while the member is in the facility, offer in-network resources to the hospital/facility case manager or discharge planner.

Contact information for case management referrals:

- Kentucky Local Commercial members: **800-944-0339**
- Kentucky Employee Health Plan (KEHP) members: **877-636-3716**

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Medical inpatient UM (cont.)

Kentucky Local Commercial UM contact information:

Tiffanie Merriman, Nurse Medical Management UM lead

- Phone: **317-287-0748**
- Email: tiffanie.merriman@anthem.com

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Medical outpatient UM

Building OP UM case in Availity:

- Make sure to load case appropriately in portal:
  - Choose correct case type/type of service.
    - For example, if this is a request for a surgical procedure or anesthesia, you should select surgical and not medical case type.
  - For out of network requests:
    - Only check Yes to this if you are asking for a GAP exception for the provider.
  - For place of service:
    - If being performed in office, you should **not** choose a servicing facility
  - Make sure to provide contact information for provider when making requests through Availity:
    - Provider name
    - Direct phone line
    - Fax number
- Make sure to appropriately use urgent level of service.

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Medical outpatient UM (cont.)

Make sure to include the appropriate member identifiers (with all submitted documents (including photos) when submitting via fax and/or Availity Essentials:

- Name
- DOB
- Member ID number
- Any case reference number (starts with letters UM)

Anthem's *Clinical Guidelines* and *Medical Policies* in Kentucky can be found at: https://providers.anthem.com/kentucky-provider/resources/manuals-policies-guidelines

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Post-claims review

Nonspecific codes (NOC):

- Processing of NOC codes can be delayed if there is not adequate description provided:
  - To ensure faster processing and reduce send-backs, provide a description on the claim or written out with the code in order to assist with identification and prompt processing

Late call penalty process after hospital discharge has occurred

- If there was not an authorization preservice or during inpatient stay, a claim is submitted, and penalty is applied unless the provider is excluded
- There may be extenuating circumstances as to why the authorization was not obtained preservice:
  - Submit a dispute with these extenuating circumstances outlined.
  - Submit medical records with the dispute.
- The dispute will be reviewed:
  - If the dispute is upheld, the provider must go through the administrative grievance process to resolve.
  - If overturned, then medical necessity is reviewed, and a medical necessity determination is made (the provider has the appeals rights based on the denial letter).

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Medicare Advantage

Medicare Advantage inpatient UM

Authorization for acute initial admission or continued stay can be requested electronically via fax, the provider portal ICR (Interactive Care Reviewer), Availity Essentials, or by telephone.

Contact information:

- Fax: **866-959-1537**
- Phone: **877-467-1199**

ICR

- ICR allows providers to electronically submit authorization requests to Anthem at no cost to them, as well as to track the status of authorizations.
- If interested and not yet registered, providers may register to use ICR at https://Availity.com.
- For additional questions regarding the ICR tool, providers can contact their local network relations representative.

Medicare Advantage inpatient UM (cont.)

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Anthem is pursuing partnerships with our Kentucky facilities to gain access to Anthem member's electronic medical records.

EMR access would:

- Decrease lack of Information denials.
- Decrease time spent by facilities to submit clinical information.
- Decrease the number of cases pended for clinical information.
- Allow information gathering to enhance collaboration with the facility for discharge planning for successful member outcomes.

Medicare Advantage post-acute care: Carelon Medical Benefits Management

Authorization for post acute initial admissions or continued stay should be requested through Carelon Medical Benefits Management.

Carelon Medical Benefits Management is partnered with Anthem to provide utilization management for in-patient post-acute services in the states of CA, CO, CT, GA, IN, **KY**, ME, MO, NH, NM, NV, OH, VA, WA, and WI.

This includes requests from SNFs, IRFs, and LTACHs.

There are three ways to submit an authorization request: portal, fax, or phone.
Use of the portal is encouraged as it is the easiest and most efficient way to submit a request.

- Portal: https://portal.myNEXUScare.com/
- Fax: **833-311-2986**
- Phone: **844-411-9622**

What member plans are included?
A list of in-scope plans can be found online at: https://providers.carelonmedicalbenefitsmanagement.com/postacute/

Carelon Medical Benefits Management has training sessions available. Please request information at: PACprovider_relations@carelon.com

Email for provider questions: pacprovider_network@carelon.com
Phone number for provider questions: **844-411-9622, option 6**

Appeals: mynexusappeals@carelon.com

Medicare Advantage member management programs

Discharge planning is a multidisciplinary process that begins at or before a member's admission and continues until the member has a safe, efficient, and effective discharge:

- Determines the type of care needed after the member leaves the hospital.
- Assists with transition of the member from one level of care to the next.
- Team approach between the facility, case management, social workers, nurses and complex discharge planners.
- Goal is to ensure the member's identified needs are met and has a safe discharge to the next level of care.

Case management

Anthem case managers are licensed registered nurses, social workers, and health educators who work with our members, using their benefits and local resources to achieve stability and/or improve their overall health:

- Outreach is via telephone.
- Focus is on our sickest and most at-risk members.

Medicare Advantage Complex Discharge Planning and SDoH

Complex Discharge Planning is a team comprised of clinical and medical management staff dedicated to identification of members at high risk for readmission and SDoH impacts on their health. This team focuses on the needs of the most complex membership.

The CDP team collaborates with the healthcare team, the member and caregivers to facilitate the development of a comprehensive and safe discharge plan. This is accomplished by outreach to members in facility throughout their clinical stay and for up to 30 days post discharge for transition of care.

One of the tools that CDP uses is the SDoH home visit program. This program can provide the consenting member with a home assessment by a trained professional to identify social needs that may prohibit compliance with the discharge plan. Issues addressed include:

- Housing
- Food
- Transportation
- Utilities
- Education/literacy
- Finances
- Personal safety
- Post discharge readiness
- Support systems

An assessment and action plan are developed by the SDoH professional and sent back to the assigned CDP for review and closure of identified care gaps.

The CDP will work with member and family for up to 30 days post discharge to assure that all necessary services and equipment are in place for the member to go home and stay home safely.

Medicare Advantage CTI

Using the evidence-based model created by Dr. Eric Coleman, our team employs transitions coaches who are certified in the Care Transitions Interventions (CTI) model. Anthem implemented the CTI program in 2016, and the program has continued to grow.:

- Goal is to reduce avoidable hospital readmissions
- Objective is for members to learn self management skills, assert a more active role in self-care, and link with community resources.
- CTI coaches work with members via phone for 30 days post hospital discharge and focus on member's personal goal as they transition home, along with the four pillars:
  - Follow-up appointments
  - Medication management
  - Red flags
  - Using a personal health record
- CTI coaches focus on empowerment, rapport building, motivational interviewing, modeling, and skill transference
- Members are identified on daily acute care census lists based on readmission risk or by internal referrals. The CTI program is offered to various lines of business.

Medicare Advantage contacts

Jill Raymer, Manager for Acute IP MA Individual, SNP, and under age 65 membership

502-269-4248

Jill.raymer@anthem.com

Pam Godfrey, Manager for CDP program

937-203-6159

Pamela.godfrey@elevancehealth.com

Sheri DeMange, Manager for CTI program

937-234-3518

Sheri.demange@anthem.com

Jeanette Davis, Director for GRS (Group Retiree Solutions)

470-825-6091

Jeanette.davis@anthem.com

Kathleen Dunn, Director for Prior Authorization

317-381-1996

Kathleen.dunn@anthem.com

CSBD grievances and appeals

What we do

Provider disputes (non-regulated)

- Claim payment disputes
- Clinical denials
- Commercial Medical
- Behavioral Health
- Pharmacy
- **95%** compliance goal

Grievances

- Complaints against plan or provider
- Quality of Service and Quality of Care
- Commercial Medical
- Behavioral Health
- Pharmacy
- All markets
- **95.5%** compliance goal

Member appeals

- Review of adverse determinations
- Admin or clinical
- Commercial medical
- Behavioral health
- pharmacy
- All markets
- **95.5%** compliance goal

Regulatory inquiries

- Regulatory complaints
- Independent medical reviews
- Risk Appeal requests
- NBPP non-formulary reviews
- All markets
- **98%** compliance goal

Provider disputes (regulated)

- Claim payment disputes
- Clinical denials
- Commercial Medical
- Behavioral Health
- Pharmacy
- **95%** compliance goal

Why it's important

- G&A is the last step for the member's full end-to-end experience.
- We fully audit the member's denial against all benefit and contractual obligations.
- We include consideration of all communications to the member related to coverage.
- G&A is governed by the following:
  - Multiple regulatory agencies
  - Multiple state Departments of Insurance
  - Department of Labor,
  - Other governing bodies (such as BCBSA)
  - Accreditation agencies (such as NCQA, URAC, etc.)
- These agencies expect G&A to accurately make a final determination based on all relevant information.
- We monitor and improve the level of care and services provided to our members.
- We leverage data and identify trends to drive policy and process changes.

What does the appeal process look like?

Legend

- Portal/web
- Mail, email, or fax
- Internal system/IQT
- Review/ research
- Task/ assignment
- Decision or sign-off
- Overturn/ approval
- Uphold/ denial

Receipt

The member, their authorized rep, or provider submits a request to appeal an adverse determination through mail, fax, web, or phone (where allowed).

G&A receives or builds the case in NextGen (mostly through automation channels such as system integration, IQT Robot, or Smart Intake).

Acknowledge

Anthem notification* in writing acknowledging receipt of the appeal.

*Acknowledgement requirements vary by market. Verbal acknowledgement, instead of written, is provided for expedited appeals where required.

Triage

A G&A analyst reviews the request and validates whether a request is a true appeal or not.

The triage analyst updates system coding and sends the appeal to a lead or manager for assignment.

A G&A lead or manager assigns the appeal to an analyst for review and resolution.

Research

A G&A analyst researches the claim, eligibility, benefits, and provider network to make a decision on an administrative appeal.

The G&A analyst will prepare the appeal to send it for review by a clinician when there is medical judgment involved.

The G&A analyst uses other internal systems and resources to gather documents and other information that supports the decisions rendered on the appeal.

Decision

The G&A analyst determines whether to approve or deny administrative appeals. A licensed clinician determines whether to approve or deny clinical appeals.

If overturning the appeal, the G&A analyst coordinates the adjustment on any impacted claims or the authorization as appropriate.

Resolution

The G&A analyst generates and sends written notification regarding the outcome of the appeal to the member and carbon copies their authorized rep or provider (when appropriate) within the required turnaround times*.

* Turnaround times vary based on market, group, funding arrangement, level of review, priority, and whether admin or clinical.

NextGen and Workstream integration

Important terminology

Adverse benefit determination	A denial, reduction, or termination of benefit coverage for healthcare services (for example, care deemed not medically necessary, care deemed experimental or investigational, plan exclusions or limitations do not allow coverage, patient ineligible on plan at time of service, etc.).
Member appeal	Formal request from the member, their authorized representative, or the provider on behalf of the member to review an adverse determination that is filed in writing or verbally where allowed. They can be administrative (contractual) or clinical (medical judgment).
Quality of service grievance	Expression of dissatisfaction by the member or their authorized representative regarding the plan or provider dealing with **non-clinical** services received or general administration of their plan (for example, staff attitude/behavior, incorrect provider directory, office appearance, etc.).
Quality of care grievance	Expression of dissatisfaction by the member or their authorized representative regarding the quality of healthcare services provided to them (e.g., hospital-acquired infection, bad medication interaction, surgery performed on wrong part of body, misdiagnosis, etc.).
Provider dispute/appeal	Formal request from the provider or their authorized representative on their own behalf to review an adverse determination that is filed in writing. They can be administrative disputes (reimbursement or contractual) or clinical appeals (medical judgment).
Regulatory inquiry/complaint	Complaints filed in writing and filed with the appropriate state or federal regulatory agency. The G&A Regulatory team receives these complaints directly from the regulatory body and are required to provide a formal response (such as a complaint sent to Virginia BOI by the provider).

Submit additional questions to:

Rebecca.george@anthem.com
and
Brian.richardson2@anthem.com

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

KYBCBS-CDCRCM-076219-25 | February 2025