

## **UTILIZATION MANGEMENT**

The Anthem Health Care Management Division has a singular dynamic focus - to continually improve the system of health care delivery that influences utilization and cost of services and measures performance. Medical Management includes a collection of processes that help to optimize the cost of quality care by effectively facilitating the right care interventions to the right members, at the right time, and in the right setting. Our goal is to provide an operationally efficient and effective system that delivers value by giving members access to quality, cost-effective health care through a customer-focused environment.

The major responsibility of the Medical Management Department is to authorize and coordinate the appropriate use of services for individuals across the care continuum. Preservice, concurrent and post-service reviews are performed for inpatient, outpatient, in-network and out-of-network services. The goal of Medical Management activities is to achieve optimal health outcomes

### **Staff Qualification and Accountabilities**

The Medical Management department employs qualified staff to carry out the day to day utilization and care management functions. Anthem is committed to encouraging and assisting staff in the continuing education process.

Inter-rater reliability audits and peer quality audits with feedback and education are performed on a regular basis to help ensure clinical and non-clinical staff are adhering to established policies and procedures. Anthem Behavioral Health and BHN staff have similar staff qualifications relevant to mental health/substance abuse specialties.

Each Anthem associate must have successfully completed an approved and established training and orientation program. The Medical Director in each state is responsible for overseeing the Utilization Management program, participating in QI initiatives and supporting day-to-day operations.

*Registered Nursing Positions:* Anthem Registered Nurses coordinate decision-making activities within Anthem Medical Management. Nurses must maintain an active license without restrictions to practice in the state in which they are employed. A minimum of two to five years of clinical experience is required to deal with the complex and varied situations encountered during the utilization management process. Certification in a specific job related area is encouraged. These certifications include Certified Case Manager (CCM); Certified Professional of Health Care Quality (CPHQ); Certified Health Educator, and/or Certified Managed Care Nurse (CMCN).

Other clinically licensed associates (e.g.licensed practical nurses, respiratory care professionals) are required to maintain an active license without restrictions to practice in the state in which they are employed. A minimum of two to five years of clinical experience is required to deal with the complex and varied situations encountered during the Medical Management process.

## **Prior Authorization of Benefits Coverage**

Requests by providers/practitioners for prior authorization of benefits are reviewed by Anthem registered nurses to determine if requests meet applicable benefit coverage and Anthem medical policy criteria. This process provides confirmation of medical necessity to both providers/practitioners and members prior to certain services, some of which may be considered cosmetic and/or experimental. The registered nurse or licensed clinical reviewer confirms eligibility, specific benefits, and medical policy. If the nurse or licensed clinical reviewer questions whether the request meets the applicable benefit and/or policy, this request is sent on to a physician reviewer for review and determination. If the request is determined not to be medically necessary or is not a covered benefit, a letter is sent to both member and provider/practitioner with instructions on appeal rights and process. The nurse or licensed clinical reviewer may also coordinate prior authorization for inpatient admissions as well as coordinate decisions and notifications with care managers and/or referral nurses to help facilitate continuity and coordination of care.

## **Prior Authorization of Elective Inpatient Admissions**

Using established medical criteria (Milliman Care Guidelines), inpatient admissions are reviewed to determine the appropriate level of care, such as acute or skilled level of care. Inpatient admissions are reviewed to determine the appropriateness of the requested treatment setting, not the appropriateness of the procedure or treatment plan. If criteria are satisfied, the hospital admission is certified. Written notification of approval is sent to the member and provider/practitioner as required by law. Cases, which do not meet criteria, are referred to a board certified, clinical peer physician for further review and consideration. UM staff may not make an adverse determination on issues regarding medical necessity. Adverse determinations of services requested are communicated in writing to the member, provider and primary care physician. This communication contains detailed instructions on accessing the appeal process.

## **Out of Network Referral Processing and Management**

Requests by primary care physician offices to refer a member to an out-of-network and/or out of state provider or facility (collectively “out of network”) are initially handled by the UM operations staff. The registered nurse reviewer or other licensed clinical reviewer considers availability of in-network providers/practitioners, continuity or transition of care, and other clinical considerations when processing requests for out of network referrals. Other components of the overall review include helping to ensure the coordination with other areas such as: care management, inpatient review, and prior authorization. The nurse reviewer or other licensed clinical reviewer utilizes the guidance of the Medical Director and/or clinical peer physician reviewer, as appropriate. The members and providers/practitioners are informed by letter of all review determinations.

## **Concurrent Review**

Anthem hospital case managers conduct concurrent review telephonically, via fax transmission and by on-site review. Concurrent review includes review of appropriateness of setting and level of care (e.g. acute, skilled), discharge planning, and coordination of alternatives to inpatient care. Information sources available to the hospital case manager include online computer access to member information such as member eligibility and benefits, provider/practitioner demographics and network affiliations, as well as medical criteria guidelines, if needed. Based on information obtained from the hospital staff and communication with the attending physician when needed, and using established medical criteria (Milliman Care Guidelines), the hospital case manager authorizes the number of days to be certified. The decision is made within 24 hours. The certification approval/denial process continues as previously described. Notification of additional certified days are provided verbally. Upon discharge the member and provider/practitioner receive written notification of certified length of stay approved as required by state law and/or local practice.

Cases, which do not meet criteria, are referred to an appropriate clinical peer board certified physician for further review and consideration. The physician reviewer is made available to communicate with the attending physician prior to making a determination. If contact is made, the decision is communicated by the physician reviewer to the attending physician. Written notification of the denial of certification is provided to all parties within the state law mandated timeframes, and includes the reason for the denial. Appeal rights and the process to appeal are given in this communication along with the right to request a copy of the clinical rationale used to make the denial determination.

Discharge planning is part of the review process and may begin prior to the member's admission or early during the hospital stay. It takes into account the specific medical requirements, the member's family and community support systems, and community practice patterns as well as the ability of the local delivery system to meet the member's needs. Anthem may facilitate the coordination of care among the physician, hospital discharge planner, and any community provider (home health agency, physical therapist, etc.) required after the member leaves the hospital.

Discharge planning is an important function in the review process, which involves utilization management associates working with the attending physician or hospital to enable the member to be discharged from the hospital when inpatient level of care is no longer medically necessary. This process includes certification for transition of certain treatments from an acute hospitalization to a less acute setting such as the home setting with medical supervision, such as long term intravenous therapy or wound care, when appropriate. The utilization management staff will assist the physician, hospital, and family in understanding the benefits available to support a discharge plan.

When referrals are generated to other facilities (i.e. hospice, nursing home, or home health care facility), Anthem will monitor and evaluate the effectiveness of the discharge plan. Anthem will work with the physician and facility regarding the services and assist transition to other care as needed.

## **Post-Service Review**

Post-service review occurs when a request for approval of services is made and the services have already been rendered. The medical record is requested and reviewed retrospectively to determine the appropriateness of the treatment setting, level of care, and/or benefit determination. In that case, the nurse reviewer or other licensed clinical reviewer will review the medical information and follow through with the same review process as described above.

Where denial is anticipated, all information is sent to a physician reviewer for review and determination. This review will be completed within 30 calendar days or within timeframes mandated by law.

## **Compensation**

Medical Management decision making is based only on appropriateness of care and service. The Plan does not compensate for denials and does not offer incentives for denials.

Statements regarding compensation are distributed to members and employers via plan newsletters, to employees through Medical Management orientation and newsletters, and to providers via newsletters and the Administrative Policies and Procedures manual (provider manual).

## **Hours of Operation**

### **Connecticut/Maine/ New Hampshire**

Hours: 8:00 a.m. to 5:00 p.m. EST, Monday through Friday with voicemail available twenty-four hours a day including weekends and holidays.

Expedited Review Line: 1-888-507-8803  
Hours: 8:00 a.m. to 9:00 p.m./365 days

Anthem's utilization management associates are available Monday through Friday by toll free telephone at a minimum of forty (40) hours per week during normal business hours in the time zones in which it conducts utilization management activities.

Anthem's telephone system is a confidential voicemail system that is capable of accepting and recording calls after hours, on weekends, and holidays. Callers are provided with instructions and may leave a message with detailed information. Telephone calls are returned by the end of the next business day, or when the information necessary to respond is received from the caller.

