Indiana | Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

# Physical and Behavioral Health Prior Authorization

2025 Indiana Health Coverage Programs (IHCP) Works Annual Seminar

Anthem

# Agenda Topics

- Anthem Health Plans
- Indiana PathWays for Aging Dual Care
- Senate Enrolled Act 480 Amendments
- Availity Usage for Increasing Efficiency
- Case Denials
- How to Reduce Risk of Denial
- Post Denial Options
- Prior Authorization (PA) Look Up Tool
- Clinical Hierarchy Updates
- Face to Face Requirements
- Provider Relations

# Anthem Health Plans

- Healthy Indiana Plan:
  - Available to low-income adults (ages 19 to 64) this plan provides health insurance that encourages active participation in health management through cost-sharing and preventive care benefits
- Hoosier Healthwise:
  - Provides health coverage for Indiana children (up to age 19) and pregnant women in low-income families
- Hoosier Care Connect:
  - Tailored for Indiana residents who are aged 59 years and younger, blind, or disabled, and who are also not eligible for Medicare
- Indiana PathWays for Aging:
  - Designed for aging Indiana residents aged 60 and over, eligible for a full coverage aged, blind, or disability category (with or without Medicare), can be receiving long term support services such as long-term care facility or are approved for a PathWays waiver, can be on the Behavioral and Primary Health Coordination program. This plan offers access to resources and health services that promote independence and enhance quality of life

# Indiana PathWays for Aging Dual Care

- PathWays Dual Care: Member has both Medicare and Medicaid benefits:
  - Example: Medicare through Anthem and Medicaid Pathways through Anthem
- Utilization Management (UM) Reviews
  - One member identification number
  - Medicare will review for both Medicare and Medicaid
  - Single UM decision letter

# Senate Enrolled Act 480 Turnaround Times

Senate Enrolled Act 480 enhances the transparency and timelines in prior authorization timelines.

Below are some changes providers might notice in Anthem processes in response to the act:

- PA Turnaround Times (TAT):
  - Standard pre-service (non-urgent): 48 hours from the received date and time
  - Urgent/expedited pre-service: 24 hours from the received date and time
  - Concurrent review: 48 hours from the received date and time
  - Retrospective review: 30 calendar days from the received date:
    - This applies to requests for admission that are received on or after the date the member has been discharged from inpatient care

*All TAT excludes weekends, state, and federal holidays*

# Senate Enrolled Act 480 Additional Information

- Peer to Peer (P2P) completed within 48 hours of request
- Medicaid excluded from no PA required for the first 12 visits for physical therapy and chiropractic
- Approved PA requests are valid for 1 year:
  - Example: Procedures and testing

# Availity Usage for Increasing Efficiency

- All MCEs are required to accept prior authorization requests through secure electronic transmission (PathWays is excluded from this requirement)
- For training on how to use Availity: https://www.availity.com/customer-support/
- Anthem's electronic transmission is Availity
  - IHCP Bulletin: BT2025100
- For other ways to submit UM requests refer to the most up to date Anthem Medicaid Provider Manual: Anthem Provider Website > Resources > Provider Manual and Guides > Introduction Chapter

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT2025100 JULY 1, 2025

## IHCP allows grace period for provider requirement to submit MCE PA requests electronically

Per Indiana *Senate Enrolled Act (SEA) 480 (2025) Section 19*, managed care entities (MCEs) are required to accept prior authorization (PA) requests through secure electronic transmission. The IHCP is allowing a three-month grace period for compliance with Section 19 of SEA 480, making this requirement effective Oct. 1, 2025.

The legislation identifies several exceptions to this requirement for certain providers. Those exceptions include:

- Financial hardship
- Lacking sufficient internet access
- Limited number of individuals covered as patients or customers to warrant compliance

The IHCP encourages providers to watch for further MCE communications to better understand how MCEs will manage exceptions, provide portal training and ensure providers are registered with MCE portals.

**For more information**

Questions about managed care PA should be directed to the MCE with which the member is enrolled. For contact information, see the *IHCP Quick Reference Guide*.

# Types of Case Denials for Medical Benefits

- Medical necessity denials:
  - Criteria not met
- Administrative denial reasons:
  - Late notification
  - Benefit exhaust
  - Failure to prior authorize
  - Non-covered service
  - Ineligible on date of service

# How to Reduce Risk of Denial:

- Submit clinical with a fully completed IHCP PA Form: IHCP Prior Authorization Request Form to avoid delays that can result in late notification denials.
- Clear and concise clinical can help minimize Medical Necessity Denials because it helps ensure we have the best information when conducting the review.
- Verify Eligibility if ever in doubt. The Provider Healthcare Portal is an excellent resource: Indiana Medicaid Provider Healthcare Portal
- Double check member eligibility and that there is an approved prior authorization before elective inpatient admissions.
- Plan ahead to avoid benefit exhaust denials.

# Post-Denial Options: Reconsideration

- Reconsideration:
  - Request within 7 business days of denial date via fax or Availity portal (Availity Essentials)
  - Submit additional clinical information to the health plan and indicate Reconsideration on the fax coversheet or in the Availity note
  - A decision will be rendered within 7 calendar days of the reconsideration request
  - Fax to specific department:
    - Physical Health Inpatient UM: 844-765-5156
    - Physical Health Outpatient UM: 844-765-5157
    - Behavioral Health UM: Inpatient- 844-452-8074, Outpatient- 844-456-2698
  - Reconsideration determinations are sent via surface mail notification letters with fax confirmation

# Post-Denial Options: Peer-to-peer and Appeal

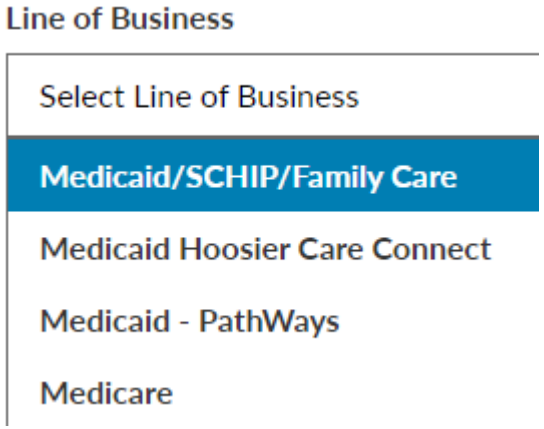
- Peer-to-peer:
  - Request within 7 business days of denial date (initial or reconsideration) for Healthy Indiana Plan, Hoosier Healthwise, and Hoosier Care Connect
  - Request within 15 business days of denial date (initial or reconsideration) for PathWays
  - Call 866-902-4628 > option 1 for IN > subsequent option 1 for physical health, option 2 for behavioral health
  - Peer-to-peer determinations are sent via notification letter with fax confirmation

- Appeal:
  - Request within 60 calendar days of the denial date
  - Fax appeal request and clinical to 855-516-1083, for oral or written instructions see Anthem provider manual > grievances and appeals chapter
  - A decision will be rendered within 30 calendar days unless the request is expedited, in which the request will be responded to within 48 hours

# Prior Authorization Lookup Tool (PLUTO)

Allows providers to search codes to determine if prior authorization (PA) is required

Search by the specific line of business (Medicaid/SCHIP/Family Care, Medicaid Hoosier Care Connect, Medicaid - PathWays)




Directs the user on which guideline is utilized for the case review

Prior authorization lookup tool is available at the Anthem provider website (Precertification lookup tool)

# Clinical Criteria Hierarchy Updates

Effective 8/1/2025: IHCP updated the prior authorization and utilization management hierarchy for MCEs:

- IHCP Bulletin: BT2025102

- Anthem Bulletin regarding Anthem's clinical criteria hierarchy for medical benefit services (excludes waivers services) effective 12/1/2025 Updated UM clinical hierarchy
- PLUTO will be the source to determine which medical policy and clinical guideline is used for a medical necessity review based on the CPT code
- To view the guideline from the Anthem provider site: Medical Polices and Clinical UM Guidelines

# Clinical Criteria Hierarchy By Department

Physical Health:

- Outpatient services
- State approved criteria is used to determine that the member is receiving medical necessity treatment and at an appropriate level of care

Inpatient services:

- Will continue to use non-customized Milliman Care Guideline (MCG) criteria
- Exception is inhaled Nitric Oxide which uses a state approved Anthem guideline

Behavioral Health:

- Non-customized MCG criteria is utilized to make medical necessity decisions for psychiatric requests
- Non-customized MCG and American Society of Addiction Medicine (ASAM) criteria is utilized to make medical necessity decisions for substance use disorder requests
- State approved Anthem clinical UM guidelines and medical polices

# Face to Face Requirements

- State Bulletin BT2025104
- New face to face required when condition changes
- Increase in hours = new face to face
- Functional assessment must support the need for home health from the physician or nurse practitioner

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT2025104 JULY 8, 2025

## Face-to-face encounter and documentation requirements clarified for home health PA requests

The Indiana Health Coverage Programs (IHCP) recently published updated documentation regarding home health prior authorization (PA) requests in *IHCP Bulletins* BT202525 and BT202545. This bulletin addresses additional questions about home health PA face-to-face encounter and documentation requirements.

**Face-to-face encounter requirements**

1. ***Who is responsible for the face-to-face encounter?***
   The qualified treating practitioner must document the face-to-face encounter. The documentation must include:
   - The date the practitioner saw the patient
   - Detailed clinical findings from the visits
   - Clear connections between clinical findings and home health care needs
   - Practitioner signatures and dates on all required documents

   The home health agency is responsible for submitting face-to-face documentation to the payer's PA contractor.

   Please note that it is unacceptable for the practitioner to verbally communicate the encounter to the home health agency, where the home health agency would then document the encounter as part of the certification for the provider to sign.

2. ***Can the face-to-face encounter be conducted via telehealth when it may be difficult to get the member to the treating practitioner's office?***
   Yes, face-to-face encounters can be conducted via telehealth. Healthcare Common Procedure Coding System (HCPCS) codes eligible for telehealth reimbursement can be found on *Telehealth and Virtual Services Codes*, accessible from the Code Sets webpage at in.gov/medicaid/providers. Providers must follow the billing policies for telehealth, which can be found in the Telehealth and Virtual Services provider reference module.

# Provider Relations

Anthem Provider Site:
- https://providers.anthem.com/indiana-provider/home

Receive email from Anthem:
- Anthem is now sending some bulletins, policy change notifications, prior authorization update information, educational opportunities, and more to providers via email.
- https://providernews.anthem.com/indiana/signup

To reach your Anthem Provider Team:
- Did you know that most questions and issues can be resolved by using the Anthem self-service tools? Please use Availity for inquiries like payment disputes, provider data updates, claims status, member eligibility, etc. You can also live chat with an Anthem associate from within the Availity portal.
- For other issues, you can message the Provider Experience team. Your Provider Experience representative will respond — usually within two business days:
  - https://providers.anthem.com/indiana-provider/contact-us/email

# UM Contacts for Anthem

- Physical health UM:
  - Director:
    - Samantha Mummert, MSN, RN samantha.mummert@anthem.com
  - Inpatient/Continued Stay Review:
    - Kasey Reisman, RN Manager kasey.reisman@anthem.com
    - Daniel Peters, RN Manager daniel.peters@anthem.com
  - Outpatient:
    - Terrie Sproat, RN Manager terrie.sproat@anthem.com
- Behavioral health UM:
  - Inpatient/Outpatient/Continued Stay:
    - Amy McConnell, DBH, LCSW Manager amy.mcconnell@carelon.com
    - Ben Pfeiffer, LCSW Manager benjamin.pfeiffer@carelon.com

# Questions


Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.



INBCBS-CD-092232-25 | October 2025