Anthem

Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Provider Bulletin
April 2022

Retroactive eligibility — Prior authorization/utilization management

Effective for dates of service on and after January 1, 2022, providers have a new option to obtain authorization for inpatient services provided to a member for whom retroactive eligibility has been identified post-discharge from an inpatient stay. Providers are now able to request authorization for inpatient services provided to these members prior to claims submission.

For patients with retroactive eligibility:

- If Utilization Management (UM) notification is required but was not performed timely and the patient has discharged:
    - Send an authorization request to the appropriate Anthem Blue Cross and Blue Shield (Anthem) team. Indicate when submitting the authorization request that the member was retroactively enrolled.
    - Include the following documentation:
        - Documentation of attempts to verify eligibility that demonstrates the member was made retroactively eligible by the State, such as screenshots of the eligibility verification tool.
        - Clinical documentation demonstrating the medical necessity for the services provided.
    - If approved, provider will receive an authorization number, which they can document on their claim at claims submission. Provider will follow normal claims filing process for approved cases.
    - If the documentation does not include sufficient details to support verification of retroactive eligibility, or if the services do not meet established medical necessity criteria, the request will be denied.
    - The authorization request must be received within 12 months of the member's eligibility start date with Anthem. If not received within 12 months, the request will be administratively denied for late notification.

Special consideration will not be given for situations in which the provider did not follow proper procedures that led to the denial, such as:

- Failure to verify eligibility at the time of service.
- Failure to notify the UM department in the required time frame, despite having access to the necessary information.

Providers may choose to continue to follow processes established in previous bulletin *Retroactive eligibility — Prior authorization/utilization management and claims processing*, which can be found at

https://providers.anthem.com/docs/gpp/IN_CAID_PU_RetroactiveEligibility.pdf. All other processes established in this bulletin are still in effect.

Submitting a prior authorization request and clinical documentation:

- Providers may request prior authorization and submit clinical documentation through the Interactive Care Reviewer (ICR) portal. The ICR is accessible via Availity at **https://www.availity.com/provider-portal**.

- Providers may submit clinical documentation via fax for all Anthem members to:
  - Physical health inpatient: **844-765-5156**
  - Behavioral health inpatient: **844-452-8074**
  - **If requesting prior authorization via fax, include the *IHCP Universal PA Form***

Providers may request prior authorization and inquire about utilization decisions or the UM process via phone:

- Call Provider Services Monday through Friday, 8 a.m. to 8 p.m., at the numbers below:
  - Hoosier Healthwise: **866-408-6132**
  - Healthy Indiana Plan: **844-533-1995**
  - Hoosier Care Connect: **844-284-1798**
- **Clinical documentation will need to be submitted via fax if the prior authorization is made via phone; verbal clinical will not be accepted.**

If you have any additional questions, contact your Provider Experience representative.

Email is the quickest and most direct way to receive important information from Anthem Blue Cross and Blue Shield.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the right or via our online form (**https://bit.ly/2XN9y9o**).