Anthem Blue Cross and Blue Shield Medicaid |
Ohio Medicaid Managed Care

# Doulas

Anthem

# Doula

Since October 3, 2024, we have allowed reimbursement for services performed by a doula.

Ohio's Revised Code (ORC) defines doula as: a trained, nonmedical professional who advocates for, and provides continuous physical, emotional, and informational support to, a pregnant woman through the delivery of a child and immediately after the delivery, including during any of the following periods:

- Antepartum
- Intrapartum
- Postpartum

## References:

- Section 4723.89 - Ohio Revised Code | Ohio Laws
- Rule 5160-8-43 - Ohio Administrative Code | Ohio Laws

# Benefits of a doula

Doulas advocate for and provide educational, nonclinical emotional, physical, and informational support to pregnant individuals and their families during pregnancy, childbirth, and after.

Doulas have been shown to improve birth outcomes, support birth equity, positively impact the social drivers of health, reduce disparities in maternal and infant outcomes, and more.

# Our Medicaid network

# Medicaid in Ohio

The Ohio Department of Medicaid (ODM) Next Generation Managed Medicaid program went live on February 1, 2023.

Since then, we have provided Medicaid coverage in all of Ohio's 88 counties.

Our Medicaid plan aligns with the ODM goals for Medicaid, putting the individual at the center of focus and improving the design, delivery, and timeliness of care coordination.

# Next Generation program

ODM has successfully launched:

- Ohio Resilience through Integrated Systems and Excellence (OhioRISE), a specialized managed care program for youth with complex behavioral health and multisystem needs — July 1, 2022
- Single pharmacy benefit manager (SPBM), an improved management and administration of pharmacy benefits for managed care recipients — October 1, 2022
- Centralized credentialing and Provider Network Management (PNM), which is ODM's single, centralized provider credentialing process. It allows care providers to require only one credentialing and recredentialing process at the state level, versus a separate additional process done by each managed care entity (MCE) for the Medicaid line of business. Submissions for enrollment and credentialing are submitted through the PNM — October 1, 2022.
- **Note**: This does not replace the credentialing and recredentialing process with us for Medicare or Commercial lines of business.

# Next Generation program (cont.)

On February 1, 2023, ODM launched the Next Generation Managed Care Plans and program requirements, including exciting improvements that support members in accessing the healthcare services and support they need.

The new Electronic Data Interchange (EDI) was also implemented, increasing the transparency and visibility of member care and services.

# Enrollment

**Prerequisites:**

- Obtain a National Provider Identifier (NPI).
- Obtain an Ohio Board of Nursing certification.
- All Medicaid care providers in Ohio need an OHID, the state of Ohio's digital identity standard, to access Medicaid's Provider Network Management (PNM) module. To create a new OHID, visit OHID (ohio.gov).

All provider enrollment applications are submitted using Medicaid's PNM module. The PNM module is the single point for care providers to complete provider enrollment, centralized credentialing, and provider demographic updates.

To begin the enrollment process, visit ODM's Credentialing Application homepage: Provider Network Management module

# Enrollment (cont.)

**Independent doulas — professional claim payments (PT09)**

Care providers — Professional claims can be submitted on behalf of a doula, either independent or nondependent, for services covered by the doula:

- Ambulatory health care clinic (PT 21)
- Federally qualified health center (FQHC) (PT 12)
- Freestanding birth center (PT 11)
- Hospital (PT 02)
- Professional medical group (PT 21)
- Rural health clinic (RHC) (PT 05)

All individual providers and professional medical groups who bill for Ohio Medicaid services must have an Ohio Medicaid number. A doula may be independent, meaning they will bill services under their own tax ID, or a doula may be affiliated with a professional medical group who bills services on their behalf. Any doula affiliated with a professional medical group must make that affiliation in the PNM portal. More information can be found at PSE Provider Registration Portal — Resources (OHPNM)

# Contracting

To initiate contracting, visit our website, select Join Our Network and follow the prompts for your provider type.

Care providers who are already contracted with us for Medicaid in Ohio and wish to add a provider to their group should submit their information through the **PNM module** and select **Anthem** on the MCP affiliation page

# Provider revalidations

- All care providers are subject to either a three- or a five-year time-limited provider agreement. Prior to conclusion, letters are both mailed and emailed at 120 days, 90 days, and 60 days, with a final notice coming at 30 days. Care providers who do not submit their revalidation could experience consequences at the state level, which would cascade to the managed care entities (MCEs), causing claims not eligible for reimbursement as a non-participating provider. Emails will come from OHPNM@maximus.com.
- Revalidation notices are posted in the PNM module and can be accessed in the correspondence folder. Care providers will also see a begin revalidation option in the PNM Enrollment Action Selection 120 days prior to the Medicaid Agreement end date. Care providers can locate this under the **Manage Application**, then the **Enrollment Actions** option within the provider file. Select **Revalidation/Reenrollment Quick Reference Guide** for step-by-step instructions.
- Care providers who need technical assistance can contact ODM's Integrated Help Desk at **800-686-1516** and follow the prompts for provider enrollment or email IHD@medicaid.ohio.gov.

# Social drivers of health (SDoH)

# SDoH programs: employment services

## Program overview:

- Support members — from those with complex needs to skilled job seekers — who are unemployed/underemployed or are looking for career exploration or educational opportunities
- Youth between the ages of six and 18

## Strategy:

- Employment Flex Funds — flexible funds to support members with employment-related expenses
- University of Cincinnati — coursework offered in Career Exploration or Job Search; instructors also provide coaching and one-on-one support
- TutorMe 24/7 — Online tutoring platform that connects students with live tutors in over 300 subjects, including a writing lab (ages six to 18)

## To make a referral:

- Employment referrals at The Community Resource Link (findhelp.com); enter ZIP code and search *Anthem*. Select the Anthem program card to see program details and referral requirements. Select **Refer** or **Apply Now** and complete the screening form with referral details and contact information.

# SDoH programs: transportation

**Standard benefit:**

We provide nonemergency medical transportation through Access2Care (A2C) to any member requesting transportation when the member must travel 30 miles or more from their home to receive medically necessary Medicaid-covered medical, vision, dental, and pharmacy appointments.

**Value-added benefits (VABs)**

To supplement the County Non-Emergency Transportation (NET) program, we provide members with 30 round trips or 60 one-way trips per calendar year for trips less than 30 miles to medical appointments and community resources, such as essential shopping; grocery stores; and women, infants, and children (WIC) appointments.

Transportation can include ambulatory sedans, vans, rideshare, bus passes/tickets, wheelchair-accessible vans, mileage reimbursement, and other appropriate modes of transportation. **Car seats and wheelchairs are not provided.**

# SDoH programs: transportation (cont.)

Provider scheduling number: **800-304-4953**

**Other scheduling numbers:**

- Transportation Services Line:
  - **800-282-9720,** Monday to Friday, 8 a.m. to 7 p.m. ET
  - Option 2 for Where's My Ride/Ride Assist.
  - TTY 711

- Member Services: **844-912-0938 (TTY 711)** 7 a.m. to 8 p.m. ET 48 hours before, up to 30 days in advance

Urgent and same day requests provided for:

- Trips to urgent care
- Hospital/facility discharge
- Chemotherapy
- Radiation
- Dialysis
- OhioRISE members

# SDoH programs: Housing Flex Fund

The Housing Flex Fund program is intended to prevent, divert, or resolve homelessness among our members by paying housing-related expenses. The program is a partnership between us and community organizations that recognize housing as a critical need in our community.

One-time intervention to help overcome a specific need:

- Unexpected expense
- Health/accident-related loss of work
- Arrears that are a barrier to exiting homelessness

The Housing Flex Fun is not a rental subsidy but rather support for a specific critical need.

Common fund requests:

- Rental arrears
- Utility arrears
- Security deposit
- Essential move-in items
- Others as approved

**Join our preferred referral network**
To make referrals to the Housing Flex Fund program, email [housingohio@anthem.com] to set up a training and an overview of program guidelines.

Funds are limited; interventions must lead to permanent, stable housing.

# Member eligibility


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# Member ID cards

Individuals enrolled with us for Medicaid in Ohio have a Medicaid ID card and have access to an electronic member ID card through the Sydney app.

**Note:** Unlike the commercial and Medicare ID cards, the Medicaid for Ohio cards do not have an alpha prefix before the member ID number.

# Determining eligibility

Providers who have an ODM-approved established trading partner can check eligibility via:

- ODM's Provider Network Management (ohio.gov)
- https://Availity.com

Providers who do not have a relationship with an established ODM trading partner can check eligibility via:

- https://Availity.com
- Calling Provider Services at **844-912-1226** TTY 711

# Member benefits

# Covered benefits and services

- Doula — new as of October 3, 2024
- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Laboratory services
- Home health and private-duty nursing services
- Hospice
- Chiropractic services
- Telehealth
- Chiropractic services
- Telehealth
- Complete list of covered services available in our provider manual

A complete list of covered services is available in our provider manual.

# Value-added services

Value-added services give us tools beyond just traditional physical and behavioral care:

- Up to two baby essential items
- Up to $75 worth of free diapers
- Up to $30 of baby food for eligible members
- Additional transportation benefits beyond the standard benefit

**All-plan link for value-added services**

Medicaid Consumer Hotline — Medicaid Managed Care (ohiomh.com)

# Non-emergent transportation

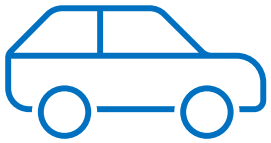
Non-emergent transportation is a benefit provided to our members by Access2Care. Services include transportation when the member must travel 30 miles or more from their home to receive a medically necessary Medicaid-covered service and/or pharmacy services, as well as special vehicle transportation for our members in wheelchairs:

- Routine rides must be scheduled at least two business days before the healthcare appointment.
- Same-day rides can be scheduled within three hours if there is an urgent need.

We will arrange and provide transportation for members who are enrolled in OhioRISE in a manner that ensures that children, youth, and their families served by OhioRISE do not face transportation barriers to receiving services, regardless of Medicaid payer.

Members should call **800-282-9720** to schedule rides.

Managed Transportation (access2care.net)



# Member care

# Access and availability standards relating to pregnancy

| Type of visit | Minimum standard |
| --- | --- |
| Prenatal care — first or second trimester | First appointment. Within [seven calendar days], follow-up appointments no more than 14 calendar days after request |
| Prenatal care — third trimester or high-risk pregnancy | Within three calendar days |

# Population health

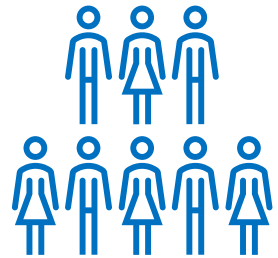
Following federal and state guidelines, we have a Quality Assessment and Performance Improvement (QAPI) program in place to advance our levels of readiness, service, and care.

Our approach employs a deliberate and defined, science-informed approach that is responsive to member and provider needs and incorporates systematic methods to identify reliable approaches to improving population health and reducing health disparities.

The QAPI program, aligned with Ohio's Medicaid Quality Strategy, includes the design and implementation of improvement projects in clinical and nonclinical areas that improve population health — including health equity — across all levels of care.

Focused populations include:

- Healthy children.
- Healthy adults.
- Women's and infants' health.
- Children with behavioral health needs.
- Adults with behavioral health needs.
- Persons with chronic conditions (for example, asthma, diabetes, hypertension), including children with special needs and older adults.



# Condition Care program

Condition Care is designed to offer holistic, member-centered care through interventions tailored to the individual's unique healthcare needs, including:

- Assessing and filling knowledge gaps to promote understanding of the disease process.
- Educating to encourage understanding of risks and complications associated with condition(s).
- Empowering members to initiate self-care and management of condition(s).
- Developing care plans, including member-centered goals to manage condition(s).
- Engaging with appropriate provider(s).
- Assisting with care coordination as needed.
- Referring to community-based programs to close SDoH needs.

Condition Care is featured on our provider website to give at-a-glance information about our program, the conditions we manage, and how to refer.

We encourage you to refer patients with any of the following conditions who could benefit from additional support: asthma, bipolar, CAD, CHF, COPD, diabetes, HIV/AIDS, hypertension, major depressive disorder (adults, children, and adolescents), schizophrenia, and substance use disorder.

To reach our team directly:

- Email: condition-care-provider-referrals@anthem.com
- Phone: **888-830-4300**

# Care Management program

The Care Management program is a collaborative effort that assists both care providers and members. The program is designed to educate and assist members to become empowered, exercise their options to access the appropriate services, and optimize their healthcare benefits to meet their individual health needs.

Services include:

- Short-term assistance to meet care gaps.
- Long-term, intensive, and holistic care management for our members with the most intense needs.

Care providers are encouraged to engage and direct development and provide feedback on our members' care plans:

- Care management phone: **844-441-1505**
- Care management fax: **877-881-1831**

# ODM's NurtureOhio program

We encourage care providers to complete the state's Pregnancy Risk Assessment Form (PRAF), which can be completed via NurtureOhio or fax. For detailed instructions, please visit Pregnancy Risk Assessment (ohio.gov).

For non-OB providers who need to notify us of a pregnancy, please use the Report of Pregnancy (ROP) Form, which can be found at the above website.

The PRAF 2.0 Provider User Manual can assist you in setting up access for your staff and assigning the prenatal visit role needed to access PRAF 2.0.

# Notification of pregnancy

We also encourage care providers to complete the maternity form located in Availity Essentials:

- Perform an eligibility and benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the member is pregnant. Select **Yes** if applicable. If you indicate yes, you may provide the estimated due date if known or leave it blank if unknown.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a maternity form will now be available. You may access the form by navigating to the Applications tab and selecting the Maternity link.
- The Availity Essentials maternity form does not replace the need to enter a PRAF on a pregnant member.

We require notification of delivery following birth. Birth notifications can be submitted via https://Availity.com or by fax at **877-643-0671**.

# Maternal child services — New Baby, New Life

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all our moms-to-be to take part in **New Baby, New Life**SM, a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum check-ups and well-child visits after the baby is born.

Our case managers are here to help you. If you have a member in your care that would benefit from care management, call us at the case manager phone number, **844-441-1505**.

Members can also call our 24/7 NurseLine, **844-430-0341**.

# Neonatal Intensive Care Unit Care Management program

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the NICU Care Management program. Parents/caregivers are provided with education and resources that outline successful strategies they may use to collaborate with the baby's NICU care team while inpatient and manage their baby's health after discharge.

The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:

- Guiding parent(s) into hospital-based support programs, if available.
- Screening parent(s) for PTSD approximately one month after their baby's date of birth.
- Referring parent(s) to behavioral health program resources, if indicated.
- Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness.

If you have a member in your care who would benefit from NICU Care Management, call the CM phone at **844-441-1505.**

Members can also call our 24/7 NurseLine, **844-430-0341**.

# Comprehensive Maternal Care

Comprehensive Maternal Care (CMC) is a community-based, statewide program that improves the health and well-being of moms, infants, and families covered by Medicaid. For more information visit: Comprehensive Maternal Care (ohio.gov)

# Working with us to serve Medicaid members in Ohio

# Doula claim reimbursement

T1032:

- Services performed by a doula birth worker per 15-minute unit
- $12.50 per unit, up to $600
- Up to 48 15-minute units at any time from the first prenatal visit to 12 months postpartum
- Telehealth services require appending the GT modifier

T1033:

- Services performed by a doula during a member's delivery
- $600 flat rate, regardless of the length of birth

Rule 5160-8-43 — Doula Services (ohio.gov)

# Diagnosis codes recommended by ODM

**Z34.x**

- Z34.0: Supervision of a normal first pregnancy
- Z34.8: Supervision of another normal pregnancy
- Z34.9: Supervision of a normal pregnancy, unspecified
- Z34.00: Encounter for supervision of a normal first pregnancy, unspecified trimester
- Z34.80: Applicable to female patients aged 12–55 years
- Z34.90: Applicable to female patients aged 12–55 years
- Z34.83: Applicable to mothers in the third trimester of pregnancy, which is defined as between equal to or greater than 28 weeks since the first day of the last menstrual period

**O80.0:** Spontaneous vertex delivery, which includes cases with minimal or no assistance

**Z37.9** is the ICD-10-CM code for an unspecified outcome of delivery.

**Z32.2** is for an encounter for pregnancy testing, childbirth, and childcare instruction.

**Z39.2** is the ICD-10-CM diagnosis code for a routine postpartum follow-up.

# Submitting claims

**Care providers who have an established ODM trading partner:**

Submit claims and associated attachments through ODM's fiscal intermediary via an approved trading partner:

- Our payer ID: 0002937
- Trading Partners (ohio.gov)

**Care providers who do not have an established ODM trading partner:**

Care providers will enter claims via direct data entry at https://Availity.com.

**Registration and contact information**

Submit an email to:

EDI-TP-Comments@medicaid.ohio.gov.

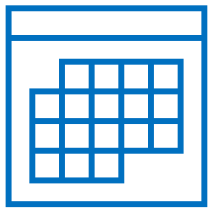
Call the Integrated Health Desk at: **800-686-1516, option 3** (EDI)

# Submitting claims (cont.)

## Timely filing requirements

Filing limits are determined as follows:

- If we are the primary payer, timely filing is 365 days from the date of service or date of discharge on the claim unless stated differently in your contract.



# Clean claims

Claims submitted correctly the first time are called clean, meaning that all required fields have been filled in and the correct form was used for the specific service provided.

A claim submitted with incomplete or invalid information may be returned. Claims will be returned for incomplete or invalid information. Claims also may be returned if they are not submitted with the proper HIPAA-compliant code set:

- In each case, an error report will be sent to the provider, and the claim will not be sent through for payment. The provider and staff are responsible for working with the EDI vendor to ensure that erroneous claims are corrected and resubmitted.

**Note:** The submission of a clean claim should not be misconstrued as a proper claim for payment. Different departments can conduct audits (pre- and post-payment), for which a repayment may be requested. Care providers are advised to follow proper coding practices using the current procedural and medical policies available. Care providers may be requested to produce medical record documentation supporting the claim(s) to validate payment.

# Checking claim status

Providers can check claim status via the following methods:

- Submit an inquiry via EDI through their approved ODM trading partner.
- Check the claim status on https://Availity.com:
  - Select **Login** or **Register** to access the secure site.
  - Homepage > Claims & Payments > Claims Status
- Watch for and confirm plan electronic reports from your vendor/clearinghouse, or, if you are using Availity Essentials as your clearinghouse, view reports under *EDI Clearinghouse/Send and Receive Files* to ensure that your claims have been accepted.
- Calling Provider Services at **844-912-1226.**
- ODM Integrated Help Desk at **800-686-1516**.

# Returned claims

We will send care providers a request for additional or corrected information when the claim cannot be processed due to incomplete, missing, or incorrect information.

We may also request additional information retroactively for a claim already paid.

**Care providers with an ODM EDI-approved trading partner:**

- To submit additional or corrected information, you should send it directly to your ODM EDI approved trading partner

**Care providers without an ODM EDI approved trading partner:**

- To submit additional or corrected information, you should send it through Availity Essentials

If we request additional information or a correction to a claim, a claim follow-up is needed, and you must submit a corrected claim through your ODM EDI-approved trading partner or Availity Essentials within 365 days from the date of service.

# EFT and ERA

**EFT:**

Electronic claims payment through EFT is a secure and fast way to receive payment, reducing administrative processes. EFT deposits are assigned a trace number that is matched to the 835 ERA for simple payment reconciliation.

Use EFT Enrollment Hub (payeehub.org) to register and manage EFT account changes.

**Note:** Commercial policies with us continue to be registered and managed by Availity Essentials.

**ERA (835):**

- The 835 eliminates the need for paper remittance reconciliation.
- The ERA (835) must be registered with ODM for the Medicaid plan.

Please work with your vendor or clearinghouse to enroll your 835s with ODM.

Use the Designation of an 835 Trading Partner (PDF) to submit your 835 registration to ODM.

# Claim overpayment recovery and refund procedure

We seek recovery of all excess claim payments from the person or entity to whom the benefit check was made payable. When an overpayment is discovered, we initiate the overpayment recovery process by sending a written notification.

If you are notified by us of an overpayment or discover that you have been overpaid, mail the refund check, along with a copy of the notification or other supporting documentation, to the following address:

Anthem
P.O. Box 933657
Atlanta, GA 31193-3657

Or fax it to **866-920-1874**

The *Recoupment Notification Form* and the *Overpayment Refund Notification Form* are located at our provider site > Resources > Forms.

# Claim overpayment recovery and refund procedure (cont.)

If a payment, a request for extended payment arrangement, or a dispute request is not received within 30 calendar days from the date we notify a provider of an overpayment, we will process the recovery, and overpaid funds will be applied to the provider's account as a negative balance.

If you believe the overpayment notification was created in error, call **844-912-1226.**

For claims reevaluation, send your correspondence to the address indicated on the overpayment notice. If we do not hear from you or receive payment within 60 days, the overpayment amount will be deducted from your future claim payments.

# Claim payment — dispute and appeal process

**First level — claim payment dispute:**

This is the initial request for an investigation into the claim's outcome. Most issues are resolved during this process.

If a care provider is dissatisfied with the outcome of a dispute determination, the care provider provider may submit a claim payment appeal.

**Second level — claim payment appeal:**

If the dispute did not resolve the issue, a more thorough analysis will occur using all applicable statutory, regulatory, contractual, and subcontract provisions, our policies and procedures, state policies, and all pertinent facts submitted by all parties.

Appeals must be submitted within 12 months from the date of service or 60 calendar days after the payment, not eligible for reimbursement, or the partial not eligible for reimbursement of a timely claim submission, whichever is later.

# Claim payment — dispute and appeal process (cont.)

The provider or the provider's authorized representative may submit a claim payment dispute or appeal in one of three ways:

- Website request: Use the Provider Availity Essentials Payment Dispute Tool at https://Availity.com Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgment of your submission.
- Written request: Include any necessary supporting documentation and mail to:
  - Anthem
    Provider Payment Disputes Unit
    P.O. Box 62500
    Virginia Beach, VA 23466
- Verbal requests: Call **844-912-1226,** Monday through Friday, 8 a.m. to 5 p.m. ET. **Note**: If you need to include supporting documentation (for example, EOB, Consent Form, or medical records), do not use this option.

The request should include:

- Your name, address, phone number, email, and either your NPI or TIN.
- The member's name and their Anthem ID number.
- A list of disputed claims, including the claim number and the date(s) of service(s).
- All supporting statements and documentation.

# Member copayments and balance billing

There is no cost-share for our members enrolled in Medicaid. Members may not be balanced-billed by providers for Medicaid covered services. This means that providers may not collect payment from a member for covered services above the amount we pay to the provider.

A member may request a noncovered service or a covered service for which prior authorization was denied. When prior authorization of a covered service is denied, the provider must establish and demonstrate compliance before collecting payment from the member.

See the provider manual for a complete list of items needed to demonstrate compliance.

Rule 5160-1-13.1 — Medicaid recipient liability (ohio.gov)

# Medical Policies and Clinical Utilization Management Guidelines

The decision process is based on health plan and state guidelines, as well as NCQA guidelines, and reflects the most up-to-date medical management standards.

Healthcare authorizations are based on the following:

- Benefit coverage
- Established ODM-developed criteria or, in the absence of ODM-developed criteria, *MCG, Medical Policies, Clinical Utilization Management Guidelines,* and/or CarelonRx, Inc. criteria, as applicable
- Community standards of care

Decisions are based on appropriateness of care and service and existence of coverage. We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are no financial incentives for utilization management decision-makers that encourage decisions resulting in under-utilization.

CarelonRx, Inc. is a separate company providing utilization review services on behalf of the health plan.

# Prior authorization lookup

## Availity Essentials has a Precertification Lookup Tool

Requirements for outpatient services can be viewed via the Precertification Lookup Tool at our provider site. Search by market, member product, CPT®/HCPCS code, code description, or drug name.

Services may be listed as requiring prior authorization that may not be covered benefits for a particular member. Please verify benefit coverage prior to rendering services.

# Prior authorization submissions and status

To request prior authorization a doula can submit through the Interactive Care Reviewer (ICR) located within Availity Essentials or by faxing to **877-643-0672**.

The authorization status can be checked by using ICR within Availity Essentials.

# Authorization review timeframes

Timeliness of utilization management decisions:

- Non-urgent preservice requests: 10 calendar days
- Urgent preservice requests: 48 hours
- Concurrent reviews: 0 to 72 hours

Emergency medical services:

- We do not require prior authorization for treatment of emergency medical conditions or post-stabilization services. Members may remain in an observation status for 48 hours. In the event of an emergency, members may access emergency services 24 hours a day, seven days a week. If the ER visit results in the member's admission to the hospital, care providers must contact us within 48 hours.

# Clinical reconsideration

A clinical reconsideration process is available to care providers following an adverse determination within 30 days from the initial non-approval.

During the reconsideration process, care providers will have an opportunity to submit additional, new clinical information to substantiate the medical necessity for a previously not approved preservice or concurrent inpatient stay.

To submit a clinical reconsideration:

- Attach new clinical information.
- Write *reconsideration* on the fax coversheet.
- Fax to **877-643-0671** (Physical Health).

# Peer-to-peer consultations

- Care providers have up to seven calendar days after the issuance of the not approval to request a peer-to-peer review.
- For the Medical Management department, call **833-308-3035.**
- We will acknowledge your request within 24 hours of your request for a peer-to-peer discussion and offer a peer-to-peer conversation within a mutually agreed-upon time.

# Preservice appeals

If an authorization is denied prior to the service being rendered to the member, the provider also has the option to file an appeal directly with us, not requiring the member consent.

Provider appeals can be submitted the following ways:

- Electronically: Use ICR in Availity Essentials at https://Availity.com.
- Fax: **866-587-3316** (Appeals department)

If filing without member consent, appeals must be submitted within 30 calendar days from the initial determination. If filing on behalf of a member, care providers have 60 calendar days from the initial determination to submit their clinical appeal along with the member's consent.

We will issue a decision within 10 calendar days for nonurgent services and 48 hours for urgent care services.

Appeals submitted by care providers without the member's consent are not eligible for state fair hearings; however, providers may request an additional external medical review (see external medical review process).

# Provider post-service authorizations

If services have been rendered to the member, care providers should file a claim payment dispute so a medical necessity review will be completed. Care providers must include medical records and provide the extenuating circumstances for not submitting the prior authorization.

Disputes are to be submitted within 12 months from the date of service or 60 calendar days from the date on the Explanation of Payment, whichever is later.

Should the provider disagree with the outcome of the review, a clinical appeal can be submitted:

- Appeals must be submitted within 30 calendar days from the initial denial. We will send written acknowledgment of the appeal to the provider within three business days of receipt.
- We will respond to appeals associated with a claim denial within 30 days.
- Care providers who have exhausted appeal rights can request an external medical review. (See EMR process)

For instructions on how to file a claim payment dispute, refer to the claim payment dispute slide.

**To file a clinical appeal:**

- Electronically: Use ICR in Availity Essentials at https://Availity.com.
- Fax: **866-587-3316** (Appeals department)

# External medical review

Services that are denied for reasons other than lack of medical necessity (for example, the service is not covered by Medicaid) are not subject to external medical review.

You have the right to request an external medical review within 30 calendar days of our decision to not approve, limit, reduce, suspend, or conclude a covered service for lack of medical necessity. The external medical review is available at no cost to you.

The request for external review must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals process has been exhausted. Care providers must complete the *Ohio Medicaid MCE External Review Request* at Permedion - Gainwell Technologies.

Care providers need to upload the request form and all supporting documentation to Permedion's provider website located at ecenter.hmsy.com (current users); new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish website access.

# State fair hearings

A request for a state hearing is defined as a clear expression, by the individual or authorized representative, to the effect that he or she wishes to appeal a decision or wants the opportunity to present his or her case to a higher authority. The request may be either made orally or submitted written or electronically.

Members must exhaust our appeals process before requesting a state hearing.

If we fail to adhere to notice and timing requirements as set forth in OAC Rule 5160-26-08.4, the member is deemed to have exhausted the appeal process and may request a state hearing.

Members enrolled in the Coordinated Services Program (CSP) are not subject to this requirement and may request a state hearing without first appealing to us.

A member or a member's authorized representative may request a state hearing within 120 calendar days from the date of an adverse appeal resolution.

# State fair hearings (cont.)

**Continuation of benefits:**

- We shall continue a member's benefits when all the following conditions are met:
- The member requests an appeal within 15 days of the issuance of the Notice of Action.
- The appeal involves the conclusion, suspension, or reduction of services prior to the member receiving the previously authorized services.
- The services were ordered by an authorized provider.
- The authorization period has not expired.

# Provider complaints

ODM maintains a Managed Care Entity (MCE) Complaint Form. This can be used by any provider who has first attempted to work directly with us, but who believes they have been unsuccessful in getting an appropriate response. Before submitting a complaint, care providers should check the plan's Claims Payment Systemic Errors (CPSE) report for the issue in question.

We will receive these complaints directly, in real time, from ODM and have 15 business days to respond to the provider with a resolution. Care providers are encouraged to use the appeals, grievance, or arbitration processes as outlined in their individual contract with the plan.

The provider complaint form can be found here:

- ODMwebsite: OH Medicaid Managed Care Provider Complain Form (ohiomh.com)
- Our provider website

# Fraud, waste, and abuse

# Understanding fraud, waste, and abuse (FWA)

## Fraud

Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person; the attempt itself is fraud regardless of whether it succeeds

## Waste

Includes overusing services or other practices that, directly or indirectly, result in unnecessary costs; waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused

## Abuse

When healthcare care providers or suppliers do not follow good medical practice, resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary

# Understanding FWA (cont.)

To help prevent FWA, care providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud.

One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at fighthealthcarefraud.com.

**Note:** Presentation of a member identification card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at **844-912-1226**.

# Reporting FWA

If you suspect that a provider (provider group, hospital, doctor, dentist, counselor, medical supply company, and so on) or any member (a person who receives benefits) has committed FWA, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting fighthealthcarefraud.com. At the top of the page, select **Report it** and complete the *Report Fraud, Waste and Abuse* form.
- Calling **866-847-8247.**

Any incident of FWA may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped by a lack of information. Hence, we encourage you to give as much information as possible.

We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals because doing so may potentially compromise an investigation.

# Staying connected

# Stay in touch

Register to stay in touch and receive all provider communications and our monthly provider newsletter, **Provider News,** via email. Register now at providers.anthem.com/oh.

**Note:** Provider News emails will come from providercommunications@email.anthem.com.

# Updating your business information

It is critical that members receive accurate and current information related to provider data. Providers and facilities must document ODM's PNM for any demographic changes.

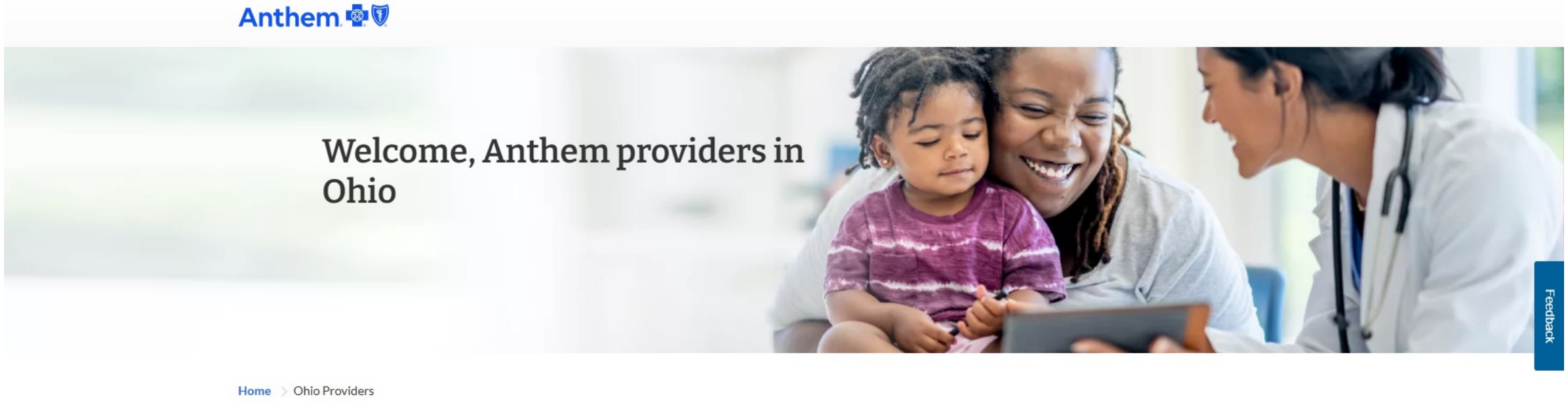
All requests must be received 30 days prior to the change or update. Any requests received sooner than a 30-day notice may be assigned a future effective date. Contractual terms may supersede the effective date request.

Notes:

- If updates are not submitted 30 days prior to the change, claims submitted for members may be the responsibility of the provider or facility.
- The Provider Network Management (PNM) module serves as the system of record for provider data.

# Our provider website

Many of the things we discussed today can be found on our provider website.



# Availity Essentials and training resources

## Availity Essentials

Availity (https://Availity.com) is a web platform used by care providers to securely access patient information, such as eligibility, benefits, claim status, authorizations, and other proprietary information.

Care providers can use a single login to access multiple health plan care providers at no cost. The registration process is easy,  and multiple resources and trainings are available about site navigation and powerful tools.

## Digital Solutions Learning Hub

Provider Education and Training (on24.com) is a one-stop shop for provider training. It consolidates resources from Availity Essentials and Anthem in an organized, easily accessible format, offering both the latest updates and foundational knowledge:

- Courses
- Live webinars
- On-demand video
- User guides

# Provider Advisory Council

We invite care providers to participate in our Provider Advisory Council. The meeting's intent is to collaborate with our provider community to gather input, discuss trends, identify challenges, and remove barriers, ultimately improving the healthcare delivery system.

If you are interested in participating, you may sign up at Provider Advisory Council (chkmkt.com).

# Resources

# Quick links

- Ohio Department of Medicaid (ohio.gov)
- Doulas
- Our provider website | home
- Provider News
- Provider reference guide: claims disputes and appeals, and clinical appeals for UM decisions | *Provider News*
- Prior authorization lookup tool
- Provider manuals and guides
- Training Academy
- Value Added Services (ohiomh.com)
- https://Avality.com
- Place of Service Code Set (cms.gov)

# Thank you

We appreciate your taking the time to attend this training and hope the information covered today answers any of your questions.

In a world of escalating healthcare costs, we work to educate our members about the appropriate access to care and their involvement in all aspects of their healthcare.

We look forward to working with you to continue this education and provide valuable healthcare to our members — your patients.

Contact information:

- Our provider website
- Provider Services: **844-912-1226**
- Please send any questions not covered in this presentation or the Frequently Asked Questions to OhioMedicaidProvider@anthem.com.
- Provider Relations territory map



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