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

Nursing facility provider orientation

Agenda

- Ohio Medicaid Managed Care (OMMC):
  - Next generation managed care, enrollment, credentialing, provider revalidations
- Social drivers of health (SDOH)
- Value added benefits
- Ventilators
- Bed hold days
- Modified Adjusted Gross Income (MAGI) Group VIII members
- Claims and billing
- Prior Authorization
- Floor to Skilled Nursing Facility (SNF) process
- Reconsideration and authorization appeals
- Availity Essentials
- Staying connected

OMMC

Anthem in Ohio

- As one of the nation's leading health plans, we already proudly served individuals in Ohio with our commercial and Medicare plans prior to February 1, 2023:
  - We are now supporting Medicaid members in all of Ohio's 88 counties.
- The Medicaid plan aligns with the Ohio Department of Medicaid's (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 multi-system 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):** ODM's single, centralized provider credentialing process; allows providers to only require 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 thru the PNM:
  - October 1, 2022

Note: This does not replace the credentialing and recredentialing process for Medicare or Commercial lines of business with the health plan.

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. Also implemented was the new Electronic Data Interchange (EDI), which has increased transparency and visibility of member care and services.

Enrollment and credentialing

Obtain an OH|ID:

- All Ohio Medicaid providers will need an OH|ID, the state of Ohio's digital identity standard, to access Medicaid's new provider network management (PNM) module. To create a new OH|ID, visit ohid.ohio.gov/wps/portal/gov/ohid/home/home.

Enrollment and credentialing:

- As of October 1, 2022, all provider enrollment applications are submitted using Ohio Medicaid's new provider network management (PNM) module. The PNM module is the single point for providers to complete provider enrollment, centralized credentialing, and provider demographic updates:
  - To begin the credentialing process, visit ODM's Credentialing Application homepage.

Provider revalidations

All care providers are subject to either three- or five-year time-limited provider agreements. Prior to termination, letters are both mailed and emailed 120 days, 90 days, 60 days, and a final notice at 30 days. Providers who do not submit their revalidation could experience termination at the state level, which would cascade to the managed care entities (MCEs) causing claim denials as a non-participating provider. Emails will come from OHPNM@maximus.com.

Revalidation notices are posted in the Provider Network Management (PNM) module and can be accessed in the Correspondence folder. 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 the **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 6 to 18.

Strategy:

- **Employment Flex Funds** — Flexible funds to support member with employment related expenses.
- **University of Cincinnati** — Coursework offered in Career Exploration or Job Search, UC instructors also provide coaching and 1-1 support.
- **TutorMe** — 24/7 online tutoring platform. Connects students with live tutors in over 300 subjects, including a writing lab. (Ages 6 to 18)

To make a referral:

- Employment referrals at anthemoh.findhelp.com. Enter *Zip Code* and search **Anthem Blue Cross and Blue Shield**. Select the ***Anthem Program* card** to see specific program details and referral requirements. Select **Refer** or **Apply Now** and complete the screening form with referral details and contact information.

SDOH — Transportation program

Standard benefit:

- We provide non-emergency 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, WIC appointments, and more.

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

Provider scheduling number:
800-304-4953

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**
  Monday to Friday, 7 a.m. to 8 p.m. ET
  TTY 711
- 48 hours before, up to 30 days in advance

Urgent/same day requests provided for:

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

SDOH — Housing Flex Fund program

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

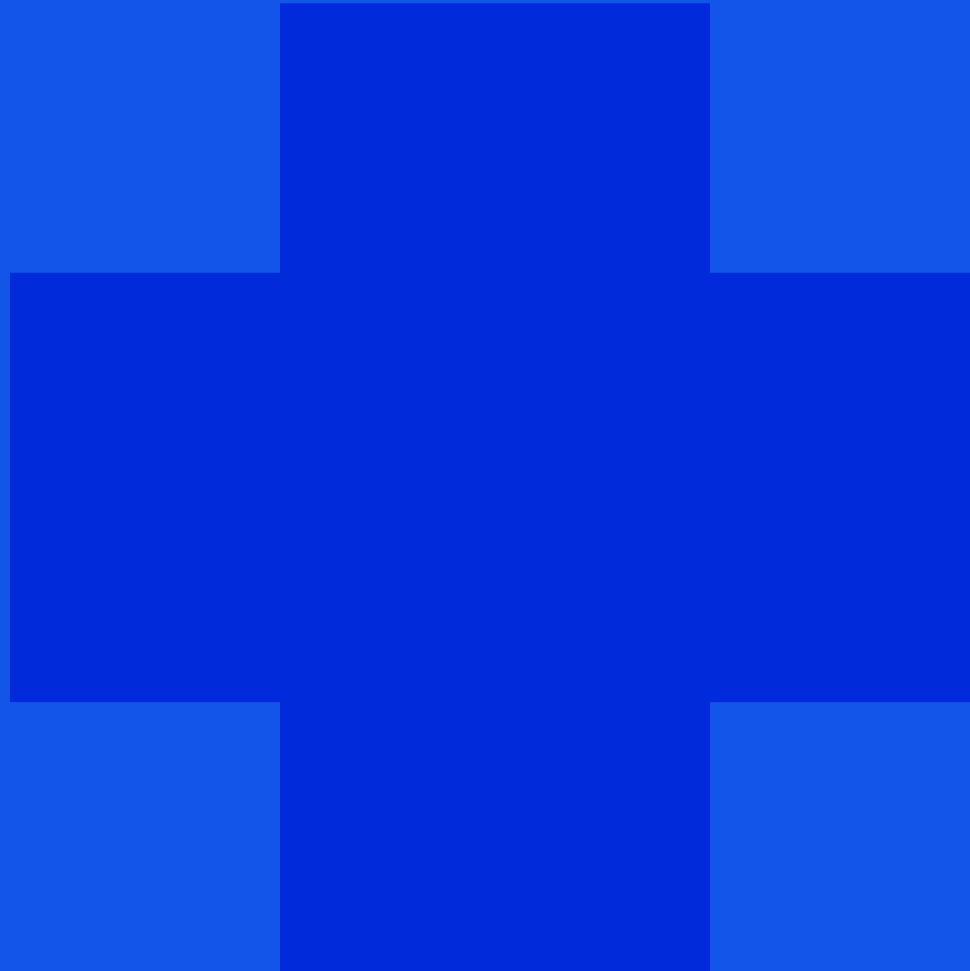
Join our preferred referral network:

- To make referrals to the Housing Flex Fund program email Housingohio@anthem.com to set up a training and overview of program guidelines.
- Funds are limited; interventions must lead to permanent stable housing.

Common fund requests:

- Rental arrears
- Utility arrears
- Security deposit
- Essential move-in items
- Others as approved
- Not a rental subsidy — support for a specific critical need

Value Added Benefits



Value-added services

- Value-added services gives us the tools — beyond just traditional physical and behavioral care — to help the people of Ohio reach their health goals. It is about keeping members connected to their community, finding or advancing employment, learning new skills, and even getting organized financially.

- All-plan link for Value-added services
  - Medicaid Consumer Hotline - Medicaid Managed Care (ohiomh.com)

Ventilators and Ohio Medicaid Ventilator program

Ventilators and Ohio Medicaid Ventilator program

- OMMC follows ODM guidance for ventilator billing
- OMMC recognizes facilities part of the ODM Ventilator program
- New applicants for the ventilator program will not be approved if they meet at least one of the criteria below:
  - Those who are on Table A or D of the CMS Special Focus Facility (SFF) list
  - Those with a one-star overall rating on the CMS five-star rating system.
- Ventilator Fact Sheet

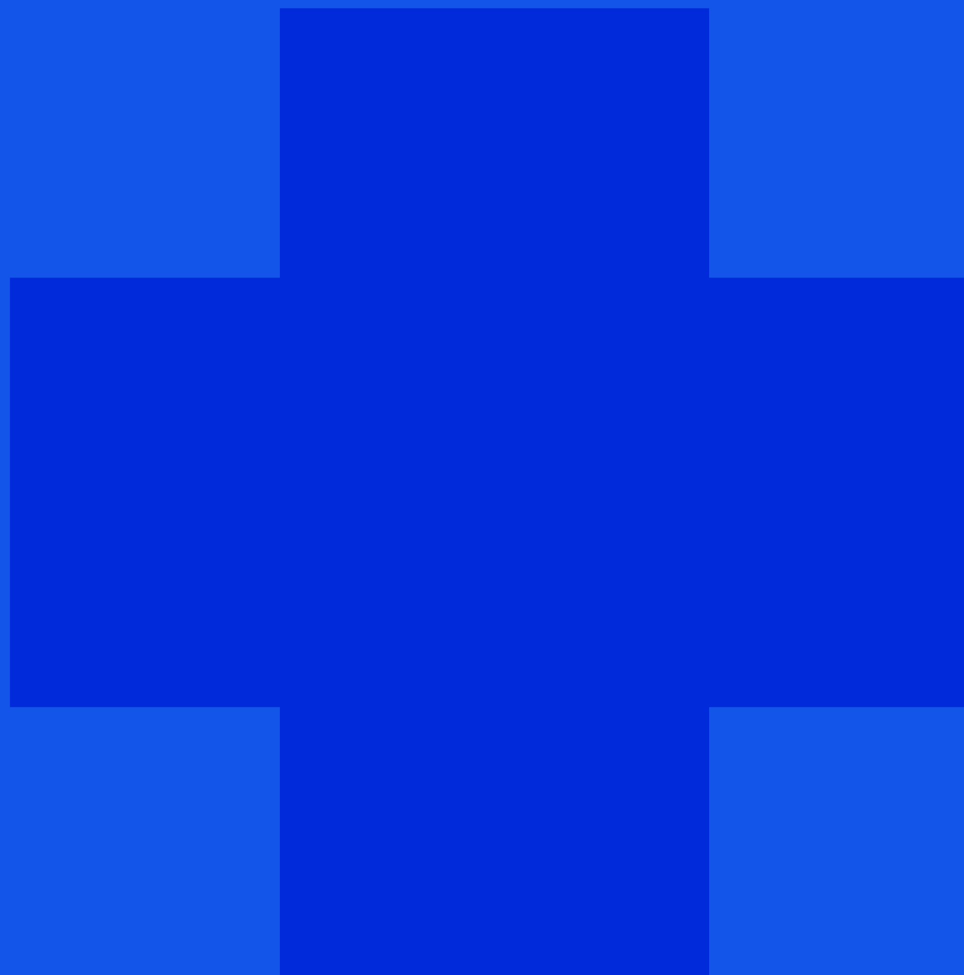
Ventilators and Ohio Medicaid Ventilator program (cont.)

Nursing facilities already approved for the Nursing Facility Ventilator program:

- As of January 1, 2024, any nursing facility (NF) participating in the NF ventilator program listed on Table A or D of the Special Focus Facility (SFF) list or designated as having a CMS one-star overall rating are reimbursed the regular NF per diem rate
- NFs who are removed from the (SFF) list or who improve their one-star will resume eligibility to receive the ventilator program enhanced reimbursement rate on or after the date they resume eligibility

CMS SFF List: https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/sfflist.pdf

Bed hold days



Bed hold days

We allow 30 bed hold days per member per calendar year:

- If a member is out of SNF less than 24 hours and returns prior to midnight a notification only is required.
- If a member is out of the SNF for more than a 24-hour day, a new authorization is required.
- Covered days include:
  - A day in which the individual is temporarily absent from the NF for hospitalization, therapeutic leave days, or visits with friends or relatives.
  - Resident must intend to return to the facility
  - Limited to 30 calendar days per resident, per year
- Payment is considered payment in full, and the NF provider shall not seek supplemental payment from the resident

Bed hold days (cont.)

Bed-hold day exclusions:

- Hospice
- Institutions for mental diseases (IMDs)
- Home- and community-based services (HCBS) waiver individual using NF for short-term respite care
- Restricted Medicaid coverage
- Facility closure and resident relocation

Bed-hold days are not available to individuals who are discharged, including:

- Those residents who are temporarily or permanently admitted to another NF.
- Exhaustion of NF bed-hold days.
- Decision to reside in a community-based setting.
- Death.

Residents eligible for payment of NF bed-hold days must:

- Be Medicaid-eligible and meet patient liability and financial eligibility.
- Meet a NF level of care (LOC) or be using Medicare Part A SNF benefit.
- Not be participating in any excluded categories as indicated in (K) of this rule.

MAGI Group VIII members

MAGI Group VIII members

MAGI Group VIII members are members who had their Medicaid extended in 2016:

- These members had a change in circumstances and didn't report it to the county.
- Nursing facilities are responsible for helping the member and the family in notifying the county of any changes the member has had since 2016.
- These members will likely qualify for another Medicaid eligibility category.

Direct link to form: https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM10203fillx.pdf

Claims and billing

Submitting claims

Providers who have an established ODM trading partner:

- Submit claims and associated attachments through ODM's fiscal intermediary via an approved trading partner
- Anthem payer ID: 0002937:
  - Link to ODM TP website:
    - medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners

Providers who do not have an established ODM trading partner:

- Providers will enter claims via direct data entry on Availity Essentials:
  - 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.
  - If the member has other health insurance that is primary, timely filing is 180 days from the date of the *Explanation of Payment* of the other carrier.

Checking claim status

- Providers can check claim status via the following methods:
  - Submit an inquiry via EDI through their approved ODM trading partner.
  - Use Availity Essentials at Availity.com. Select **Login** or **Register** to access the secure site. From the Availity Essentials homepage, select **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 your claims have been accepted by Anthem.
  - Calling Provider Services at **844-912-1226**.
  - ODM Integrated Help Desk at **800-686-1516**.

Returned claims

We will send 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:

- Providers with an ODM EDI approved trading partner:
  - To submit additional or corrected information, you should send the following directly to your ODM EDI approved trading partner:
- Providers without an ODM EDI approved trading partner:
  - To submit additional or corrected information, you should send the following 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.

Claims 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 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
    PO Box 933657
    Atlanta GA 31193-3657
  - Fax 1-866-920-1874
- The *Recoupment Notification Form* and the *Overpayment Refund Notification Form* are located on our provider site at providers.anthem.com/oh > Claims Forms.

Claims overpayment recovery and refund procedure (cont.)

- If a payment, request for extended payment arrangement, or 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, contact Provider Services at **844-912-1226**.
  - For claims re-evaluation, 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:
  - The initial request for an investigation into the outcome of the claim
  - Most issues are resolved during this process
  - If a provider is dissatisfied with the outcome of a dispute determination, the 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 utilizing all applicable statutory, regulatory, contractual, and subcontract provisions; our policies and procedures; state policies; and all pertinent facts submitted from all parties.
  - Submit within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial 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 Availity.com
    Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement 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 23466-1599
  - **Verbal request:** Call Provider Services at **844-912-1226**:
    - Monday through Friday, from 8 a.m. to 5 p.m. **Note:** If you need to include supporting documentation (for example, *EOB*, *Consent Form*, or medical records), do not use this option.

Claim payment — dispute and appeal process (cont.)

- The request should include:
  - Your name, address, phone number, email, and either your NPI number or TIN.
  - The member's name and their ID number for the health plan.
  - 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.

Prior authorization

Medical Policies and *Clinical Utilization Management Guidelines*

The decision-making 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*, and *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.

Prior authorization

Definitions:

- Skilled nursing services — refers to specific tasks that must, in accordance with Chapter 4723 of the Revised Code, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.
- Skilled Rehabilitation Services — refers to specific tasks that must, in accordance with Title 47 of the Revised Code, be provided directly by a licensed or other appropriately certified technical or professional health care personnel.

ODM level of care:

- Protective level of care (LOC) — described in the Ohio Administrative Code (OAC) rule 5160-3-06; Medicaid will not pay for a nursing facility stay if the individual only meets a protective level of care.
- Intermediate LOC — described in OAC rule 5160-3-08; Medicaid will pay for a nursing facility stay if the individual meets an intermediate level of care.
- Skilled LOC — described in OAC rule 5160-3-08; Medicaid will pay for a nursing facility stay if the individual meets a skilled level of care.
- ODM FAQ Nursing Facility Definitions link — NF-Definitions-Common-Terminology.pdf (ohio.gov)
- ODM FAQ Managed Care and Nursing Facility-Based Levels of Care link — FAQ-NF-LOC.pdf (ohio.gov)

Prior authorization (cont.)

How to submit:

Care providers can submit an authorization two ways:

- Availity Essentials Availity.com
- Physical health fax line: **877-643-0671**

Timelines:

- Nonurgent preservice: 10 Calendar days
- Urgent preservice: 48 hours
- Urgent requests **must** include the word *expedited*.

Note: A prior authorization is not required if a member has other health insurance (OHI) or is receiving hospice.

Care providers who receive a denial from the primary payer for an authorization should submit a claim with the denial and current medical documentation.

Prior authorization (cont.)

Documents needed:

- *Preadmission Screening and Resident Review* (PASRR) (federally required)
- *Ohio Medicaid Managed Care/MyCare Ohio Nursing facility Request Form* (federally required)
- Hospital discharge notes
- Nursing facility assessment notes
- Therapy notes (if applicable)
- Medication Administration Records (MARs)
- Physician signed ordered
- Treatment plan include discharge plan
- Any other documentation that will support the member’s condition

Note: This documentation is also needed for concurrent reviews.

Out-of-network provider's process:

- We will pay out-of-network nursing facilities.
- Out-of-network providers will need an authorization for all services
- Out-of-network providers will follow the normal prior authorization process
- Out-of-network rate reimbursement is 100% of the Ohio Medicaid Fee Schedule

Prior authorization status

Providers can check the status of an authorization by using the Interactive Care Reviewer located within Availity Essentials at Availity.com.

Floor to skilled nursing facility (SNF) process

Floor to SNF process

- This process helps members move to a skilled nursing facility faster.
- Hospital and nursing facility must be in network.
- All documentation previously mentioned is required.
- Patients should not be moved without an authorization.
- Authorization must state requesting floor to SNF.
- There are exclusions for this process.

Floor to SNF process (cont.)

- Care provider (hospital, individual practitioner, SNF liaison) identifies the member's need for SNF.
- Care provider contacts the SNF to refer the member.
- Care provider evaluates the member by completing the SNF worksheet.
- Care provider verifies member has OMMC.
- Care provider confirms member's six-click score is 18 or below.
- If member qualifies for Floor to SNF, then the health plan must receive the notification of admission within 48 hours or next business day of admission to the SNF.
- SNF sends all documentation: SNF worksheet, Initial six-click score, *Preadmission Screening and Resident Review (PASRR)*, detailed hospital/outpatient clinicals.
- Documentation must be received within 72 hours or three business days on weekends or holidays.
- Initial therapy evaluation notes must be completed within 24 hours of SNF admission.
- If all documentation is received, we will then prenote seven days.

Floor to SNF inpatient prior authorization process

We require the documentation of the *PASRR* form for initial and concurrent stay prior authorization requests to an in-network SNF for OMMC members.

The floor to in-network SNF inpatient prior authorization process requires that the nursing facility and provider must be in-network. A member needs to have a six-click score of 18 or below (physical and occupational therapy) and the member must not have any exclusions:

- Transfer from an acute rehab facility
- Transfer from a long-term acute care hospital (LTACH) facility
- Transfer from a psychiatric/geropsychiatric hospital unit
- Member whose prior level of function (PLOF) is non-ambulatory
- Member has been admitted to a hospital from a SNF or acute rehabilitation facility.
- Member was denied an LTACH admission.
- Member was denied a standard SNF precertification request.

Floor to SNF inpatient prior authorization process (cont.)

The referring care provider/facility or SNF is required to submit the Ohio Medicaid Managed Care/MyCare Ohio Nursing Facility Request Form and *PASRR* form in the initial 24-hour therapy evaluation period and clinical information within three business days after the date of admission to aid in members' care coordination, discharge planning, and member management. Documentation listed is required before a final determination is made by the health plan.

PASRR regulations (Ohio Administrative Code Rule 5160-3-14) require that all individuals seeking admission to a Medicaid-certified nursing facility, regardless of payer source, be assessed for indications of serious mental illness and/or a developmental disability unless the member meets requirements for a Hospital Exemption. For your convenience, the *PASRR* form can be downloaded here.

If the member does not qualify for the Floor to SNF prior authorization, the referring provider/facility must go through the standard pre-certification process.

Reconsideration and authorization appeals

Reconsideration

- A reconsideration process is available to care providers following an adverse determination within 30 days from the initial denial.
- During the reconsideration process, care providers will have an opportunity to submit additional, new clinical information to substantiate medical necessity for a previously denied pre-service or concurrent Inpatient stay.
- To submit a reconsideration, please submit new clinical information and place *reconsideration* on the cover sheet.
- The reconsideration process is the same for OON providers.

Peer-to-peer consultations

- **Peer-to-peer consultations:**
  - Providers have up to seven calendar days after the issuance of the denial to request a peer-to-peer review.
  - For behavioral health, call **844-441-1506.**
  - For Medical Management department, call **833-308-3035.**
  - If you request a peer-to-peer discussion, we will, within 24 hours of your request, acknowledge your request and offer a peer-to-peer conversation within a mutually agreed-upon time.

Provider — preservice appeals

- If an authorization is denied prior to the service being rendered to the member, the care 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: Availity Essentials at Availity.com
  - Fax: directly to the Appeals department at **866-587-3316**
- Appeals must be submitted within 30 calendar days from initial determination. We will send written acknowledgment of the appeal to the member and their representatives within three business days of receipt.
- We will issue a decision within 10 calendar days for non-urgent services and 48 hours for urgent care services.
- Appeals submitted by care providers without the consent of the member are not eligible for state fair hearings; however, care providers may request an additional external medical review (see external medical review process).
- The appeals process is the same for OON care providers.

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 (DOS) or 60 calendar days from the date on the *Explanation of Payment*, whichever was later.
- Should the care provider disagree with the outcome of the review an appeal can be submitted:
  - Appeals must be submitted within 30 calendar days from 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)
- Disputes and UM appeals can be submitted the following ways:
  - Electronically: Using Availity Essentials at Availity.com
  - Fax: Directly to the appeals department at **866-587-3316**

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 deny, limit, reduce, suspend, or terminate 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. Providers must complete the *Medicaid MCE External Review Request Form* located at hmspermedion.com.
- Providers need to upload the request form and all supporting documentation to Permedion's provider website located at ecenter.hmsy.com (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 processbefore 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 termination, 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.

Availity Essentials

Availity Essentials resources and Custom Learning Center

- Availity Essentials (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.
- Healthcare providers can use a single login to access multiple health plan providers at no cost. The registration process is easy, and multiple resources and trainings about site navigation are available.

Availity Essentials/Total Member View

- Total Member View (TMV) is a dashboard that simplifies administration by coordinating access to member-centric patient information. Using this application allows care providers, who are part of a patient's care and service team, to easily access the patient's record through Availity Payer Spaces. Providers can view clinical and case management data about a particular member's record through this tool:
  - Demographic information, Care Summaries, claims details, authorization details, pharmacy information, and care management related activities.
  - Providers have the option to include feedback for each gap in care that is listed on the patient's Active Alerts that are posted in the application *Member Summary*.
  - The *Total Member View Availity User Guide* illustrates step-by-step instructions on accessing and navigating through the Availity Essentials platform and how to use the system. This guide is available through the Digital Solutions Learning Hub.

Request for additional information (RAFI)

- Digital Request for Additional Information (RFAI) is the easiest way to submit attachments requested by your payer using Availity Essentials. There is no need to fax or mail paperwork to complete your claim submissions anymore; just use the digital channels provided for your organization.
- The notification center is located on the top of the Availity Essentials home page. If your payer has requested documentation, there will be a message stating requests in your work queue. Select the hyperlink to navigate to the Attachment Dashboard and view the request.
- The Attachment Dashboard is where all attachment requests are displayed. You can use the hyperlink in the notification center or navigate to **Claims & Payments** > **Attachments New**.
- To locate a specific RFAI request, the request number will begin with RFAI. If you notice multiple requests in your dashboard, take advantage of the filters. You have the option to search, filter, and sort for multiple values such as tax ID, NPI, and request type.
- Select **Upload Attachment** to view the type of document requested. Your uploaded requests will be visible in the History tab once accepted. Select the **Record History** icon on the right side of the request to view the Availity Transaction ID for specific Availity Essentials questions or select **Health Plan Transaction ID** if you need to contact your payer for questions.
- This dashboard, located in Payer Spaces, allows your organization to understand how many digital requests have been sent, how many finalized claims there are based on your attachment submissions, and the average turnaround time from the initial payer request to the claim finalization. To view your Digital RFAI Progress Dashboard application, select **Payer Spaces** from the drop-down menu and choose your payer tile:
  - Training is available on the Availity Essentials website.

Staying connected

Provider Advisory Council

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

If you are interested in participating, please complete this application.

Stay in touch

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

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

Helpful links

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- Availity Essentials: Availity.com
- PNM: ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx
- Find Help: Anthem FindHelp
- OAC rules for nursing facilities: codes.ohio.gov/ohio-administrative-code/chapter-5160-3
- OAC NF covered days and bed hold days: codes.ohio.gov/ohio-administrative-code/rule-5160-3-16.4
- OAC on coverage: codes.ohio.gov/ohio-administrative-code/rule-5160-26-03
- OAC rule on PASRR: codes.ohio.gov/ohio-administrative-code/rule-5160-3-15.1

Thank you

- We appreciate you taking the time to attend our training and hope the information covered today answered 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:
  - Provider website: https://providers.anthem.com/oh
  - Provider Services: **844-912-1226**
  - Please send any questions not covered in this presentation or *Frequently Asked Questions* to OHMedicaidENCPESupport@elevancehealth.com.

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