Important COVID-19 update: Prior authorization and other policy adjustments (Updated April 17, 2020)

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COVID-19 Update: Anthem suspends select prior authorization rules and announces additional policy adjustments in response to unprecedented demands on health care providers

Anthem recognizes the intense demands facing doctors, hospitals and health care providers in the face of the COVID-19 pandemic. Beginning March 26, 2020, unless otherwise required under state and federal mandates, as detailed below, Anthem health plans will suspend select prior authorization requirements, member cost sharing, and claims review and handling protocols to allow health care providers to focus on caring for patients diagnosed with COVID-19. These adjustments apply to members of all lines of business except as noted below, including self-insured plan members and in-network and out-of-network providers, where permissible. We encourage our self-funded customers to participate, although these plans may have an opportunity to opt out.

Medicare adjustments and suspensions may have different timeframes or changes where required by federal law.

Where permissible, these guidelines apply to Federal Employee Plan (FEP®) members. For the most up-to-date information about the changes FEP is making, go to https://www.fepblue.org/coronavirus.

Inpatient and respiratory care

- **Prior authorization requirements are suspended for patient transfers.** Prior authorization will be waived for patient transfers from acute IP hospitals to skilled nursing facilities, rehabilitation hospitals, long-term acute care hospitals, and Behavioral Health residential/intensive outpatient/partial hospitalization programs, and to home health including ground transport in support of those transfers. Although prior authorization is not required, Anthem requests voluntary notification via the usual channels to aid in our members' care coordination and management.

- **Extending the length of time a prior authorization is in effect** for elective inpatient and outpatient procedures to 90 days. This will help prevent the need for additional outreach to Anthem to adjust the date of service covered by the authorization.

- **The 21-day inpatient requirement** before transferring a patient to a long-term acute care hospital is suspended.

- **Concurrent review for discharge planning** will continue unless required to change by federal or state directive.

- **Prior authorization requirements are suspended for COVD-19 Durable Medical Equipment** including oxygen supplies, respiratory devices, continuous positive airway pressure (CPAP) devices, non-invasive ventilators, and multi-function ventilators for patients who need these devices for any medical reason as determined by a provider, along with the requirement for authorization to exceed quantity limits on gloves and masks.

- **Respiratory services** for acute treatment of COVID-19 will be covered. Prior authorization requirements are suspended where previously required.

COVID-19 testing

Laboratory tests for COVID-19 at both in-network and out-of-network laboratories will be covered with no cost sharing for members.

Claims audits, retrospective review, peer to peer review and policy changes

Anthem will adjust the way we handle and monitor claims to ease administrative demands on providers:

- **Hospital Claims audits** requiring additional clinical documentation will be limited for next 90 days, though Anthem reserves the right to conduct retrospective reviews on these findings with expanded lookback recovery periods for all lines of business except Medicare. To assist providers, Anthem can offer electronic submission of clinical documents through the provider portal.

- **Retrospective utilization management review** will also be suspended during this 90-day period, and Anthem reserves the right to conduct retrospective utilization management review of these claims when this period ends and adjust claims as required.

- **Suspend peer-to-peer reviews** except where required pre-denial per operational workflow or where required by state during this time period for all lines of business except Medicare.

- **Our Special Investigation programs** targeting provider fraud will continue, as well as other program integrity functions that help ensure payment accuracy.

- **New payment and utilization management policies and policy updates** will be minimized, unless helpful in the management of the COVID-19 pandemic.

Otherwise, Anthem will continue to administer claims adjudication and payment in line with our benefit plans and state and federal regulations, including claims denials where applicable. Our timely filing requirements remain in place, but Anthem is aware of limitations and heightened demands that may hinder prompt claims submission.

Provider credentialing

Anthem will continue to process provider credentialing within the standard 15 to 18 days even if we are unable to verify provider application data due to disruptions to licensing boards and other agencies. We will verify this information when available.

If Anthem finds that a practitioner fails to meet our minimum criteria because of sanctions, disciplinary action, etc., we will follow the normal process of sending these applications to committee review, which will add to the expected 15 to 18-day average timeline. We are monitoring and will comply with state and federal directives regarding provider credentialing.

Providers should watch Provider News Home for any future administrative changes or policy adjustments we may make in response to the COVID-19 pandemic.

URL: https://providernews.anthem.com/virginia/article/covid-19-update-anthem-suspends-select-prior-authorization-rules-and-announces-significant-policy-adjustments-in-response-to-unprecedented-demands-on-health-care-providers

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