An overview of our medical necessity review process

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A medical necessity review may be called many things - including utilization review (UR), utilization management (UM) or medical management - within the Evidence of Coverage or benefit booklet. Requirements for medical necessity review vary based on the member's benefit plan. Reviews of a medical service may occur:

- when it is requested or planned (prospective or pre-service review)
- during the course of care (inpatient or outpatient ongoing care review)
- after services have been delivered (retrospective or post-service review)

With so many variables, it may help to get a clear picture of what to expect and how the process works.

Timing is Important
We are committed to deciding cases quickly and professionally. Here are several time frames you can expect: **Click on the attachment** to view the requirements.

Urgent Review Requests
An urgent review request is a request for pre-service review that in the view of the treating provider or any physician with knowledge of the member's medical condition, could without such care and treatment, seriously threaten the member's life or health or their ability to regain maximum function or subject them to severe pain that cannot be adequately managed without such care or treatment.

Notification of Delay in Review Determination
If we do not have the information we need to make our decision, we will try to get it from the physician or other health care provider who is requesting the service, medical procedure or equipment. If a delay is anticipated because the information is not readily available, we will notify the member as well as the requesting physician or other health care provider in writing. Delay letters include a description of the information we need to make a decision and also specify when the decision can be expected once the information is received. If we

do not receive the necessary information, we will send a final letter explaining that we are unable to approve access to benefits due to lack of the information requested.

We Use Professional, Qualified Reviewers
Experienced clinicians review requests for services using medical criteria, established guidelines and Anthem Blue Cross Medical Policy. Requests for covered benefits meeting those standards are certified as medically necessary.

Only a Peer Clinical Reviewer May Determine That a Service is Not Medically Necessary
Peer Clinical Reviewers (PCRs) are California licensed health care professionals qualified and clinically competent to evaluate the specific clinical aspects of the request and/or treatment under review. PCRs are licensed in California in the same license category as the requesting physician or other health care provider. If you need to discuss a Medical Policy or a medical necessity review decision, an Anthem Blue Cross Medical Director or Peer Clinical Reviewer is available at 800-794-0838. If the PCR is unable to approve a service, the requesting physician, another health care provider or the member has the right to request an appeal.

Decisions Not to Approve Are in Writing
Written notice is sent to the member and the requesting physician or other health care provider within two business days of the decision. This written notice includes:

- a clear and concise explanation of the reason for the decision
- the name of the criteria and/or guidelines used to make the decision
- the name and phone number of the Peer Clinical Reviewer who made the decision, for peer-to-peer discussion
- instructions for how to appeal a decision o specific provisions of the contract that excludes coverage if the denial is based upon benefit coverage

Access to Criteria is Open
Anthem Blue Cross medical necessity guidelines and criteria for specific services are available to members, member representatives, health care providers and the public. Members may call the number on the back of their ID card for a copy of the guidelines used to determine their case. Anthem Blue Cross Medical Policy is also available at www.anthem.com/ca. Providers can access UM criteria by selecting “Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements” from the Provider Home page; or call 1-800-794-0838 to request that a paper copy be sent to you. The requested criteria is provided free of charge.

A Determination of Medical Necessity Does Not Guarantee Payment or Coverage
The determination that services are medically necessary is based on the clinical information provided. Payment is based on the terms of a member's coverage at the time of service. These terms include certain exclusions, limitations and other conditions, as outlined in the member's Evidence of Coverage or benefit booklet. Payment of benefits could be limited for a number of reasons, for example:

- the information submitted with the claim differs from that given at time of review
- the service performed is excluded from coverage
- the member is not eligible for coverage when the service is actually provided

Decisions About Coverage of Service
Our utilization management decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization.

We Are Available for Questions
If you need to request precertification, need information about our UM process, or have questions or issues, call our toll-free number: 1-800-274-7767. Our associates are available Monday through Friday (except holidays), 8:00 a.m. to 5:00 p.m., Pacific Time. If you call after hours or do not reach someone during business hours, you may leave a confidential voice mail message. Please leave your name and phone number; we will return your call no later than the next business day during the hours listed above, unless other arrangements are made. Calls received after midnight will be returned the same business day. Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. Language Assistance For those who request language services, Anthem Blue Cross provides service in the requested language through bilingual staff or an interpreter, to help members with their UM issues.

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TDD/TTY Services

TDD (telecommunications device for the deaf) or TTY (telephone typewriter, or teletypewriter) is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. If you have a hearing or speech loss, call 711 to use the National Relay Service or the number below for the California Relay Service. A special operator will contact Anthem to help with member needs.

1-800-855-7100 (English TTY/ English Voice)

For Federal Employee Program, call the number on the member ID card. Utilization management is administered by Blue Shield of California.

URL: https://providernews.anthem.com/california/article/an-overview-of-our-medical-necessity-review-process

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