Important COVID-19 update: Prior authorization and other policy adjustments (Updated May 29, 2020)

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Please note that the following information applies to Anthem's Commercial health plans. Please review the Medicare and Medicaid specific sites noted below for details about these plans.
Commercial: Provider News Home
Medicaid: Medicaid Provider News - COVID-19
Medicare: Medicare Advantage Provider News Archives

COVID-19 Update: Anthem updates guidance on prior authorization requirements and other 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 crisis. Unless otherwise required under State and Federal mandates, Anthem health plans is making adjustments to assist providers in caring for members. 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 suspended for patient transfers through May 30, 2020.** 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 issued on or before May 30, 2020, is in effect** for elective inpatient and outpatient procedures to 180 days. This will help prevent the need for additional outreach to Anthem to adjust the date of service covered by the authorization.

- **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 COVID-19 treatment, 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 through June 24, 2020, 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 through June 24, 2020, 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** through June 24, 2020, 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.

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

Through June 24, 2020, Anthem will process provider credentialing within the standard 15-18 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 15-18 day average timeline. We are monitoring and will comply with state and federal directives regarding provider credentialing.

Please note that the above information applies to Anthem's Commercial health plans. Please review the Medicare and Medicaid specific sites noted below for future administrative or policy adjustments we may make in response to the COVID-19 changes pandemic.
Commercial: Provider News Home
Medicaid: Medicaid Provider News - COVID-19
Medicare: Medicare Advantage Provider News Archives

URL: https://providernews.anthem.com/wisconsin/article/important-covid-19-update-prior-authorization-and-other-policy-adjustments-6

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