Georgia Therapy Tri-alliance meeting with AIM/Anthem

October 7, 2019

In attendance:

AIM: Gina Giegling, PT, Aim Specialty Health (working on development of the Rehab program), Yvonne Sullivan – PT, provider manager, Kerrie Reed, Medical director for rehab services -Physiatrist

Anthem – Jameka Smith

Tri-alliance – Nicole Walker, Aileen Deogracias (GOTA); Amie Locicero, Susan Cook (PTAG), Marla Mann, Kelly Ball (GSHA)

The Tri-alliance would like to thank AIM and Anthem for meeting today to discuss provider questions regarding Anthem’s new prior authorization process with AIM. The Tri-alliance posed several questions to AIM to start the conversation, which are discussed below. It should be disclosed that many of the questions discussed today center around the pediatric population including children with more significant disabilities

Background: Anthem worked with AIM to develop the prior authorization program in 2019. It is live currently in Medicaid markets in a few states. AIM went live with most commercial markets in July 2019. AIM faced some significant data insufficiency and stability issues initially, so implementation was postponed. Re-launching in Georgia for commercial patients will be effective on 11/1/19. The prior authorization portal will be available for prior authorization requests beginning on 10/21/19.

1. **Who needs an authorization and where can we find this information?  If the patient is not in the AIM system is it safe to assume they do not require an authorization? Most providers will want proof.   Is there a way to print a confirmation such as “No authorization needed”?**

It was realized during the initial implementation that Availity did not provide all the information needed for providers to determine if a prior authorization is needed. Therefore, providers can now use the AIM portal to determine if prior authorization is required. Providers will enter the member info including date of birth, or name and ID number. Providers will see a list of the programs that AIM administers for that program. Select Rehab. Select diagnosis and service date – if it goes into clinical questions an auth is required and you are starting the prior authorization process. If you see “an order number is not needed” then you don’t’ need a preauthorization. It is recommended that you print this screen and save in their file. It is probably a good idea to verify at the beginning of every month if a child needs an authorization as sometimes plans change and start requiring pre-authorizations.

1. **Do children in the State Health Benefit Plan require prior authorization?** Self funded groups make their own decision to opt in or out of the program. Anthem was going to research to determine if members in the State Health Benefit plan require prior authorization. They will get back to us about this issue
2. **Do initial evaluations require prior authorizations?** For commercial products, initial evaluation codes do not require prior authorization. However, providers should go to the AIM portal up to 2 business days after their initial therapy visit to start an initial authorization for therapy.
3. **What is the time frame for submitting authorization requests?  How long after the evaluation can we request for authorization?  Is the 48 hour limit only for cases where therapy is provided on the same day as the evaluation?  How do we request # of visits or treatments?  How are you determining # of visits/treatments?  Most of the children we serve are chronic (i.e., Developmental delay, Down syndrome, etc) not acute cases (i.e., Stroke, Total Knee Replacement). They are going to need long term ongoing care. The amount of PA’s that are required needs to be reasonable. Asking for a PA every month on a child who is going to need services for several years is not reasonable and wastes everyone’s time. Most authorizations approved so far have been for only 4-8 visits which is clearly not enough for pediatric cases. What Pediatric Utilization review guidelines are used to determine authorization?**  Providers must request a prior authorization within 2 days of their initial **therapy** (not evaluation) visit – not later. The provider will request their first treatment date and will be required to answer several clinical questions. In addition, an evaluation report, plan of care, treatment daily notes, and progress notes may also be requested for upload. The system authorizes visits not codes so a provider doesn’t have to list all codes they will be utilizing – just one code. If you want any provider from your facility to be able to provide services then chose “provider unknown.” The AIM Portal will make immediate decision and let you know if your request has been approved or denied. Once the initial authorization expires, you can request a 2nd allocation of visits. After the second authorization, then you can do a recurring request. This would apply to children who will require long term therapy such as children with Autism, Down syndrome, etc. We discussed the need to differentiate between pediatric and adult authorizations as pediatrics often require longer treatment periods where adults may only need short-term treatment. AIM is working on refining pathways for pediatrics including habilitative versus rehabilitative services which require increased visits and increased time frames. Regardless, all therapy services still have to meet medical necessity guidelines.
4. **Are there any diagnoses that do not require authorization?  Autism?  Other?** None currently
5. **Authorization Denials for developmentally delayed children in the CIS program may be problematic.  If the EOBs/EOPs deny for “no authorization” or criteria that does not consider EPSDT, the claim may not be payable by Medicaid or Medicaid CMOs as secondary insurance.  EPSDT and Medicaid cover habilitative services whereas not all commercial insurances policies cover chronic conditions. For example: If the BCBS claim denies for “no authorization” the secondary coverage will also deny payment.  Therefore children eligible for basic therapy services in Georgia will not receive medically needed services under Medicaid’s Early Periodic Screening, Diagnostic and Treatment Program (EPSDT). In order to allow coverage by Medicaid, these claims will need a BCBS denial reason of “reached maximum benefits” or “not a covered benefit” versus “no authorization” or “not medically necessary” in order for the children to access their secondary Medicaid benefits.** We discussed this situation with AIM and Anthem. AIM reported that providers could get a denial reason of “not medically necessary” or “benefits exhausted.” If a plan has a certain number of visits per year, there are some diagnoses such as congenital abnormalities which can be extended beyond 40 visits. If the request is something that goes beyond typical allowances then it will be sent to medical management for review.
6. **Will BCBS issue PAs for multiple clinics? Say a client is getting OT from two different therapists for example.** Multiple providers of one discipline can treat a child if operating under the same Tax ID. If a child receives services from two different providers of the same discipline with different Tax ID numbers then the request would probably get routed for a manual review and questions.
7. **If all visits in a PA are not utilized, will the provider be able to get a date extension?** No. If you use up all visits in an authorization early you can request additional visits. It is best for therapist to wait until most or all of the visits have been used before making an additional request for visits.
8. **Where can providers get more information about AIM?** The resource link below goes to the AIM Provider Microsite which contains the Anthem Clinical Guidelines, the AIM Request checklists, the CPT codes, FAQs, as well as information about upcoming training webinars. In addition, providers can review the latest AIM Rehab Program Training deck for additional information.

<http://www.aimproviders.com/rehabilitation/Resources.html>

The Tri-alliance felt this meeting was very informative and productive. We appreciate AIM and Anthem taking the time to meet with the provider groups.

Respectfully submitted,

Kelly J. Ball

October 9, 2019