Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Long-Term Services and Supports Authorization Guide

The table below outlines prior authorization requirements for members enrolled in Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus). This list will be updated as needed. Providers are responsible for verifying eligibility, benefits and their participation status before providing services to Anthem CCC Plus members.

Failure to obtain prior authorization for the services listed below (except during continuity of care) may result in a reimbursement denial. For assistance or authorization requests, call Anthem CCC Plus Provider Services at **1-855-323-4687**, **option 4**.

Continuity of care and requested documentation	
Consumer/agency-directed personal and respite care services	
• Agency/service facilitator name • Address, phone and fax number • NPI number • Start date for services • Primary diagnosis code • Procedure code(s)	• Copy of previous Keystone Peer Review Organization (KEPRO)/Department of Medical Assistance Services (DMAS) or prior MCO health plan authorization approval confirmation **and/or** *DMAS 99* and *DMAS 97 A/B* (care plan) or *DMAS 7/7A*, as applicable (starting 9/1/18)
Adult day health care services	
• Agency/center name • Address, phone and fax number • NPI number • Start date for services • Primary diagnosis code • Procedure code(s)	• Patient's schedule (for example, Monday, Wednesday and Friday schedule) • Copy of previous KEPRO authorization approval confirmation **and/or** *DMAS 99* and *DMAS 301* (care plan)
Personal emergency response system (PERS)	
• Company/agency name • Requesting provider (if different than agency providing services) • NPI number of PERS company and requesting/ordering provider • Address, phone and fax number of requesting PERS provider	• Address of requesting/ordering provider for verification • Start date for services • Primary diagnosis code • Procedure code(s) • Copy of previous KEPRO authorization approval confirmation

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New authorization or renewal requests and required documentation	
Service facilitator visits	
• Service facilitator/company name • Address, phone and fax number • NPI number	• Start date for services • Primary diagnosis code • Procedure code(s)
Consumer/agency-directed personal and respite care services (Commonwealth Coordinated Care Plus Waiver — *members 21 years and older*)	
• Agency/service facilitator name • Address, phone and fax number • NPI number • Start date for services • Primary diagnosis code • Procedure code(s)	• *DMAS 99*[1]*, Uniform Assessment Instrument (UAI), DMAS 96* and *DMAS 97 A/B* (care plan) • For increase/decrease, reason for change in hours • If transfer from another agency, *DMAS 225* • *DMAS 100*[2] *for supervision and work verification letter, as applicable*
Consumer/agency-directed personal and respite care services (Commonwealth Coordinated Care Plus Waiver and EPSDT — *members under 21 years of age, effective September 1, 2018*)	
• Agency/service facilitator name • Address, phone number and fax number • NPI number • Start date for services • Primary diagnosis code • Procedure code(s) • *DMAS 99*, *UAI* and *DMAS 96* (if Commonwealth Coordinated Care Plus Waiver is approved)	• *DMAS 7* and *DMAS 7A* • Individualized Education Program (IEP), as applicable, if requesting services during school day • Most recent *DMAS 90* (last two weeks of PCA progress notes) if available • For new requests: hospital/facility discharge summary, three most recent physician visit notes
Adult day health care services	
• Agency/center name • Address, phone and fax number • NPI number • Start date for services • Primary diagnosis code • Procedure code(s)	• Patient's schedule (for example, Monday, Wednesday and Friday schedule) • *DMAS 99*, *DMAS 96* and *DMAS 301* (care plan) • *DMAS 225*
PERS	
• Company/agency name • Requesting provider (if different than agency providing services) • NPI number of PERS company and requesting/ordering provider • Address, phone and fax number of requesting PERS provider	• Start date for services • Primary diagnosis code • Procedure code(s) • *DMAS 100A*

Private duty nursing **(Tech Waiver members — *21 years and up*)**	
• Agency/service facilitator name • Address, phone number and fax number • NPI number • Start date for services • Primary diagnosis code • Procedure code(s) • *DMAS 99*, *UAI* and *DMAS 96*	• Current *CMS 485* • *DMAS 116* • *DMAS 103* • *DMAS 108* • If respite requested, *CMS 485* to document this need
Private duty nursing **(Tech Waiver members — *under 21 years of age, effective September 1, 2018)***	
• Agency/service facilitator name • Address, phone number and fax number • NPI number • Start date for services • Primary diagnosis code • Procedure code(s) • *DMAS 99*, *UAI* and *DMAS 96* • *DMAS 62* • Current *CMS 485*	• Last two weeks of nursing notes (for renewals only) • IEP, as applicable, if requesting services during school day • Hospital/facility discharge summary, three most recent physician visit notes (for new requests) • If respite requested, *CMS 485* to document this need

Frequently asked questions

The following are frequently asked questions about long-term services and supports (LTSS) requests for Anthem CCC Plus members.

Q How can I locate the case manager for a specific member?

A Call Anthem CCC Plus Provider Services at **1-855-323-4687** or log into Patient360 and the primary case manager's name will be noted at the top of the member's dashboard.

Q How and where can I submit authorization requests?

A You may fax all LTSS authorization requests and documents to **1-844-864-7853** or you can submit the request through the Interactive Care Reviewer self-service provider tool by logging into **https://www.availity.com**.

Q Where can I find authorization information on the provider website?

A

1. Log in to our secure provider self-service website at **https://mediproviders.anthem.com/va**.
2. Select **Member Information** from the left navigation.
3. Choose **Patient360**.
4. Enter the member's information.

Q How do I check member eligibility?

A First, verify the member's Anthem CCC Plus enrollment by using the **Virginia Medicaid DMAS website** or calling the MediCall automated voice response system at **1-800-844-9730** or **1-800-772-9996**. Then, log into the **Availity Portal** or call Anthem CCC Plus Provider Services at **1-855-323-4687** to obtain the member's Anthem CCC Plus ID number.

Q What if I need to renew an authorization request?

A Providers must submit a service authorization request if a member requires continued services and the current authorization will end. There are no automatic renewals of service authorizations. **It's the provider's responsibility to track and submit all authorization requests timely.**

When a current authorization is due to expire, please submit the following renewal documents mentioned above. For example:

- Most recent *DMAS 99* for adults 21 and older — must at least be within the last 90 days (based on member's visit schedule of 30, 60 or 90 days)
- Most recent *DMAS 97 A/B, DMAS 301*, etc. — dated within the last 365 days
- Most recent *DMAS 62, DMAS 7/7A* — dated within the last 365 days
- Most recent *CMS 485* — dated within the last 365 days

To ensure there's no break in coverage for authorization, please submit the request at least five days prior to but no more than 30 days prior to the expiration date. Effective October 15, 2018, HealthKeepers, Inc. now actively enforces authorization timelines to ensure timely processing and adequate care for our members. We will authorize service retroactively up to 10 calendar days after service.

Failure to obtain precertification for a scheduled/elective procedure/request may result in an administrative review and a denial of services.

Q The DMAS website says my patient is enrolled in Anthem CCC Plus. What are my next steps?

A Call Anthem CCC Plus Provider Services at **1-855-323-4687, option 2** to confirm the member's enrollment and receive the member's ID. Another option is to log on to the **Availity Portal** to verify eligibility. Using the three-letter prefix "VAQ" and the 12-digit Medicaid number, you can obtain the member's ID. Next, call Anthem CCC Plus Provider Services and ask a team member to transfer you to **option 4**. Notify him or her that you are the servicing provider for the member and request the care coordinator's name and contact information. We ask that you reach out to the member's care coordinator and leave a voicemail if necessary. For additional support, contact your local Provider Relations representative.

Q I received a referral for a member who is enrolled in Anthem CCC Plus; however, I am not a participating provider at this time. What are my next steps?

A Every Anthem CCC Plus member has a care coordinator. After verifying membership, call Anthem CCC Plus Provider Services at **1-855-323-4687**, **option 4** to obtain the care coordinator's name and contact information. We ask that you reach out to the member's care coordinator and leave a voicemail if necessary. For additional support with this inquiry, you can also contact your local Provider Relations representative prior to seeing the member.

Q I received a call from an Anthem CCC Plus care coordinator informing me that, per their assessment, the member requires a change in hours. What are my next steps?

A Our care coordinators will make every effort to request your involvement in the member's assessment visit to identify these changes together. However, if you're unavailable and we complete this visit independently, we ask that you schedule an appointment with the member as soon as possible for a reassessment.

The start date for the change in hours will be the date of the agency or service facilitator visit. If the agency or service facilitator agrees with the assessment and an agreement is reached, a change in

hours — either an increase or decrease — can be supported. The agency or service facilitator will need to fax in the required documentation as listed above, including a rationale for the increase or decrease in hours. The agency or service facilitator can review the case manager's assessment on the Patient360 website under the *Case Management* tab. For additional support, you may also reach out to your local Provider Relations representative.

Q Does nursing home custodial care require authorization?

A No, authorization is not required. However, if it's a new admission to the facility and the member was not previously custodial, we do require the provider submits the *Nursing Facility Admission Form* or the *DMAS 96* so we can change the member's designation and notify DMAS of the change. You can access a *DMAS 96* at **https://www.virginiamedicaid.dmas.virginia.gov** > Provider Services > Provider Forms Search. *The Nursing Facility Admission Form* can be found at **http://www.dmas.virginia.gov/#/cccplusproviders** > Charts > How to Do Business with Each Health plan by Provider Type > *Nursing Facility Admission Form for CCC Plus 11.3.17*.

Q How do I access information from HealthKeepers, Inc. about the Anthem CCC Plus plan?

A You can call Anthem CCC Plus Provider Services at **1-855-323-4687**, Monday to Friday, 8 a.m. to 8 p.m. ET, to speak with a representative. Our provider website, found at **https://mediproviders.anthem.com/va**, also contains provider guides, manuals, tutorials and contracts. In addition, the **Patient360** tool on our website allows you to look up authorization details, care summaries, care management activities and more. For additional support, you can also reach out to your local Provider Relations representative.

Contact information

Anthem CCC Plus Provider Services
Monday to Friday, 8 a.m. to 8 p.m. ET
Phone: **1-855-323-4687** (authorizations and case management: **option 4**)

LTSS fax: **1-844-864-7853**

Availity Portal
Monday to Friday, 8 a.m. to 7 p.m. ET
Phone: **1-800-282-4548**

Additional resources

- **Provider website**
- **Provider manual**
- **Patient360**
- **DMAS Provider Services**
- **DMAS procedure codes**
- **Virginia Medicaid DMAS website**