

Managed Care – Medical Management (Central Region Products)

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Core Care Management Activities

Healthcare Management Services

Healthcare Management Services (HMS), Highmark Blue Shield's medical management division, is responsible for all the medical management services provided to Highmark Blue Shield members, including utilization management, case management and disease/condition management. These services are provided either directly by HMS staff or through contracted relationships managed through HMS to ensure that all health care services received by Highmark Blue Shield members are coordinated and integrated.

Goal of HMS medical management

The goal of medical management is to collaborate with providers in managing targeted members and services at the right time using clinically appropriate and cost effective resources.

How medical management services are requested

Medical management services are requested in the following ways:

- Electronically
- Telephonically

Medical management processes

Medical management is conducted through the processes of referrals and authorizations, which are explained in detail in Section 10, "Managed Care Referrals and Authorizations." This section will provide the medical management processes applicable to each product as well as some general processes that pertain to all products.

Provider-driven care management

Network providers are responsible for obtaining required authorizations. If the authorization is not in place at the time the service is provided, the claim will be pended for retrospective review. If payment for the service is subsequently denied, the member cannot be billed for the services. This is known as provider-driven care management, and it applies to all Highmark Blue Shield products.

Checking for authorizations

Providers who have access to NaviNet (Highmark Blue Shield's Internet-based inquiry system) can verify if an authorization has been obtained, by checking the referral/authorization inquiry function. If the provider does not have access to NaviNet, or if NaviNet is not available, authorization information may be available from the requesting provider or by contacting Healthcare Management Services at 1-866-731-8080 during the hours of 8:30 a.m. to 7:00 p.m., Monday through Friday. For urgent care, HMS is also available between the hours of 8:30 a.m. and 4:30 p.m. on Saturday and Sunday.

If the member still wants a service for which authorization cannot be obtained

If an authorization has not been obtained because it has been determined that the care is either not medically necessary or a non-covered service, the member may still want to receive the service. In such cases, the provider can have the member sign a waiver formally accepting financial responsibility for the specific service to be received.

Authorization is not a guarantee of payment

When an authorization is given, it serves as a statement about medical necessity and appropriateness; it is not a guarantee of payment. Payment is dependent upon the member having coverage at the time the service is rendered and the type of coverage available under the member's benefit plan. Some benefit plans may also impose deductibles, coinsurance, co-payments and/or maximums that may impact the payment provided. Providers may consult OASIS, InfoFax or NaviNet (if you have access) to obtain benefit information.

Failure to obtain authorization

Failure to pre-authorize or pre-certify a service or admission may result in retrospective review. Highmark Blue Shield has the right to review the service retrospectively for medical necessity and compliance with other applicable standards, and to deny payment when necessary. If the review is performed, and

- **HMS determines that the service *was* medically necessary**, the claim will be paid at the higher level.
- **HMS determines that the service *was not* medically necessary**, no payment will be made for the claim. In this situation, the network provider must write off the entire cost of the claim and may not bill the member (except for any non-covered services).

Options if the authorization is not in place at the time of service

For elective services, the treating physician should obtain the required authorization prior to the member's arrival for services. However, if a Highmark Blue Shield member presents him- or herself for non-emergency services and the required authorization appears not to be in place, the provider has the following options:

- Perform an authorization inquiry on NaviNet.
- Contact HMS to obtain the required authorization.

Criteria are available

The criteria that HMS uses to make its determinations are available free of charge upon request from an HMS Care or Case Manager.

Medical Management for ClassicBlue Indemnity Members

Although ClassicBlue Traditional and Comprehensive plans do not require its members to select a primary care physician, limited medical management processes do apply. The following services require authorization:

- All inpatient admissions, including acute hospital, acute rehabilitation, skilled nursing facility, long term acute and mental health and substance abuse.
- Outpatient physical and manipulation therapy services require an approved treatment plan for members with a ClassicBlue Comprehensive program.

Medical Management for PPOBlue Members**Certain services require HMS authorization**

Although PPOBlue does not require its members to select a primary care physician, limited medical management processes do apply. The following services require authorization:

- All inpatient admissions, including acute hospital, acute rehabilitation, skilled nursing facility, long term acute and mental health and substance abuse.
- Outpatient physical and spinal manipulation therapy services require an approved treatment plan.

Medical Management for DirectBlue Members

DirectBlue members and primary care physicians

While DirectBlue members are not required to select a primary care physician, they are encouraged to do so. If the member does choose a primary care physician, the name of the primary care physician is printed on the member's identification card. Even if a DirectBlue member selects a primary care physician, he or she is not required to have health care services coordinated by that physician.

Referrals and authorizations

DirectBlue members do not need a **referral** in order to seek care from a network specialist. However, certain services do require **authorization** under DirectBlue:

- Inpatient admissions, including acute hospital, acute rehabilitation, skilled nursing facility, long term acute, mental health and substance abuse
- Selected surgical procedures (see list referenced in the appendix)
- Physical, manipulation, speech and occupational therapy services
- Durable medical equipment (deluxe, customized, non-standard)
- Home health care
- Hospice

Additional information about authorizations can be found in Section 10, "Managed Care Referrals and Authorizations."

Medical Management for SelectBlue Members

Referrals

Referrals are required when the member's primary care physician wishes to refer the member to another provider for services. Details about the referral and authorization procedures can be found in Section 10, "Managed Care Referrals and Authorizations."

Services requiring authorization

For SelectBlue members, authorization is required for the following services:

- Inpatient admissions, including acute hospital, acute rehabilitation, skilled nursing facility, long term acute, mental health and substance abuse
- Selected surgical procedures (see list referenced in the appendix)
- Physical, manipulation, speech and occupational therapy services
- Durable medical equipment (deluxe, customized, non-standard)
- Home health care
- Hospice

Specific services requiring authorization are also listed on the *Referral Request Form* which can be found in the appendix.

Additional information about authorizations can be found in Section 10, "Managed Care Referrals and Authorizations."

When Coordination Is Not Required for SelectBlue Members

Under the specific circumstances detailed below, coordination of care by the primary care physician is not required for SelectBlue members. Provided that all other requirements of the benefit program are met (e.g., the provider participates in the network associated with the member's benefit program), SelectBlue will reimburse eligible services at the higher, coordinated level in these circumstances.

Emergency services

Emergency services (including emergency room services and emergency ambulance transports) are reimbursed without a referral or authorization in cases where a **prudent layperson** would believe that an emergency medical condition existed. A prudent layperson is one who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed.

Women's health care

Female members of SelectBlue can self-refer at any time to any ob-gyn or licensed nurse midwife in their program's network, for in-office treatment of any obstetrical or gynecological condition. The network ob-gyn can also send the member to a participating hospital for diagnostic and certain surgical procedures. If inpatient care is needed, or if the care the member needs requires an authorization, the ob-gyn is responsible for contacting HMS. If an authorization is not in place, the hospital is responsible for initiating the request.

Mental health and substance abuse

Members may self-refer at any time to any PremierBlue Shield network specialist for outpatient treatment.

Laboratory services, imaging and radiological studies

Members do not need a referral for these services, but they must have a prescription from the network provider.

When Coordination of Care Can Be Provided By Someone Other Than the Primary Care Physician for SelectBlue Members

When coordination of care is required for members with SelectBlue coverage, there are circumstances in which someone other than the member's primary care physician can provide it. Provided that all other requirements of the program are met (e.g., that the provider participate in the PremierBlue Shield network), Highmark Blue Shield will reimburse eligible services at the higher, coordinated level in these circumstances.

60-day treatment period

When the primary care physician refers a SelectBlue member to a PremierBlue Shield specialty provider, that specialist can treat the member for the referred condition in his or her office for a period of 60 days from the anticipated date of services listed on the initial referral. This 60-day treatment period does not apply to providers such as doctors of chiropractic, physical therapists, home health care and durable medical equipment suppliers. For these providers, the referral applies only to services as specified on the referral form.

During the 60-day referral period, the specialist to whom a member has been referred can also direct that member to a participating hospital for a diagnostic or surgical service. When this occurs, the specialist is permitted to coordinate the care.

If the service does not require an authorization, such as a laboratory service, only a physician order (script) is required. If the services require an authorization, it is the specialist's responsibility to obtain the authorization from HMS.

Coordination of behavioral health care services

Highmark Blue Shield contracts with Magellan Behavioral Health for the management of inpatient, intensive outpatient and partial hospitalization behavioral health services. In the event of an emergency, these services may be reimbursed at the higher level provided by the member's benefit plan even without authorization. If the services are rendered on a non-emergent basis or after an emergency situation has been stabilized, authorization is required for the higher level of reimbursement. If the member self-refers to a network behavioral health hospital or unit for non-emergency services, those services will be reimbursed at the lower level unless the member or provider notifies Highmark Blue Shield or Magellan within 48 hours of the admission.

Important!

Please be aware that in all other circumstances except those defined above, eligible services will be reimbursed at the lower, self-referred level if the SelectBlue member does not coordinate care through the primary care physician, or if the provider of service does not participate in the PremierBlue Shield network. Services requiring authorization are subject to review for medical necessity. If the services are determined to not be medically necessary, they are not eligible for reimbursement.

Continuity of care

When a member's care is provided or coordinated by someone other than the primary care physician, that provider is responsible for communicating the relevant information (e.g., outcomes, test results) back to the primary care physician. Continuity of care for the member must be maintained.

Criteria for Medical Necessity Decisions**Definition of "medically necessary"**

"Medically Necessary" or "Medical Necessity" means: services or supplies provided by a health care provider that Highmark Blue Shield determines are:

- Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury; and
- Provided for the diagnosis or the direct care and treatment of the member's condition, illness, disease or injury; and
- In accordance with standards of good medical practice; and
- Not primarily for the convenience of the member or the member's provider; and
- The most appropriate supply or level of service that can safely be provided to the member.

When applied to hospitalization, this further means that the member requires acute care as an inpatient due to the nature of the services rendered or the member's condition, and the member cannot receive safe or adequate care as an outpatient.

National criteria and corporate medical policy

Highmark Blue Shield uses nationally recognized evidence-based criteria and/or corporate medical policy in making its determinations of medical necessity and clinical appropriateness. Physicians review and approve both criteria sets and recommend changes that incorporate regional and local variations in medical practice. In addition to the criteria, clinical and peer reviewers also consider individual member needs such as age, co-morbidities, etc. when making medical necessity decisions.

Milliman Care Guidelines 8th Edition

The Milliman Care Guidelines 8th Edition, a nationally recognized criteria set including optimum recovery guidelines, guide the Healthcare Management Services clinical staff in reviewing the medical necessity and appropriateness of services.

Highmark Blue Shield medical policy

Highmark Blue Shield's medical policies are developed to clarify and support the benefit language present in member benefit documentation. These policies are based on extensive medical research and input from professional consultants and actively practicing physicians.

The medical policies address issues such as the following:

- Anesthesia services
- Consultation
- Durable medical equipment and supplies
- Pathology
- Diagnostic medical services
- Radiology
- Nuclear medicine
- Surgery
- Cosmetic and reconstructive surgery
- Maternity services
- Therapies
- Evaluation and management services

Medical policy also addresses services considered to be experimental or investigative and those judged to be “of current questionable usefulness.” It addresses the relationship among services on a claim and provides guidance on which services must be combined for billing purposes.

Availability of criteria

Milliman Care guidelines specific to the case being reviewed are available upon request by contacting Healthcare Management Services at 1-866-731-8080 from 8:30 a.m. through 7:00 p.m., Monday through Friday. For urgent care, HMS is also available between the hours of 8:30 a.m. and 4:30 p.m. on Saturday and Sunday.

Highmark Blue Shield medical policy is available to participating providers through our Web site, at www.highmarkblueshield.com. If for any reason this resource is not available, you may request a policy from Healthcare Management Services at 1-866-731-8080 between the hours of 8:30 a.m. and 7:00 p.m., Monday through Friday. For urgent care, HMS is also available between the hours of 8:30 a.m. and 4:30 p.m. on Saturday and Sunday.

Case Management

Case management is a systematic, proactive and collaborative approach to effective assessment, monitoring and evaluation of options and services required to meet an individual member’s health needs. It involves the coordination of the available resources such as condition management, care management and health education programs.

Identifying members for case management

Highmark Blue Shield’s case management staff use clinical and utilization indicators to identify members who could benefit from case management. The indicators include but are not limited to the following:

- Complex disease processes
- High-cost cases
- Psycho-social issues
- Member exposure to financial risk
- Complications of care
- Multiple admissions

Provider referrals for case management

If a provider identifies a member who could benefit from coordinated case management services, please contact the Healthcare Management Services case management staff at 1-866-731-8080 to discuss the case.

Case management processes

If it is determined that a member would benefit from case management and the member accepts case management, his or her case is assigned to a Highmark Blue Shield case manager. The case manager is then responsible for the following processes:

- Contacting the member and his or her providers
- Assessing the member's needs
- Identifying the particular problems affecting the member's care
- Developing, implementing, coordinating and evaluating a plan of care in collaboration with the member's providers

Emergency Services**Emergency services**

An emergency service is any health care service provided to a member after sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the enrollee, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any body organ or part.

“Prudent layperson”

A prudent layperson is one who is without medical training and who draws on his or her practical experience when deciding whether emergency medical treatment is needed.

Highmark Blue Shield's policy on reimbursement of emergency services

Emergency services are reimbursed without a referral or authorization in cases where a prudent layperson believed that an emergency medical condition existed. If the emergency condition results in an inpatient admission, authorization is required within 48 hours of the admission.

Emergency transportation and emergency service

Emergency transportation and the related medical emergency services provided by a licensed ambulance service are considered to be emergency care and therefore are covered **without** referral or authorization.

