Unit 1 Core Care Management Activities

Healthcare Management Services

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

Goal of HMS medical management

Mission Statement For Integrated Clinical Services
Integrated Clinical Services is committed to working seamlessly with members, providers, and accounts to proactively use information and care management techniques to assure patient safety, quality and cost efficiency, helping our members live longer, healthier lives.

How medical management services are provided

Providers can contact HMS by telephone, at (866) 803-3708, option 1, between the hours of 8:30 a.m. and 7:00 p.m., Monday through Friday, and 8:30 a.m. to 4:30 p.m. on Saturdays and Sundays.

Utilization management

The goal of utilization management is to ensure members' access to timely, high quality services appropriate to their needs, in the acute inpatient, acute rehabilitative, skilled nursing, home health and outpatient settings.

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Who performs utilization review functions?

Care management incorporates a comprehensive integrated solution that encompasses all aspects of engagement and management by providing information, support and interventions across the continuum of care. The components of the care management program recognize that an individual member may have different needs at different points in time and that efforts to identify and address those needs must be integrated and coordinated. The services provided below are integrated into Highmark's total care management plan:

- Health Information and Support
- Utilization Management
- Advocacy and Health Coaching
- Care Coordination/Outreach Case Management
- Intensive Case Management
- Prevention and Wellness
- External Review Services
- Coordination with Behavioral Health
- Medical Technology Assessment Reviews

These activities and functions are used to optimize appropriate utilization of healthcare resources within the appropriate settings including acute inpatient, outpatient, home health care, skilled nursing and rehabilitation.

The core components of utilization management are pre-certification, concurrent review, retrospective review and discharge planning.

Unit 1 Pre-Certification

Pre-certification is provider-driven

The pre-certification process is provider-driven for all in-network care. This means that it is the network provider's responsibility to obtain authorization for the services to be rendered.

Inpatient admissions: all Highmark Blue Shield products

All facility admissions require pre-certification, for all Highmark Blue Shield products. Pre-certification is required for admission to acute inpatient, acute rehabilitative, long-term acute care and skilled nursing facilities. It is used as an opportunity to identify members who may benefit from post-discharge case management or condition management.

Outpatient surgical procedures: DirectBlue

Under DirectBlue, selected outpatient surgical procedures require pre-certification (or pre-authorization). Since the particular procedures requiring pre-authorization may vary by contract, facilities should always be certain that the ordering physician has obtained an authorization number. If none has been obtained, it is the hospital's responsibility to initiate the request.

For more information on pre-authorization of therapy services for members, please see Therapy Requirements page 3-1 of this manual.

Timing of pre-certification

Hospitals should pre-certify all **routine elective** admissions or services at least 5 to 7 days prior to the scheduled date.

All **urgent** and **emergent** admissions should be communicated to Healthcare Management Services within 48 hours of the admission or one HMS business day, whichever is later.

Verify pre-certification

Hospitals can verify that an admission or service has been pre-certified by consulting the NaviNet Referral/Authorization Inquiry function. If for any reason NaviNet is unavailable, pre-certification information may be obtained from the admitting/ordering physician or by calling Healthcare Management Services at (800) 803-3708. HMS hours of operation are 8:30 a.m. to 7:00 p.m., Monday through Friday, and 8:30 a.m. to 4:30 p.m. on Saturdays and Sundays. ***For additional ways of obtaining authorization information, please see Appendix A of the Hospital Facility Manual.***

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Information needed to complete request for pre-certification

Specific information is needed in order to complete a request for pre-certification. Please be prepared to provide the following information:

- Relevant demographic information
- Diagnosis
- Services requested
- Admission or procedure date
- Proposed length of stay and frequency/duration of services
- Symptoms of the present illness or condition
- Pertinent past medical history
- Pertinent lab, radiology, or diagnostic test results
- Treatment plan and goals
- Psycho-social issues impacting care
- Providers involved in the member's care
- Discharge planning information (i.e., anticipated plan across the continuum of care)

Review of pre-certification requests

Healthcare Management Services reviews all pre-certification requests and provides required notifications within the timeframes mandated by applicable regulations and standards. Timely review is dependent upon the availability of complete documentation.

Pre-certification of inter-facility transfers

Please follow these guidelines when a Highmark Blue Shield member must be transferred between hospitals:

- When a member who has been admitted to one facility is transferred to another facility, **the hospital initiating the transfer** is responsible for contacting HMS.

- When a member has been evaluated in the emergency room of one hospital and must be transferred to become an inpatient at another hospital, **the receiving hospital** is responsible for contacting HMS.

Unit 1 Concurrent Review

Concurrent review	Concurrent review is conducted for all admissions to facilities that are reimbursed on a per-diem or percent of charge basis. Facilities that are reimbursed on a per-case basis may contact Healthcare Management Services at any time for assistance with specific post-discharge requirements, including potential transfer to another facility.
Timely review	Healthcare Management Services reviews all requests for Concurrent Review and provides the appropriate notifications within time frames required by all applicable regulations and standards.

Unit 1 Retrospective Review

Why retrospective review is performed

Facilities have a contractual obligation to cooperate fully with admission and outpatient service review procedures. If a facility fails to comply with the pre-admission procedures or an outpatient authorization requirement, Highmark Blue Shield has the right to review such admissions or services retrospectively for medical necessity, for compliance with other applicable standards, and to deny payment when appropriate. In such situations, facilities must hold the Highmark Blue Shield member harmless with respect to payment for services.

Medical record requests for retrospective reviews

In conducting a retrospective review, Highmark Blue Shield will request relevant portions of the medical record to be sent to the Medical Review department, at the following address:

Highmark, Inc.
Medical Review
P.O. Box 890392
Camp Hill, PA 17089-0392

Timeframes for retrospective reviews

Retrospective reviews are completed within 30 calendar days from receipt of all the supporting information reasonably necessary to complete the request.

Appeal of retrospective reviews that result in denial determinations

If the physician issues a denial decision at the conclusion of the review, the facility may elect to appeal this denial.

For more information on provider appeals, please see pages 9-1 through 9-2 of this manual.

Unit 1 Discharge Planning

Highmark Blue Shield contracted vendors/ providers

Services and equipment needs at discharge should be arranged with Highmark Blue Shield contracted vendors or providers. Names of contracted vendors and providers are available through NaviNet. If for any reason NaviNet is not available, this information can be obtained from Healthcare Management Services by calling (866) 803-3708, option 1, between the hours of 8:30 a.m. to 7:00 p.m., Monday through Friday, and from 8:30 a.m. to 4:30 p.m. on Saturdays and Sundays.

Discharge planning

The discharge planning process should be initiated as soon as possible after admission, to facilitate a timely and coordinated transition to the next level of care.

The hospital should coordinate this effort, involving the vendor or provider and Healthcare Management Services as needed.