Chapter 4

Health Care Management

Unit 1: Care Management

In This Unit

4.1 Care Management

Healthcare Management Services

Healthcare Management Services (HMS), Highmark Blue Shield's medical management division, is responsible for all the care 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 management services received by Highmark Blue Shield members are coordinated and integrated.

Goal Of HMS Care Management

To deliver a comprehensive and integrated care management program which positively impacts both members' health and medical benefit costs.

How Care Management Services Are Requested

Medical management services are requested in the following ways:

- Electronically
- Telephonically
- Fax

Medical Record Review

Highmark reserves the right to request and review medical records for visits whether or not preauthorization is required. If such review determines that any or all treatments were not medically necessary, were not billed appropriately, or were not performed, a refund will be requested. If a refund is requested, the practitioner may not bill the member for the services.

Utilization Decision Making

Highmark makes utilization review decisions based only on appropriateness of care and service and the existence of coverage. They do not reward practitioners, providers, Highmark employees or other individuals conducting utilization review for issuing denials of coverage or service, nor do they provide any financial incentives to utilization management decision makers to encourage denials of coverage.

Continued on next page

4.1 Care Management, Continued

Criteria Used

Highmark uses McKesson Health Solution's InterQual® criteria in its processes for assessing the medical necessity and appropriateness of health care services. The Interqual® criteria are applied to assessment of acute adult, acute pediatric, acute rehabilitative, long-term acute, skilled nursing and home health services. These criteria are applied in conjunction with applicable Highmark Medical Policy, Medicare Advantage Policy, and Highmark Government Services Administrative Policy.

Note: If you would like more information about the criteria used for determinations, please contact HMS at 1-866-731-8080.

Medical Necessity Criteria

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, CMS as to the Medicare Advantage program, etc.), Highmark Blue Shield has adopted a universal definition of medical necessity. The term "Medically Necessary," "Medical Necessity" or such other comparable term in any provider contract shall mean health care services (or such similar term as contained in the applicable benefit agreement or plan document to include, but not be limited to, "health services and supplies," "services and supplies" and/or "medications and supplies") that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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.

Continued on next page

4.1 Care Management, Continued

InterQual®

InterQual® Level of Care criteria is a nationally recognized criteria set used by 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 should be combined for billing purposes.

Continued on next page

4.1 Care Management, Continued

Availability Of Criteria

InterQual® Level of 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. Behavioral Health criteria can be obtained by calling 1-800-628-0816.

Highmark Blue Shield medical policy is available to participating providers through our region-specific Web sites by accessing www.highmark.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.

4.1 Case Management

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. Case Management is a collaborative process involving the physician, the patient and support system, the case manager, and other healthcare service providers to encourage and assist patients to achieve their optimum level of wellness, self-management, and functional capability.

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:

- *High risk diagnoses*
- *Situation and discharge planning needs*
- *Psycho-social issues*
- *Financial issues*
- *Complex care coordination needs*
- *Multiple admissions*
- *Health risk assessment screening*

Case Management Services

Highmark case managers are licensed, experienced healthcare professionals able to assist your patient by providing the following services, including but not limited to:

- *Assessment of knowledge deficits regarding their condition, treatment, or benefit issues*
- *Reinforcement of educational information as directed by the physician or service provider*
- *Evaluation and reinforcement of medication use and adherence which is particularly important in polypharmacy situations*
- *Evaluation and reinforcement of adherence with treatment regime*
- *Intervention to assist with obtaining medical supplies or equipment*
- *Coordination of service providers*
- *Communication of adverse situations to the physician or service provider*
- *Evaluation and assistance with financial concerns*
- *Assessment and assistance with advance care planning*

Continued on next page

4.1 Case Management, Continued

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. Case management is a voluntary program and is free to Highmark members. The case manager is responsible for the following processes:

- *Contacting the member and his or her providers*
- *Comprehensive assessment of the member's needs*
- *Identifying the issues and/or barriers affecting the member's care.*
- *Developing, implementing, coordinating and evaluating a plan of care in collaboration with the member and his or her providers*

Provider Referrals For Case Management

Highmark encourages providers to identify members who could benefit from coordinated case management services, please contact the Healthcare Management Services case management staff at 1-800-596-9443 to discuss your patient's needs.

*Please consider the following conditions for **Case Management referral**:*

- *Patients with multiple medical or behavioral health concerns or services*
- *Patients who lack a consistent caregiver, have financial concerns and require community resources*
- *Patients with a life-altering diagnosis or condition such as brain trauma, cancer, or debilitating neurological condition*
- *Patients with difficulty achieving self management resulting in frequent emergency room visits or hospital admissions*

4.1 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.

Definition of 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.

Reimbursement Of Emergency Services

Emergency services are reimbursed without 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 Services

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** authorization.