The Utilization Management Department is comprised of licensed, registered nurses who provide utilization management services to facilitate the prompt, efficient delivery and monitoring of medically necessary and cost-effective health care services to members in the most appropriate setting by qualified practitioners. HealthPlus plan medical directors are available for consultation and to provide oversight. The program employs a comprehensive approach to provide medical services by the integration of key utilization management activities.

These activities include, but are not limited to:

- Referral management
- Pre-service review of selected services
- Inpatient admission review
- Concurrent review
- Retrospective review
- Activities targeted at specific conditions, and specialized clinical programs to provide effective care for members across the continuum of care

No Utilization Incentives

HealthPlus utilization management decision-making is based only on appropriateness of care and service and the existence of coverage. HealthPlus does not specifically reward any person involved in the utilization review process for issuing denials. HealthPlus does not compensate any person with responsibility for the utilization management program in a manner which would motivate them to make inappropriate review decisions.

Pre-certification Authorization

Pre-service review is required for selected elective inpatient procedures and ambulatory and outpatient services outside of the PCP's expertise. Listed below are examples of services requiring pre-service review:

- Oral surgery
- Out-of-plan (non-contracted) services
- Inpatient physical rehabilitation
- Durable medical equipment
    - power-operated vehicles (POV)
    - items that might be considered "deluxe"
    - unlisted codes
    - items over $3,000 or per claim
    - CPAP and BIPAP
    - Bone stimulators
- Chiropractic services
- Skilled nursing facility
- Procedures requested to be performed in a hospital setting or surgical center
- Outpatient physical therapy, occupational therapy and speech therapy
- Behavioral health services (inpatient, partial hospital, intensive outpatient and continued outpatient therapy
- Specialist services (e.g., genetic testing, uterine artery embolization, infertility, capsule end oscopy, transplantation, adult sterilization, autologous chondrocyte transplant, termination of pregnancy, external counter pulsation, biofeedback, left ventricular device, vagus nerve stimulation)
- Certain medications
- High-tech imaging and nuclear testing through CareCore
- Cosmetic surgery
- Bariatric services

- Preferred Provider Organizations (PPO) members are responsible for obtaining prior authorization for select services

The utilization review staff conducts pre-service review (or the pharmacy staff in the case of medications), using the appropriate, approved guidelines and criteria. Pre-certification is not required in the case of urgent or emergency services provided as necessary to screen and stabilize a member's condition where a prudent lay person, acting reasonably, would believe that an emergency existed. Emergency services are covered when rendered by a non-affiliated provider inside or outside the service area, when the emergency prevents the member from receiving emergency services at an affiliated provider. Emergency services authorized by a practitioner or representative permitted to act on HealthPlus' behalf are also covered in accordance with the member contract.

Inpatient Admission Review and Certification

All contracted acute care facilities are required to notify HealthPlus of inpatient admissions. Behavioral health inpatient, partial hospitalization and intensive outpatient admissions and skilled nursing facility admissions are authorized before the admission. The admission review process is performed by the utilization reviewer and occurs within 24 hours of admission or the first working day after the admission in coordination with the PCP and/or attending physician.

The utilization reviewer also performs admission review on cases involving members who receive services at non-participating (out-of-network) facilities. Members in stable condition and deemed appropriate for transportation by the attending physician may be transferred to a participating facility for continued treatment. Those members not in stable condition, who require continued care, are followed via telephone with the facility.

Application of Medical Necessity Criteria

In making determinations regarding medical necessity/appropriateness for medical, behavioral and pharmaceutical care, the medical management and pharmacy staff primarily make use of nationally accepted, objective, evidence-based guidelines or criteria appropriate to the service under review. In the absence of national guidelines/criteria, HealthPlus may develop internal, evidence-based guidelines with the involvement of appropriate professionals. These criteria are reviewed annually by practitioners with professional knowledge or clinical expertise in the area being reviewed and have an opportunity to give advice or comment during the development, adoption and review of these guidelines/criteria. All benefit determinations are made in accordance with the benefit design of the applicable subscriber contract. The utilization reviewer verifies eligibility, availability of benefit, consults with the treating physician, and gathers other relevant clinical information, including but not limited to history of presenting problem, patient treatment plans and goals, second opinion information if appropriate, etc.

Information could be gathered from the following additional sources:

- Internal sources (member demographics, enrollment information, case records)
- Treating physician
- Facility medical record (e.g., inpatient, outpatient, special unit, rehabilitation, clinic, office)
- Primary Care Physician
- Specialist(s)
- Ancillary service provider(s)

Admission Notification

The following information is required to process an admission:

- Member name
- HealthPlus subscriber number
- Diagnosis
- Admitting physician name
- Attending physician name

- Route of admission
- Telephone number of the utilization department

Upon notification of an admission, a HealthPlus utilization reviewer will perform a case review using approved guidelines within 24 hours of the admission/entry to services, or the first working day thereafter. Providers are notified of the determination of authorization with an assigned confirmation number by telephone, written or faxed confirmation within 24 hours of the determination.

PPO members are required to notify HealthPlus of elective hospitalizations at least five days prior to the scheduled admission and within twenty-four hours or as soon as possible for emergency admissions.

Concurrent Review

Concurrent review is the process of continual reassessment of the medical necessity and appropriateness of acute medical or behavioral inpatient, partial hospitalization and intensive outpatient care during a facility admission. The review continues to identify case management needs, quality of care issues and assistance in arranging timely discharge. Out-of-area admissions require an approved referral and are reviewed via telephone.

Concurrent review is conducted by the utilization reviewers and is performed each business day with decisions rendered and appropriate parties notified of length of stay recommendations on the same day. Failure to receive information needed to review a stay results in an administrative adverse determination regarding all or part of the admission.

The utilization reviewers refer all questionable cases which do not satisfy the specified guidelines to the appropriate medical director for review and determination.

Utilization Management Decisions

HealthPlus makes decision and notification activities in a consistent and timely manner to minimize disruption in the provision of health care for its members. Decision-making at HealthPlus is based only on appropriateness of care, service and is made in compliance with state, federal and accrediting agency regulations. All benefit determinations are made in accordance with the benefit design of the applicable subscriber contract.

Adverse medical necessity determinations can only be made by a HealthPlus physician reviewer. When HealthPlus utilization staff or pharmacy staff is unable to approve proposed or continued care for reimbursement as requested by a practitioner, the appropriate medical director reviews the request and any available clinical information. Based on the medical director's review, the utilization or pharmacy staff may issue an adverse determination to the member, practitioner/provider and the PCP. The notification includes the rationale for the denial and an explanation of the process for appeal. ***Utilization management staff is available to discuss any concerns during normal business hours. On-call staff returns urgent after-hours calls as soon as possible and non- urgent after-hours calls are returned the next business day. To speak with staff in utilization management, call HealthPlus Customer Service at 1-800-332-9161.***

Practitioners may ***also*** discuss any utilization decision with a HealthPlus physician reviewer or appropriate behavioral health reviewer.

If you wish to discuss a decision with a physician reviewer, call our Customer Service Department and ask to speak with a physician reviewer.

1-800-332-9161

HealthPlus notifies practitioners of any utilization management adverse determination. The adverse determination notice includes information on how to contact a physician reviewer or appropriate

behavioral health reviewer by telephone to discuss the decision. A copy of the medical necessity criteria, guideline or benefit provision used to make the decision is available upon request.

Questions or requests to review specific medical necessity criteria may be directed to our Customer Service Department.

1-800-332-9161

Post-Service Review

Post-Service review is performed for the following reasons:

- To evaluate the appropriateness of member and practitioner/provider inpatient and outpatient utilization patterns, as well as to identify any quality of care concerns
- To evaluate cases where circumstances prevented the member, facility or provider from seeking authorization of care
- To match the authorized services to charges received

When the service requires clinical review, HealthPlus clinical staff applies the applicable criteria and/or member's benefit. If all the clinical documentation is provided at the time of the request, HealthPlus renders a decision and provides written notification to the member, PCP and attending provider within 30 days of the receipt. If the documentation is not present to support an approval, the required specific information is requested from the PCP and/or member. A decision is made and written notification is provided to the member and provider within 15 days of receipt of the additional information.

If the clinical staff is unable to approve the request based on medical necessity, the clinical information is forwarded to a plan medical director for review. Denial notifications include the reason for denial, a description of how to file an appeal and the availability of a medical director to discuss the individual merits of the case with the practitioner.

Discharge Planning

Discharge planning is a critical component of the utilization management process that begins upon admission with an assessment of the patient's potential discharge care needs. It includes preparation of the patient and his or her family for continuing care needs and initiation of arrangements for placement or services needed after acute care discharge to ensure optimal clinical outcomes. The clinical staff works in collaboration with hospital discharge planners, admitting and attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs. This process begins upon admission and is revised as needed throughout the admission. While alternative levels are considered for post discharge care, members also may be referred for HealthPlus condition-specific case management services.

Appeals

HealthPlus is committed to a systematic approach for seeking resolutions in situations where payment for services is not authorized. Whenever concerns or issues cannot be resolved through routine inquiry procedures, the appeal process may be initiated by the provider. A routine inquiry is one in which the provider seeks and receives clarification about the decision made by HealthPlus and is in agreement with the decision. An appeal is initiated when a provider requests, in writing, within 60 days of the adverse determination, the desire to have the decision reconsidered. A cover letter requesting appeal (or reconsideration) along with supporting documentation indicating the reason for the appeal must be submitted. HealthPlus will respond to the provider via letter with the results of the reconsideration within 45 days from the date of the receipt of the supporting documentation.

Confidentiality

The medical management process deals with sensitive information concerning the health care services delivered to members by providers. The documents created and reviewed as a part of the utilization management process are confidential and privileged information and are maintained in compliance with appropriate federal and state law concerning the confidentiality of medical records.

All employees and consultants retained by HealthPlus must maintain a standard of ethics and confidentiality regarding both member information and proprietary information. To ensure the appropriate handling of confidential information, all employees are required to sign a confidentiality statement upon employment, and annually thereafter. Ongoing monitoring is performed to ensure compliance with confidentiality policies.

Employees also are required to receive HIPAA Privacy and Security Standards training within a reasonable time of employment and thereafter as policies, procedures or the law changes. Similarly, HealthPlus requires clinical and administrative service organizations which HealthPlus contracts with to sign a Business Associate or confidentiality agreement.

The Case Management Department is comprised of licensed, registered nurses and social workers that integrate medical and behavioral health case management services to HealthPlus members. HealthPlus plan medical directors (physicians) are available for consultation and to provide oversight.

HealthPlus of Michigan's case management program has four components - complex case management, primary case management for targeted chronic diseases, behavioral health/substance abuse case management, and medical social services.

- **Complex case management** - Complex case management (CCM) is available to members who have experienced a critical event or diagnosis that requires the extensive use of health care resources. Members who qualify for CCM may encounter barriers to accessing care, and require assistance navigating the health care system. These members have multiple comorbidities, may also be receiving treatment from multiple physicians and providers, have difficulty adhering to treatment recommendations, and have competing psychosocial concerns. Case managers coordinate member care with the assistance of the member's practitioners, family, friends and/or community agencies to facilitate appropriate delivery of services.

- **Primary case management** - Members who do not qualify for CCM may be eligible for primary case management (PCM). PCM focuses on self-management of targeted, high impact, chronic conditions and preventive care.

- **Behavioral health and substance abuse case management –** Eligible members with behavioral health and substance abuse issues are provided support by behavioral health case managers to help coordinate care and to aid in recovery.

- **Medical social services**
  Members who have psychosocial, financial or transportation needs, or who need access to governmental or community resources are eligible for Social Services. Medical social workers work closely with case managers to provide support to members.

Members may be co-managed by medical and behavioral health case managers and social workers, as needed, through integration and coordination of services within the department.

The primary goals of the case management program are:

1. To help members regain optimum health or improved functional capability
2. To improve the member's functional status and quality of life
3. To achieve optimum clinical outcomes
4. To improve the self-management of diseases and conditions
5. To reduce unplanned admissions and emergency room usage
6. To improve medication adherence
7. To educate the member and family about preventive care
8. To ensure care is delivered in the right setting, at the appropriate time
9. To assist members and families with end of life issues

The CCM program is designed to assist the individual in regaining optimum health or improved functional capability, and to ensure care is delivered in the right setting, at the right time and in a cost effective manner.

Member Identification and Access to Case Management

Early identification of members who qualify for CCM is critical to the success of the HealthPlus CCM program. The CCM program utilizes a variety of methods to support the early identification of members in need of services based on predictive modeling, health risk appraisals, claims reflecting high-cost utilization and pharmacy reports, as well as emergency room visit, hospital discharge and authorization data. Providers may refer members or members may self-refer to the program. HealthPlus receives CCM referrals from other internal and external sources.

Referrals may be submitted via the Medical Management software system, interoffice mail, FAX, US mail, face-to-face contact or by telephone.

Selection Criteria for Complex Case Management

At a minimum, a member must have the following characteristics in order to be selected for the CCM program.

- The member has experienced a critical event or has a diagnosis that requires extensive use of resources, and/or end of life issues. Examples may include:
    - Multiple Traumatic Injuries
    - Neuromuscular Disease
    - End of Life Issues
    - Cystic Fibrosis
    - Hemophilia
    - Lupus
    - Cardiovascular Conditions with Neurological Deficits
    - Catastrophic
    - Transplants Evaluation
    - HIV/AIDS
    - High-Risk Neonates
    - End Stage Organ Failure
- Member faces barriers that hinder positive outcomes, such as an unwillingness or inability to follow treatment plans and/or lack of social or caregiver support

In addition, a member may have one or more of the following characteristics:

- Member needs assistance in navigating the system to facilitate appropriate delivery of services
- Member has multiple diagnoses and co-morbidities, high utilization and/or complex treatment plans involving multiple providers, modalities or treatment sites
- Member is at risk for complications or has complications or co-morbidities that could result in frequent admissions, frequent emergency room visits not resulting in an admission or have hospital stays greater than 10 days
- Member has competing psychosocial concerns that require coordination of care

The complex case manager reviews and evaluates each referral to determine the member's needs. Members who qualify are enrolled in the CCM Program. Members not appropriate for CCM may be

eligible for primary case management, behavioral health case management, social services, or require services from the special interventions program.

The PCM program focuses on members with specific chronic conditions. Primary case managers foster self-management through education and prevention based on evidence-based guidelines to meet the day-to-day needs of these members. Potential return-to-work dates are discussed, as applicable.

Member Identification and Access to Case Management

Candidates for PCM are identified through predictive modeling, health risk appraisals, utilization review activities, medical/pharmacy/ER claims data, behavioral health, disease management, pharmacy, other internal departments, families and providers.

Providers can refer and members may self-refer to the program. Primary case managers review and assess the member to determine his/her needs. Barriers are identified and short- and long-term goals established. Members who qualify are enrolled in the appropriate PCM program. Targeted conditions include cardiovascular, heart failure, diabetes, asthma, and chronic obstructive pulmonary disease (COPD).

Cardiovascular Conditions

The objective of this program is to optimize the member's health and improve his/her quality of life through education and the development of a self-management plan. Through focused education, members are better able to control and respond to symptoms, slow progression of the disease, and reduce emergency room visits, hospital admissions and other related health care costs.

Members with heart failure may be eligible for the heart failure home monitoring program. This program supports timely interventions by the provider through daily monitoring of the member's blood pressure, pulse, pulse oximetry, and weight from home.

Diabetes Program

The goal of the diabetes program is to improve compliance and help members make any needed lifestyle modifications. Case managers provide the education and guidance that help participants attain target blood glucose levels to lower the risk of complications from diabetes. Members partner with the health care team and the case manager to develop a self-management plan that includes regular blood glucose and hemoglobin A1c testing, blood pressure checks, foot exams, annual dilated eye exams, nephropathy and other appropriate screenings.

Asthma Program

The objective of the asthma program is to educate members about their condition, teach them how to follow a prescribed care plan, and identify and avoid symptom-inducing triggers. By helping the member develop self-management skills, members can improve his/her quality of life, reduce or avoid ER visits, hospitalizations, and other health care costs.

Chronic Obstructive Pulmonary Disease (COPD) Program

This program supports the member's COPD treatment goals, supports slowing the progression of the disease, improvement of overall health, and the reduction of hospital admissions.

Special Interventions/Triage Program

Members who require case management services on a short-term basis, but do not meet CCM or PCM criteria, are included in the special interventions program.

Referrals for the special interventions program are received from providers, utilization management, pharmacy, families and other sources previously described. Examples of cases in the special interventions program include those associated with high-risk pregnancy, home infusion, transplant management, special provider requests, members who utilize high cost medications, surgical cases

requiring short-term follow-up management, or any other cases who may fall outside of the targeted conditions.

Case managers work collaboratively with utilization reviewers, hospital staff and providers to reduce gaps that lead to member safety issues, medication errors, and miscommunication between patients, caregivers and providers. They ensure coordination and continuity of health care for members being transferred between healthcare locations, providers or within levels of care and/or across health care settings.

The key focus of this program is to:

- Facilitate communication and interaction between providers to formulate and execute a common plan for transition of care which can occur:
    - Between health care settings; acute to sub acute, ambulatory to SNF
    - Across health states; hospital to hospice or palliative care, home to assisted living
    - Between providers; acute care provider to palliative care specialist, generalist to specialist
- Clarify discrepancies regarding the care plan, the member's status, or the member's medications
- Communicate with members and their families on follow-up care, understanding their condition, medication compliance and navigating the complexity of the health care systems
- Ensure that the patient's/caregiver's preferences are incorporated into the plan
- Identify the member's social support and their function in the member's care
- Link member to community services, behavioral health or social services

Upon discharge to home, the case manager will:

- Assess the member for further case management needs
- Evaluate the impact of planned interventions and identify additional member needs
- Ensure members schedule a follow-up appointment , as applicable
- Evaluate for medication adherence and monitor for prescription refills
- Assess functional status
- Refer members to Health and Lifestyle, Disease Management, Behavioral Health and other internal programs, as appropriate

Member Identification
Members are identified for the Social Services Program through referrals from case management, utilization management, disease management, health and lifestyles, pharmacy, customer service, providers and family members. Members may also self refer.

Selection Criteria
Social workers work collaboratively with case managers and other HealthPlus staff to help members receive needed services. Social workers perform a comprehensive assessment to determine the needs of the member regarding:

- End of life issues
- Establishment of a primary care physician
- Education regarding appropriate emergency room use
- Activities of daily living
- Durable medical equipment
- Psychological and substance abuse screening
- Home safety concerns
- Conflicts with medical treatment and religious beliefs
- Language interpretation problems
- Domestic abuse screening
- Benefits evaluation
- Environmental needs
- Caregiver support
- Pain management issues

Coordination of Care and Services and Linkage to Community Resources
Case managers and social workers may work collaboratively to coordinate member care through arrangements with community and social service programs. Assistance in coordinating and transitioning care for members with special care needs can be provided through contracted and/or non-contracted providers. Coordination of financial, social, psychosocial, transportation, and environmental services, as well as caregiver support, is available to all members in the Medical Case Management Program.

Integration and Coordination of Medical and Behavioral Health Services
Behavioral disorders can have a medical basis or implications for the member's physical health. In addition, a high percentage of members with chronic conditions suffer from behavioral health and/or substance abuse disorders. The medical and behavioral case management team has a process to ensure integration of services and effective communication among providers to maximize the member's ability to actively engage in his/her health care plan of treatment. Triggers for a referral to behavioral health case management may include known or member-reported substance abuse, reported feelings of helplessness or hopelessness, poor SF-8 score or failed depression screen, member responses to assessment questions, lack of support system, suicidal/homicidal ideation or other symptoms.

Referrals to Other HealthPlus Programs
The case managers and social workers frequently identify candidates for other HealthPlus programs and work with staff to ensure coordination of services. These programs include:

Disease management programs that support the member with ongoing education and reinforcement of self-management goals. Members with diabetes, coronary artery disease, atrial fibrillation, heart failure, asthma, or COPD may be candidates for disease management.

Pharmacy programs that assist members with medication management and may offer financial alternatives, as applicable.

Health and lifestyles programs that provide education regarding healthy living including nutrition, exercise, and preventive care. Reasons for referrals may include tobacco cessation, weight management or other. The case manager works collaboratively with staff from other HealthPlus programs to ensure coordination of services for members.

Summary

The HealthPlus case managers can be a valuable member of your health care team. The case manager will work with you and your patient to identify barriers, establish short- and long-term goals, develop a self-management plan, coordinate his/her care and support the member in achieving optimal overall health.

For further information about HealthPlus case management or to make a referral to the HealthPlus Case Management Department, please call Customer Service at:

1-800-332-9161

To contact the Case Management Department, call:

(810) 230-2050

Utilization Case Management Quick Check

Medical Management

Question	Answer	Additional Information
Is there an authorization telephone number for hospital, rehab and nursing home admissions?	Contact the Utilization Case Management Department in your region.	HealthPlus Utilization Case Management Department: (810) 230-2029 Fax: (810) 230-2002 or (989) 797-4000 Fax: (989) 799-8494
How do I appeal an adverse determination?	If you wish to discuss an adverse determination, contact a HealthPlus medical director. If the discussion with the medical director is not satisfactory, your next step is to request an appeal in writing, and include the appropriate supporting documentation.	HealthPlus Customer Service: 1-800-332-9161 HealthPlus ATTN: Utilization Case Management Department PO Box 1700 Flint, MI 48501-1700 or HealthPlus ATTN: Utilization Case Management Department 5454 Hampton Place Saginaw, MI 48604