Section 4
Medical Utilization Management
(Care Management)

The Blue Cross and Blue Shield of Vermont integrated health management department performs focused medical utilization review for selected inpatient and outpatient services. Medical utilization management is part of the overall Blue Cross and Blue Shield of Vermont care management program.

The focused inpatient utilization is based on an analysis of the individual hospital’s utilization and practice patterns, and may vary by provider. Utilization patterns at the network hospitals are reviewed quarterly. As utilization patterns change, the Plan evolves the focus of the inpatient utilization review process. Registered Nurses conduct telephonic review on those inpatient cases that meet the focus criteria for that quarter.

Integrated health management staff also review targeted outpatient procedures and services through the prior approval process.

Registered nurse reviewers are authorized to grant approval for services that meet plan guidelines, and deny services excluded from the benefit plan. A plan physician makes all denial decisions that require an evaluation of medical necessity.

Components of the medical utilization management program include:

- Pre-certification of admissions
- Prior approval/Pre-service
- Concurrent review
- Retrospective review/Post-service
- Discharge planning in collaboration with facilities, members and providers
- Medical claim review

To facilitate transmission of the necessary information for utilization review and associated utilization management (UM) decisions during a single, initial contact, BCBSVT provides members, practitioners, and facilities access to a toll free number with a choice of options to reach the appropriate person for assistance. The utilization management staff of the integrated health management department is available to receive and place calls during normal business hours (8 a.m. to 4:30 p.m., Monday through Friday). Integrated health management staff do not place outgoing calls after normal business hours. In addition, members and/or providers who need to contact the Plan after normal business hours may utilize the toll free number and leave a voice message related to non-urgent/non-emergent care that is reviewed the next business day for appropriate disposition. Information may be sent via fax or Web at any time, with the ability to attach clinical information with the request, but if sent after hours, it is addressed the next business day. For urgent or emergent care, a nurse and physician are available to providers (by toll free telephone number) 24 hours a day, seven days a week to render utilization review determinations. When speaking with others,
the integrated health management staff identify themselves by name, title and as an employee of Blue Cross and Blue Shield of Vermont. All inquiries related to specific UM cases are forwarded to integrated health management staff for resolution, regardless of where the initial inquiry was received within the Plan.

Case managers collect data on all case managed cases, including the following:

- Age of member
- Previous medical history and diagnosis
- Signs and symptoms of their illness and co-morbidities
- Diagnostic testing
- The current plan of care
- Family support and community resources
- Psychosocial needs
- Home care needs if appropriate
- Post hospitalization medical support needs including durable medical equipment, special therapy, and medications/infusion therapy

The following information sources are considered when registered nurses perform utilization management review:

- Primary care physician and/or attending physician
- Member and/or family
- Hospital medical record
- Milliman Health Care Management Guidelines, Inpatient and Surgical Care and Ambulatory, and Recovery Facility Guidelines
- Blue Cross and Blue Shield of Vermont medical policies
- Blue Cross and Blue Shield Association medical policies
- Board certified specialist consultants
- TEC (Technology Evaluation Center) assessment
- Health care providers involved in the member’s care
- Hospital clinical staff in the utilization and quality assurance departments
- Plan medical director and physician reviewers

A more intensive review occurs for some requested procedure/service(s) based on the need to direct care to specific providers, coverage issues, or based on quality concerns about the medical necessity for the requested procedure/service(s). A more intensive review may require office records and/or additional medical information to support the request. The services which require additional medical information include, but are not limited to:

- Possible cosmetic procedures, e.g. breast reduction
- Organ transplants
- Out-of-network for point of service product(s) and managed products
- Experimental procedures/protocols

Individual member needs and circumstances are always considered when making UM decisions, and are given the greatest weight if they conflict with utilization management guidelines. In addition, both behavioral and medical services staff consider the capability of the Vermont health care system to actually deliver health services in an alternate (lesser) setting when applying utilization management criteria. If the requested services do not meet the Plan’s criteria, clinical staff documents the member’s
clinical needs and circumstances, and any limitations in the delivery system and forward that information to a medical director for a decision.

The utilization review nurse may contact the hospital utilization review staff and/or the attending physician to obtain the clinical information needed to approve services. However, if the utilization review nurse cannot obtain sufficient information to determine the medical necessity, appropriateness, efficacy, or efficiency of the service requested, and/or the review is unresolved for any other reason, the Plan’s nurse reviewer refers the case to a Plan physician reviewer.

Before an adverse determination is issued, the Plan’s physician reviewer attempts to consult with the attending specialty physician and/or PCP to discuss possible alternatives. The Plan’s physician reviewer considers the individual clinical circumstances and the capabilities of the Vermont community delivery system for each case. In making the final determination, the actual clinical needs take precedence over published review criteria. In the event of an adverse decision, both the member and participating provider can request an appeal. The appeal procedure is documented more specifically later in this document.

For services that have been prior approved, BCBSVT does not limit or deny payments for services rendered for which prior written approval was obtained, except in cases of fraud or abuse. During the concurrent review process, if services or treatments are provided to the member that were not included in the original request, and are determined to be not medically necessary, the Plan may deny those services or treatments and the member is not to be held liable. This means that the member is not penalized for care delivered prior to notification of an adverse determination. For further details see provider contracts. BCBSVT utilization staff will not accept any financial incentive relating to UM decisions.

Clinical Review Criteria

The plan utilizes review guidelines that are informed by generally accepted medical and scientific evidence and consistent with clinical practice parameters as recognized by health professionals in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition. Such guidelines include nationally recognized health care guidelines, MCG, Level of Care utilization System (LOCUS), Child and Adolescent Level of Care Utilization (CALOCUS) and the American Society of Addiction Medicine (ASAM) Criteria.

In the absence of a national guideline from the above mentioned, the Plan’s internal medical policy and the Blue Cross and Blue Shield Association Medical Policy and/or the TEC Assessment Publications are utilized as resources to reach decisions on matters of medical policy, benefit coverage and utilization management.

The Blue Cross and Blue Shield Association Medical Policy Manual provides an informational resource which, along with other information, a member Blue Cross and Blue Shield plan (and its licensed affiliates) may use to:

• Administer national accounts as they may decide to have their employee benefit coverage so interpreted; and
• Assist the Plan in reaching its own decisions on matters of subscriber
coverage and related medical policy, utilization management, managed care and quality assessment programs.

These guidelines are reviewed on an annual basis by the clinical advisory committee to assure relevance with current practice, taking into account input from practicing physicians, and other health providers, including providers under contract with the Plan, if applicable, and are available to all providers under contract with the Plan, as well as to members and their treating providers upon request.

Providers and members may request a copy of the applicable criteria from the Integrated Health Management department by facsimile (802) 371-3491, phone (800) 922-8778, option 1, or mail at BCBSVT, PO Box 186, Montpelier, VT 05601-0186.

The Plan has adopted the nationally recognized guidelines for the treatment of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Substance Use Disorders and Major Depression. Nationally recognized experts in each condition developed the guidelines. The guidelines are available for you to read or print on the following websites:

- Evaluation and Management of Congestive Heart Failure in the Adult, American College of Cardiology and American Heart Association: www.cardiosource.org/

The Plan has adopted nationally recognized preventive health and clinical practice guidelines for Adult and Pediatric Preventive Immunizations, Adult and Children and Adolescent Clinical Preventive Services, and treatment of Substance Abuse, Opioid Abuse, and Depressive Disorder. Nationally recognized experts developed these guidelines. The guidelines are available for you to read or print on the following websites:

- Adult Preventive Immunization, Centers for Disease Control and Prevention: www.cdc.gov/vaccines/schedules/hcp/adult.html
- Pediatric Preventive Immunizations, Centers for Disease Control and Prevention: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- Guidelines for the Treatment of Patients with Substance Abuse, Opiod Abuse, American Psychiatric Association: http://psychiatryonline.org/guidelines.aspx
In addition to the nationally recognized preventive health and clinical practice guidelines listed above, BCBSVT bi-annually adopts new clinical practice guidelines and reviews clinical guidelines that the Plan previously adopted. The Plan has adopted guidelines for the treatment of Chronic Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Asthma, Overweight and Obesity, and Hypertension. The guidelines may be evidence-based guidelines or consensus guidelines developed by providers. These guidelines are available at www.bcbsvt.com/provider/reference-guides/clinical-practice-guides, by calling Customer Service at (800) 924-3494 or by emailing customerservice@bcbsvt.com.

Prior approval/referral authorization is required for coverage of selected supplies, procedures, and pharmaceuticals before services are rendered, as outlined in member certificates and outlines of coverage. Even members with BCBSVT/TVHP as a secondary carrier, including those with Medicare as the primary carrier, need to obtain a prior approval for applicable services. These lists are updated annually based upon Vermont practice patterns. The current lists are available on the provider resource center located at www.bcbsvt.com. Requests for prior approval/referral authorization can be submitted by phone, mail, fax or Web to medical services at the Plan utilizing the appropriate form for supplies and procedures, or pharmaceuticals. These prior approval/referral authorization requests may come from the referring provider, the servicing provider or the member. Forms can be obtained from the provider resource center located at www.bcbsvt.com or by calling customer service.

Prior approval/referral authorization requests are reviewed by a Plan registered nurse, a Plan/TVHP medical director, a Plan contract dentist reviewer, a Plan pharmacist reviewer, or a Care Advantage Inc., (CAI) consultant medical director. The registered nurse may approve services but does not issue medical necessity denials. The dentist and pharmacist reviewers’ only review requests pertinent to their disciplines. Determinations to deny or limit services are only made by physicians under the direction of the medical director.

Upon receipt, the reviewer evaluates the prior approval request. If insufficient information is present for determination, additional information is requested, in writing, from the member or provider. The notice of extension specifically describes the required information. The member or provider is afforded at least 45 calendar days from receipt of the notice within which to provide the specified information, or the Plan will deny the request for benefits as not medically necessary based on the information received, and the charges may be denied when claims are submitted without prior approval.

Once the information is sufficient for determination, the registered nurse reviewer approves requests that meet pre-established medical necessity criteria and are covered benefits. If medical necessity criteria are not met, the registered nurse reviewer refers the case to a Plan medical director for decision. The physician reviewer may request additional information or contact the requesting physician directly to discuss the case. Appropriate
clinical information is collected and a decision formulated based on adherence to nationally accepted treatment guidelines and unique individual case features. References used to make determination include, but are not limited to the following:

- Blue Cross and Blue Shield Association TEC Assessment
- Blue Cross and Blue Shield Association Medical Policy Manual
- Blue Cross and Blue Shield of Vermont Medial Policy Manual
- Medical director review of current scientific literature
- Review of specific professional medical and scientific organizations, (i.e. SAGES)
- Milliman, Current Edition

Once a determination is made, the member, provider and the referred-to-provider are notified in writing for approvals and denials. Decision letters contain the following:

- A statement of the reviewers understanding of the request;
- If applicable, a description of any additional material or information necessary for the member to perfect the request and an explanation of why such material or information is necessary;
- If the review resulted in authorization, a clear and complete description of the service(s) that were authorized and all applicable limits or conditions;
- If the review resulted in adverse benefit determination, in whole or in part;
  - The specific reason for the adverse benefit determination, in easily understandable language
- The text of the specific health benefit plan provisions on which the determination is based;
- If the adverse benefit determination is based on medical necessity, an experimental/investigational exclusion, is otherwise an appealable decision or is otherwise a medically-based determination: an explanation of the scientific or clinical judgment for the determination, and an explanation of how the clinical review criteria and the terms of the health benefit plan apply to the member’s circumstances;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline or protocol or other criterion will be provided to the member upon request and free of charge within two business days or, in the case of concurrent or urgent pre-service review, immediately upon request;
- If the review is concurrent or pre-service, what, if any, alternative covered benefit(s) the Plan will consider to be medically necessary and would authorize if requested;
- A description of grievance procedures and the time limits applicable to such procedures;
- In the case of a concurrent review determination or an urgent, pre-service request, a description of the expedited grievance review process that may be applicable to such requests;
- A description of the requirements and timeframes for filing grievances and/or a request for independent external review in order for the
member or provider to be held harmless pending the outcome, where applicable;
• Notice of the right to request independent external review after a grievance determination, in the language, format and manner prescribed by the Department; and
• Local and toll free numbers for the department’s health care consumer assistance section and the Vermont Office of Health Care Ombudsman

For all lines of business, the Plan adheres to Vermont Rule H2009-03, NCQA accreditation, and federal timeliness standards. For non-urgent pre-service review decisions, the Plan must provide notice of adverse determination to the member and treating provider (if known), within a reasonable period, not longer than 15 calendar days after receipt of the request. Verbal notification must be given to the member and treating provider (if known) with written notification sent within 24 hours of verbal notification.

If additional information is needed because of lack of information submitted with the prior approval request, the Plan sends a written request for additional information within 15 calendar days of receipt of the request. The notice of extension specifically describes the required information. The member or provider has at least 45 calendar days from receipt of the notice within which to provide the specified information.

The Plan does not retroactively deny reimbursement for services that received prior approval, except in cases of fraud including material misrepresentation. See provider contracts for more complete details.

Pre-certification of Admissions

Under the Plan’s certificates of coverage, pre-certification of scheduled inpatient admission is required. Pre-certification enables the Plan’s medical services staff to assess the medical necessity of the requested procedure and the appropriateness of the requested setting of care (inpatient versus outpatient). Clinical information pertinent to the request is collected as needed. The information is reviewed in conjunction with nationally recognized health care guidelines and/or other data sources identified earlier in the description.

If the medical services staff cannot certify the request, the case is referred to a Plan medical director. The Plan medical director may contact the attending physician or consult a specialist to address unresolved questions or to discuss other possible alternatives prior to issuing an adverse determination. The medical director may approve or deny a service.

Written notification of both approval and denial determinations are sent to the member and treating provider (if known) occurs within 15 days of request. Copies of the letter are sent to the treating providers, facility and member. The Plan’s medical services department also keeps a copy as part of the member’s electronic record. In the case of an adverse determination, the appeal process is outlined in the letter and is also discussed later in this program description.

Each case reviewed is evaluated for case and/or disease management. Both medical services staff and physician reviewers participate in a team effort that focuses on the member’s unique needs. The appropriateness of services, access to, cost effectiveness and quality of services are
all stressed.

The Plan does not retroactively deny reimbursement for services that received prior approval/pre-certification except in cases of fraud including material misrepresentation. See provider contracts for more complete details.

Admission Review

All admissions that require review, but occur without pre-certification, are considered urgent or emergent and are evaluated within 24 hours or one business day of notice to the Plan. Admission reviews in this category are reviewed as noted above. A registered nurse and medical director are available to providers (by toll free telephone number) 24 hours a day, seven days a week, to render utilization review determinations for urgent or emergent care. Verbal notifications of all urgent and non-urgent decisions are made within 24 hours to both the member and provider. Written notifications are issued within 24 hours of verbal notification.

Concurrent Review

Concurrent review applies to inpatient hospitalization or any ongoing course of treatment. During inpatient hospitalization for circumstances requiring focused review, the Plan’s nurse reviewers monitor the care being delivered using Milliman Health Care Guidelines, Current Edition and/or locally approved health care guidelines. Through telephonic review, the Plan’s nurse reviews the medical information provided by the facility’s UR staff while the member is hospitalized. Authorization of continued hospitalization is based on the medical appropriateness of the care being delivered and the member’s unique needs. The Plan uses the concurrent review process to facilitate discharge planning with the treatment team.

If there is a length of stay or level of care issue, it is discussed with the Plan’s medical director and if necessary, the attending physician and the hospital utilization review coordinators within 24 hours of obtaining the necessary medical information. In the event of an adverse decision, verbal notification is provided to the member and treating provider (if known), and a written notification is sent, within 24 hours of the verbal notification, to the member and the provider(s).

During the concurrent review process, if the medical services staff identifies a quality of care issue, the case is referred to the QI department or the credentialing committee for investigation. Once the investigation is completed, follow up to the hospital and/or attending physician is the responsibility of the credentialing committee. A copy of the risk appraisal form is placed in the provider’s risk management file at the time of the investigation.

The Plan does not retroactively deny reimbursement for services that received prior approval/pre-certification except in cases of fraud, including material misrepresentation. See provider contracts for more complete details.

Discharge Planning and Discharge Outreach

Discharge planning occurs during the inpatient concurrent review process. During the concurrent review process, the Plan’s nurse case manager works collaboratively with the caregivers to facilitate appropriate and timely services. The extent of the nurse’s direct role in planning and arranging post-discharge care varies with the patient needs and includes a collaborative approach with the hospital staff, care team, patient/family
and community resources representatives as appropriate. Upon discharge, each member is contacted by the discharge outreach coordinator, an RN, who reviews the member’s discharge plan and assists with coordination of services as needed. During the outreach, the nurse will assess the need for referral to case management, disease management or behavioral health management and will facilitate said referral if applicable.

**Urgent Pre-Service Review**

Urgent pre-service review applies to any request in which the member’s health could be compromised by delay. Expedited decisions are reached and providers are notified within 72 hours of the request. Verbal notification is provided to the member and treating provider (if known) with written confirmation of the decision within 24 hours of telephone notification.

**Case Management**

Blue Cross and Blue Shield of Vermont adopted the Case Management Society of America’s case management definition: Standards of Practice for Case Management revised 2010.

“Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.”

The specialty case management program is a member-centered, proactive program designed to identify the at-risk members as early as possible. The program works collaboratively with our disease management, behavioral health, dental, and pharmacy partners, and is focused on chronic diseases that are typically high-cost and are potentially actionable with appropriate intervention and lifestyle changes. The nurse case manager applies the four primary functions of case management: advocacy, assessment, planning and facilitation, to identify barriers to the member attaining appropriate, timely and quality care. The program is an organized effort to identify potentially high cost/high risk members with complex health needs, as early as possible, assess alternative treatment options, assist in stabilizing or improving member’s health care outcomes and manage health care benefits in the most cost effective manner. The managed diagnostic categories and focus populations include diabetes, general, HIV/AIDS, acute and chronic neurology, progressive degenerative disorders, end of life/palliative care, high-risk obstetrics, pediatrics, transplant and oncology with or without metastasis.

The Plan annually assesses the characteristics and needs of its member population and relevant subpopulations and reviews and updates the case management process and case management resources to address member needs if necessary.

If it is determined that the member has the potential to benefit from case management, a welcome packet is sent defining case management’s role and the member’s rights and responsibilities in participation. Once the member consents to participate in and collaborate with the case manager, a comprehensive assessment is completed with the member who is considered to be an active participant on the interdisciplinary team and the health care team. In collaboration with the member, case manager and provider, a member-specific case management plan of care is developed to support the member’s clinical plan of care, which includes both short and long term, prioritized goals, nursing interventions, a
member self-management plan and discharge criteria.

Case management services may be terminated once the goals are met and the member no longer requires case management services or, since the program is voluntary, the member requests termination of services. Case management services can be reinstated at any time. All information regarding the member is considered confidential and is not shared with anyone who is not part of the interdisciplinary team without written consent of the member or person with medical power of attorney.

Episodic case management/authorization of services targets individuals who have short-term intervention needs, usually for a period of six to 12 weeks or for a specific illness episode. This applies also for members who demonstrate evidence that their needs are being met by support groups or other community agencies and whose only needs are to have services authorized. The value of this program is to expedite care from hospital to home or an alternative setting and to promote continuity of service across the continuum.

Providers are encouraged to refer BCBSVT/TVHP members directly into our case or disease management programs by calling (800) 922-8778, option 1. Our intake triage staff will record the information and complete outreach to the member for enrollment.