

## 2011 Utilization Management Program

Blue Shield of California and Blue Shield of California Life & Health Insurance Company operate a Utilization Management (UM) program to direct and monitor the appropriateness of healthcare services provided to members. The UM program involves evaluation of the utilization of services provided to members before, during, and after services are performed. The program involves the cooperative participation of network hospitals, physicians, and other healthcare providers, plus members, to deliver a timely and effective program focused on improved outcomes and quality care.

A designated Blue Shield senior-level medical director is actively involved and oversees the development and implementation of the UM program and UM policies and procedures. Additional input is provided by actively practicing healthcare providers in the Blue Shield networks. These providers are supported by Blue Shield regional medical directors, medical management managers, care/case management nurses, and support staff, in sufficient numbers to assure timely interventions and interactions with providers and members.

At least annually, the UM program's plan, policies, and procedures are reviewed, revised, updated as necessary, and approved by the statewide Blue Shield Utilization Management Committee.

The UM program ensures that UM decision making is based solely on appropriateness of care and services, and the existence of benefit coverage. Blue Shield does not reward practitioners, vendors, or other individuals for issuing denials of coverage of care or service. There are no financial incentives for UM decision makers to encourage decisions that result in underutilization.

Medical decisions are made by qualified individuals, and with the use of criteria that is evidence-based and supported by clinical principles and processes, without undue influence of plan management concerned with Blue Shield's fiscal operation. The UM program also ensures that contracting physicians are not penalized for authorizing appropriate medical care and referrals.

In some cases Blue Shield may delegate the implementation of the UM program to an Independent Practice Association (IPA) or medical group (MG) contracted with Blue Shield for HMO business. Blue Shield's team of Performance Improvement nurses monitor the IPA or MG to assure a timely and effective program, consistent with Blue Shield's internal program. Prior to delegation, the IPA/MG must demonstrate the ability to implement Blue Shield's UM program. The Performance Improvement nurses perform an onsite audit, and an annual evaluation of the IPA/MG's performance of UM functions, decisions, and operations against accreditation and regulatory standards, including Blue Shield internal standards, the National Committee for Quality Assurance (NCQA) standards (HMO), Centers for Medicare & Medicaid Services (CMS) regulations for Medicare Advantage (HMO), Knox-Keene regulations 1300.70, Health Care Service Plan Quality Assurance Program (Department of Managed Health Care), URAC standards (PPO), and Department of Labor in accordance with the Employee Retirement Income Security Act (ERISA).

## Scope

The Blue Shield UM program includes management and evaluation of care and services in all settings, including doctors offices and clinics, day surgery centers, hospitals, skilled nursing facilities, rehab centers, and care provided in the home. The program includes activities such as pre-authorization of services; the review of member care while in a facility setting (such as a hospital, a chemical dependency treatment center, a skilled nursing facility, or a rehab center); and post-service review of all care including but not limited to facility, outpatient or office care, and prescription drugs. The program also includes member support through case management of complex medical care, chronic condition management (also called disease management), and the health advocacy program. The UM program uses care coordination, referrals, and member education to help assure members receive medical care at the right time, in the right location, by the right caregiver, for the best clinical outcome, and within the benefits available. *For commercial HMO and PPO, refer to Blue Shield's MHSa UM program for a description of the applicable behavioral health UM activities.*

UM activities include the following:

- Monitoring and assessing the delivery of care, including review and evaluation of medical necessity and appropriateness, under- and over- utilization of services, continuity and coordination of care, timeliness, cost effectiveness, and quality of care and service, as well as outcomes.
- Ensuring that members have access to the appropriate care and service within their health plan benefits that is consistent with accepted standards of medical practice.
- Retaining the ultimate responsibility for the determination of medical necessity for Blue Shield members.
- Ensuring that denials related to utilization issues are reviewed and handled efficiently according to Blue Shield UM timeliness standards.
- Evaluating the effectiveness of the UM Program, utilizing member- and provider-specific data which includes member and provider satisfaction surveys.
- Identifying, educating, and managing members with select chronic conditions, promoting increased member participation in the self-management of their disease, improving quality of life for members, and reducing acute exacerbations of their illness.
- Monitoring Independent Physician Associations and medical groups delegated for UM activities and reporting timeframes determined by Blue Shield, and conducting regular provider audits with follow-up as needed to ensure continued compliance with Blue Shield standards.
- Monitoring performance to ensure qualified healthcare professionals perform all components of the UM program.
- Maintaining a process for a licensed physician to conduct reviews on cases that may not meet medical necessity criteria.
- Maintaining a process that promotes UM staff and Blue Shield medical directors' access to appropriate board-certified specialists as needed in determining medical necessity.
- Defining and monitoring the process used to avoid conflict of interest by staff reviewers and committee members.
- Ensuring the confidentiality of member and provider information.

## **Staffing**

All UM program activities are supervised by licensed medical professionals. The UM program is supported by a staff of non-licensed employees, who perform a variety of non-clinical/administrative support functions such as support to the professional clinical staff; data entry; creation of letters, reports and files; verification of member eligibility and benefits; and serving as the initial point of contact for members and providers regarding UM activities.

All clinical activities, such as review of care for medical necessity, are performed by a registered nurse licensed in the state of California, or other appropriate medical professional such as a physical therapist or pharmacist licensed in California. If the medical professional has any question about the medical necessity of services to be rendered, or appropriateness of the setting for service based on review criteria and guidelines, the case is forwarded to a Blue Shield medical director for case review. The Blue Shield medical director contacts the attending physician to discuss the case, if necessary. Only a Blue Shield medical director licensed in the state of California is authorized to make a denial for coverage based on medical necessity.

Blue Shield members and providers may contact Blue Shield with questions or comments about the UM program by calling (800) 541-6652. In addition to regular business hours during the traditional work week, messages may be left after hours on a dedicated, confidential voice mail message line, to be reviewed on the next business day.

## **Confidentiality**

Due to the nature of routine UM operations, Blue Shield has implemented policies and procedures to protect and ensure the confidential treatment of personal and health information of our members and privileged medical record information. Upon employment, all Blue Shield employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality. In addition, all UM staff and committee members are required to sign a confidentiality agreement on an annual basis.

Both the Blue Shield UM staff voicemail phone message line for utilization review information and the computer network system are controlled by a secured password system, accessible only by the individual employee.

The facsimile machines used for utilization review purposes are located within the department to assure monitoring of confidential medical record information by Blue Shield UM staff.

## **Goals**

The UM program promotes the delivery of high-quality care in the most cost-effective manner for Blue Shield's members.

- Assures effective and efficient use of appropriate medical services
- Analyzes and reviews data to identify patterns and trends regarding over- and under-utilization of services
- Establishes a process for medical necessity review; before, during, and after care is provided

- Promotes and maintains cost-effective quality care through use of established, evidence-based clinical guidelines
- Promotes early identification, intervention, and referral to the appropriate level of care
- Identifies members with special care needs and facilitates the delivery of appropriate care
- Promotes preventive care and health promotion programs
- Identifies actual and/or potential quality issues during utilization review activities and refers to internal Blue Shield staff for investigation , follow up, and resolution
- Assures compliance with accrediting and regulatory agencies
- Recommends and formulates changes in medical policy, guidelines, and procedures as a result of utilization-pattern analysis and industry trends.

### **Integration with the Quality Management Program**

The UM program works together with the Quality Improvement Program. The goals and performance in utilization management are monitored and measured as part of the impact on quality outcomes. In addition:

- The UM program is evaluated and approved annually by the Blue Shield Utilization Management Committee.
- Aggregate UM data, satisfaction surveys, member grievances, denials, and appeals are reviewed by the Blue Shield Utilization Management Committee.

The Blue Shield Utilization Management Committee reports to the Quality Management Committee. The UM staff may identify actual and/or potential quality issues during utilization review activities. These issues are referred to staff dedicated to addressing quality issues for further investigation, follow up, and resolution.

The Utilization Management Program is reviewed and evaluated for effectiveness at least annually.

Recommendations for revisions and improvements are made as deemed necessary. The UM program is reviewed, updated, and approved annually by the Blue Shield Quality Management Committee and the Governing Board.

External reviews of the program are conducted by other agencies such as the National Committee for Quality Assurance (NCQA) and URAC, the state Department of Managed Health Care (DMHC), and the federal Centers for Medicare & Medicaid Services (CMS).