

CARE MANAGEMENT

Section V

I. INTRODUCTION

The Care Management Program operates under the direction of the Team Leader of Care Management and the Medical Director of Community Health Plan. The program provides for a timely review of the medical necessity of hospital admissions, referrals, levels of care, extended durations of stay, appropriate setting for services, alternative levels of care and ancillary services rendered (ambulatory visits, x-ray, lab, home health, and pharmacy). The Care Management Program has an identifiable structure with specific objectives and a coordinated process for all program activities including:

- Guidelines For Medical Appropriateness
- Prior Authorization
- Concurrent Review
- Denial of Services
- Retrospective Review
- Referral Management
- Requests for Participating Out of Network Care
- Requests for Experimental/Investigational
- Case Management
- Disease Management
- Expedited Appeal Process
- Pharmaceutical Management
- Behavioral Health Management

II. GUIDELINES

The clinical guidelines used for all clinical operations and services rendered through Community Health Plan (CHP) are:

- *The Milliman Care Guidelines*[®] based on nationally recognized criteria
- Literature Searches
- *Oak Group MCAP Clinical Review Criteria*[™]

The Milliman Care Guidelines[®] are used as a basis for approving and denying authorization for treatment. The *Guidelines* apply to most patients in most situations but never to every patient or every situation. The unique characteristics of each patient are taken into consideration. Use of the *Guidelines* requires, and never replaces, clinical judgment.

The *Guidelines* assist clinicians in making informed decisions in many health care settings including hospital, acute and subacute medical and rehabilitation, skilled nursing facilities, home health care, and ambulatory facilities. When the continuum of care is used, more intensive levels of care are reserved for patients who cannot be managed safely and effectively at lower levels.

The *Guidelines* and criteria by which Community Health Plan sets its clinical standards are reviewed and revised, if necessary, on an annual basis. Services that do not meet criteria will be denied. The provider may request a copy of the guidelines used to make the determination. Utilization statistics that may be generated on a monthly basis are:

- Average length of stay
- Days/1000
- Admissions/1000
- Disease Management outcomes, ROI, Member Utilization

III. VERIFICATION FOR ELIGIBILITY FOR BENEFITS

The Provider is responsible for verifying eligibility for benefits with Community Health Plan. Provider may inquire as to the current status of a patient's eligibility. Provider shall not rely upon Community Health Plan's response to such inquires as a guarantee of eligibility, as the accuracy of such responses is limited to the information available to Community Health Plan at the time of the inquiry.

IV. PRIOR AUTHORIZATION

To ensure appropriate medical treatment and to control health care costs, prior authorization is required for certain identified procedures and services, and for confinement to a hospital or facility. Prior authorization is based upon the communication of clinical findings that support medical necessity. As part of this prior authorization process, we will discuss with you the necessity of hospitalization, the planned course of treatment, the length of the hospital stay, outpatient services, medical necessity of the proposed treatment and other medical alternatives.

The provider must furnish clinical information to Community Health Plan prior to obtaining authorization. The Primary Care Provider or the Consulting Provider is responsible for seeking prior authorization for procedures or services on the prior authorization list, or for confinement. If prior authorization is not received prior to providing treatment, the treatment will not be covered or benefits will be paid at a reduced rate.

Prior authorization of services will be approved by a member of the Care Management team, under the direction of the Medical Director. Services requiring prior authorization are established by the Medical Director and approved by the Provider Relations/Quality Review Committee (PR/QRC).

The primary reasons for prior authorizations of services are:

- To notify Community Health Plan of an upcoming case, which facilitates concurrent medical review throughout treatment.
- To allow Community Health Plan to prepare for potentially high-cost care.
- To ensure that care takes place in the most appropriate cost-effective setting (i.e., care is rendered in a network facility rather than an out-of-network facility).
- To capture concurrent data for financial allocation rather than waiting for claims to be submitted.
- To ensure that members are informed of all their options for care.
- To perform early discharge planning on identified high risk and/or selected diagnosis.

The Primary Care Provider/Specialist office will contact Community Health Plan for prior authorization of any hospital admission, except for emergency admissions. A member of the Care Management team will determine eligibility, benefits, medical necessity, and appropriateness of care based on clinical guidelines. If the request does not meet guidelines, the Medical Director will review and a response will be given in writing within two business days of receiving the information necessary to make a determination.

All scheduled admissions must be prior authorized before admission. Payment of claims for admissions that are not prior authorized are subject to denial.

Care Management must receive adequate clinical information on all emergent admissions within one business day; if they do not, payment is subject to denial.

Procedure for Prior Authorization

- The provider initiates a prior authorization request by telephone (816) 271– 1247 select Provider Option 3, then Medical Prior Authorization Option 2 or (800) 447–5819 select Provider Option 2.
- **Fax:** (816) 271–1266
 - The provider must call Community Health Plan between 8:00 am – 5:00 pm Monday – Friday (no holidays) and provide the following information:
 - Caller name and phone number.
 - Member name, member number, and relationship to subscriber.
 - Provider requesting service.
 - Service/confinement requested and clinical history.
 - Diagnosis ICD-9/CPT if applicable.
 - Admitting provider and facility (if applicable).
 - Anticipated confinement or service date.
- If the information provided meets clinical guidelines for medical necessity, a member of the Care Management team will issue a prior authorization number to the provider. Written or electronic confirmation will be sent to the provider, the requesting physician or primary care provider (PCP), if different than the requesting physician, and the member.
- Prior authorization with CHP for specialty pharmacy medications can be obtained by telephone at (816) 271-1247 or (800) 447-5819. Once the authorization is obtained, simply fax the prescription, accompanied with a patient specialty pharmacy prior authorization form to CHP at (816) 271-1266 or (800) 447-3894. A copy of the prior authorization form can be found in the Provider section of our web site at mychp.com or the forms section of the Provider’s Reference Manual.

Adverse Determinations

In the event of an adverse determination, Community Health Plan will notify the provider rendering the service by telephone within 24 hours of making the adverse determination, and generate written or electronic confirmation of the telephone notification to the member and provider within one (1) additional business day from the initial telephonic notification of the adverse determination. Such notification shall include:

- A general description of the reason that the service is denied.
- Information regarding the appeal rights.
- Instructions on how to obtain the written clinical rationale that was used in making the determination.

Any services on the prior authorization list that have not been prior authorized by the Community Health Plan Care Management are subject to denial of payment.

All admissions not prior authorized as above will be subject to denial of payment.

Community Health Plan Prior Authorization List

(Effective: November 1, 2008)

- Pharmaceuticals (See reverse side) “Includes medications given in an outpatient setting”
- All Inpatient Hospital Admissions including: Acute Rehabilitation, *Skilled Nursing,
*Partial Hospitalization and Intensive Outpatient treatment for Mental Illness and
Chemical Dependency
- Accident Related Dental Services/Oral Surgery
- Chronic Lyme’s Disease Treatment
- Clinical Trials
- Cosmetic/Plastic Surgery
- DME (Durable Medical Equipment): All rental DME; **Repair/Replacement DME**; Contracted
DME providers with purchase price of \$1000 or greater (physicians may dispense DME with
purchase price less than \$200)
- Electro Convulsive Therapy (ECT) Both inpatient and outpatient
- External Counter Pulsation (EECP)
- Formula for Phenylketonuria (PKU)
- Home Health Care
- Home Infusion Therapy
- Hospice
- Hyperbaric Chamber Therapy
- Intrathecal Pain Pump and Implantation
- Neuropsychological Testing
- Neurostimulator implantation
- Organ and Bone Marrow Transplants
- Ossatron
- Osteogenic stimulation (bone stimulator): invasive and noninvasive
- Outpatient MRI, MRA, CT, and PET scans unless performed in the Emergency Room
- Pain Management (multi-modality pain management)
- Prosthetics and Orthotic Appliances: Prosthetic/Orthotic products with the purchase price of
\$1,000 or greater. (Physicians may dispense with purchase price less than \$200)
- Reconstructive Surgery/Prosthetic Devices following a mastectomy
- Reduction Mammoplasty/Reconstruction
- Services not available in network
- Stereotactic Radiotherapy (ie: Cyber Knife, Gamma Knife, Novalis Shaped Beam Surgery)
- Temporary codes (CPT Category III)
- *Therapies: Physical, Occupational, Speech, Nutritional Counseling

Bold highlights represent new items added to listing

*May have visit limits

Authorization is based upon eligibility

SPECIALTY PHARMACY PRODUCT LISTING (Prior Authorization and Specialty Pharmacy Enrollment Required) FORMS AVAILABLE AT www.mychp.com					
Growth Hormone		Interferons / Hepatitis		Arthritis / GI / Psoriasis	
Genotropin	Nutropin	Alferon N	Pegasys	Amevive	Orencia
Geref	Nutropin AQ	Baraclude	PEG-Intron	Enbrel	Orthovisc
Humatrope	Omnitrope	Copegus	Rebetol	Euflexxa	Raptiva
Increlex	Saizen	Epivir HBV	Rebetron	Healon GV	Remicade
Iplex	Serostim	Hepsera	Ribapak	Healon 5	Rituxan ¹
Nordiflex	Trev-Tropin	Infergen	Ribasphere	Humira	Supartz
Norditropin	Zorbtive	Intron A	Ribavirin	Hyalgan	Synvisc
		Intron A Pen	Tyzeka	Kineret	
Hematopoietic		Miscellaneous		RSV / Pulmonary	
Aranesp	Neumega	Actimmune	Macugen	Aralast	Revatio
Epogen	Neupogen	Apokyn	Myobloc	Flolan	Synagis
Leukine	Procrit	Botox	Sensipar	Letaris	Tracleer
Neulasta		Flolan	Solaris	Prolastin	Ventavis
		Lucentis	Visudyne	Pulmozyme	Xolair
				Respigam	Zemaira
				Remodulin	
Lysosomal / Enzyme		Osteoporosis		Multiple Sclerosis	
Aldurazyme	Fabrazyme	Forteo	Reclast	Avonex	Novantrone
Ceredase	Myozyme			Betaseron	Rebif
Cerezyme	Naglazyme			Copaxone	Tysabri
Elaprase	Zavesca			Mitoxantron	
Hormonal Therapies		Blood Factors		Infertility	
Acthar HP	Somavert	Advate	Koate-DVI/HP	Bravelle	Luveris
Eligard	Supprelin LA	Alphanate	Kogenate FS	Cetrotide	Menopur
Leuprolide	Synarel	Alphanate SD	Monarc-M	Chorex-10	Novarel
Lupron Dep-ped	Trelstar	Bebulin VH	Monoclade-P	Crinone	Ovidrel
Lupron	Trelstar LA	Benefix	Mononine	Follistim AQ	Pregnyl
Lupron Depot	Vantus	Feiba VH	Novoseven	Ganirelix	Prochieve
Octreotide	Viadur	Genarc	Profilnine SD	Gonal-F	Profasi
Sandostatin LAR	Zoladex	Helixate FS	Proplex-T	Gonal-F RFF	Repronex
Somatuline		Hemofil-M	Recombinate	HCG	
		Humate-P	Refacto		
		Hyate-C	Stimate		
Oral Oncology²		HIV / AIDS		Immune Globulin	
Agrylin	Revlimid	Agenerase	Rescriptor	Baygam	Immune Globulin
Alkeran	Sprycel	Aptivus	Retrovir	Bayrho-D	Iveegam
Anagrelide	Sutent	Atripla	Reyataz	Carimune NF	Micrhogam
Anzemet ²	Tarceva	Combivir	Sustiva	Cytogam	Nabi-HB
Cyclophosphamide	Temodar	Crixivan	Trizivir	Flebogamma	Octagam
Cytosan	Thalomid	Epivir	Truvada	Gamastan	Panglobulin
Emend ²	Tykerb	Epzicom	Videx/EC	Gammagard	Polygam S/D
Etoposide	Vepesid	Fuzeon	Viracept	Gammagard SD	Rhogam
Gleevec	Xeloda	Hivid	Viramune	Gammar-P	Rhophylac
Kytril ²	Zofran ²	Invirase	Viread	Gamunex	Vivaglobin
Mesnax	Zolinza	Kaletra	Zerit	Hyrho-D	WinRho S/D
Nexavar		Lexiva	Ziagen	H-Big	
		Norvir	Zidovudine		

¹ Rituxan requires prior authorization and specialty pharmacy utilization except when used for Oncology.

² Oral Chemotherapy and Anti-emetics: Prior authorization and specialty pharmacy only required for member outpatient use

V. CONCURRENT REVIEW

Concurrent review encompasses aspects of patient management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment.

- All inpatient concurrent review requests for extension of coverage are considered urgent.
- Provider requests for extension of coverage for a course of clinically urgent outpatient treatment received prior to the expiration of the current certified number of visits/treatments are handled expeditiously as an urgent concurrent review request.
- Provider requests for routine extension of an ongoing outpatient course of treatment are handled as a new prior authorization request.

Concurrent review is conducted on-site or telephonically. The concurrent review process includes:

- Obtaining necessary information from providers and facilities concerning the care provided to members.
- Assessment of the clinical condition and ongoing medical services and treatments to determine benefits coverage.
- Early identification of continuing care needs to facilitate discharge to the appropriate setting.
- Discharge planning and coordination.
 - Discharge planning is initiated at any stage of the patient management process. Assessment of potential discharge planning needs begins at the time of notification, and coordination of discharge plans commences with identification of post-discharge needs during pre-certification or concurrent review.
- Licensed registered nurses trained in utilization and case management will conduct concurrent review. Trained licensed registered nurses with behavioral health experience conduct behavioral health concurrent reviews.
- Clinical information must be provided by the facility/provider on the date due as determined by Care Management. If the clinical information is not supplied on that date, further claims payment for subsequent services may be denied.
- If a question of medical necessity arises during the stay, the nurse will refer the case to the Medical Director or his/her designee.

- Concurrent review determination will be made within one (1) business day of obtaining all of the necessary information. If the determination is to certify an extended stay or additional services, CHP will notify the provider by phone within one (1) business day. Care Management staff will also provide written or electronic notification to the member and provider within one (1) business day after the telephonic notification.
- For adverse determination from the concurrent reviews, Care Management will notify the provider telephonically within one (1) business day along with instructions on how to initiate an expedited appeal. Staff will also generate written or electronic notification to the member and provider within one (1) business day of the telephonic notification.

VI. MEDICAL NECESSITY

Medically necessary determination is based on those services and supplies that are

- Essential to identify or treat a patient's condition, illness or injury;
- Consistent with the patient's symptoms, diagnosis or treatment of the underlying condition;
- In accordance with professional standards of medical care generally accepted in the medical community at the time;
- Not solely for the convenience of the patient or any other person or entity;
- The most appropriate type and level of service or supply;
- Provided only for an appropriate duration of time; and
- Provided in the most appropriate setting.
- The term 'appropriate' shall mean taking patient safety and cost effectiveness into consideration. When specifically applied to an inpatient, medically necessary further means that diagnosis cannot be made or treatment cannot be safely and effectively provided on an outpatient basis.

A claim may be denied if the Medical Director deems that the care or treatment rendered to a member was not medically necessary according to the following criteria:

- *The Milliman Care Guidelines*[®]
- *Oak Group MCAP Clinical Review Criteria*[™]
- Literature Searches
- External Review

The appropriate provider and member shall be notified in writing of the reason for the denial. Information regarding the appeal rights of the member, and how to obtain the clinical rationale, will be included in the notification of denial.

If the Medical Director determines that requested services are not medically necessary and the member chooses to proceed with the services anyway, such medical services will be regarded as member-requested and will become the member's financial responsibility. The provider (hospital or provider) should have the member sign a form acknowledging that they have been informed and agree to continuation of said services and the financial responsibility for them.

VII. RETROSPECTIVE REVIEW

Retrospective review is the process of reviewing coverage requests for initial certification:

- After the service has been provided, or
- When the member is no longer an inpatient or receiving the service.

A review initiated while a member is hospitalized is considered a concurrent review.

A review as the result of a prior authorization or claim denial is considered an appeal.

Retrospective review includes making coverage determinations for the appropriate level of service consistent with the member's needs at the time of service after confirming eligibility and the benefits available under the member's benefits plan.

The purpose of retrospective review is:

- To analyze retrospectively any potential quality and/or utilization issues.
- To initiate appropriate follow-up action, based on quality or utilization issues.
- To review initial requests for certification, in anticipation of claim adjudication, made after discharge or after the provision of service.
- To analyze submitted documentation to determine rationale behind failure to follow clinical guidelines.

If no prior authorization of the service was obtained, a denial may be issued. A Care Management nurse may perform an on-site review of the medical records or request that the records be submitted to CHP for review. If medical necessity is not apparent in the medical record documentation that is reviewed, the records are referred to the Medical Director for further review and a determination of medical necessity.

For retrospective review determination, Community Health Plan will make the determination within thirty (30) business days from the date that all necessary information was received. A notice of the determination will be provided to the member within five (5) business days of making the determination.

In the case of an adverse determination, Community Health Plan will notify the provider rendering the service, and the member with the following information:

- Principal reason for the determination.
- Instructions for requesting a written statement of clinical rationale.
- Instructions for initiating an appeal or reconsideration.

VIII. REFERRAL MANAGEMENT

The definition of a referral is a request for the provision of any service that is not considered within the scope of practice of a Primary Care Provider. The referral assures quality service to our member and monitors and controls costs. By capturing data provided through the referral process, Community Health Plan will be able to provide reports of utilization to providers and suggest areas to be explored for improvement.

A commercial member with Community Gold Plus/Community Choice or Point of Service benefit plan may access in network at a reduced level of benefits.

Under the HMO benefits, the specific aspects of the referral system are:

- Any in-network services not provided by the primary care provider, chiropractor or a participating OB/GYN physician must have received an initial appointment made by their primary care provider.
- Once a referral is approved by the primary care provider, a specialist may:
 - See the member for the approved number of visits (within time specified)
 - Perform office lab and x-ray (excluding items on the prior authorization list)
 - Order lab and x-ray from a participating provider (excluding items on the prior authorization list)
 - Perform office or outpatient surgery (excluding items on the prior authorization list) at a participating facility.
- Community Health Plan will not allow any retroactive referrals (request for referral after the member has seen a specialist).
- A member with diabetes may obtain a dilated retinal exam from a participating ophthalmologist/optomologist annually, without a referral from their PCP. Benefits for other vision exams are specific to the group benefit plan.
- A member may access a participating Diabetic Education Center that is accredited by the American Diabetes Association (ADA) without a referral from their PCP.

Referral Protocol

- Once the need for a referral is realized, the PCP must call the specialist's office and make the first appointment. Documentation in the progress notes needs to include the member's symptoms or diagnosis and the name of the specialist the member is being referred to.
- Please have the following information available when calling the specialist's office:
 - Specialist name and phone number
 - Member name
 - Date of birth
 - Diagnosis or diagnosis code
 - How many visits/what service(s) are requested
- The PCP will forward to the specialist appropriate lab test results, x-rays or other medically appropriate data that would aid the specialist.
- The specialist will evaluate and treat the member as requested by the PCP and document recommendations and treatment.
- The specialist must furnish the PCP a written report of the findings of the consultation and a treatment plan. A Coordination of Care form to use for this purpose is available in the Provider section of www.mychp.com (see form on next page).
- If the specialist determines that the member needs to see another specialist the PCP will generate a new referral. For emergency situations, the specialist may call Community Health Plan to expedite the authorization process if unable to reach the PCP. The specialist will communicate with the PCP on the following work day.
- An OB/GYN physician is allowed to refer a member to a facility and/or specialist for services or consultation related to the diagnosis and treatment of OB/GYN conditions, including breast disease and urologic conditions related to GYN disorders. If the OB/GYN physician determines additional specialty care is required, and is not related to an OB/GYN condition, the member must obtain a referral from their PCP.

CHP Coordination of Care Form Section 1 – Patient Information	
Patient Name:	Birth Date:
Patient Contact Phone Number:	Referral/Consult Date:
Section 2 – Reason for Referral	
Patient having _____ symptoms.	
Needs _____	
<input type="checkbox"/> Evaluation for _____	Behavioral Health referral
<input type="checkbox"/> _____ Testing	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> _____ Surgery	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Counselor	
Section 3 – Indicators	
<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Major Depressive Disorder
<input type="checkbox"/> Medical Comorbidities	<input type="checkbox"/> Addiction
<input type="checkbox"/> Medication Management	<input type="checkbox"/> Behavior Health Comorbidities
<input type="checkbox"/> Pain	<input type="checkbox"/> Other _____
Section 4 – Requested Services	
<input type="checkbox"/> One time consult (recommendations only) <input type="checkbox"/> Referral (see and manage)	
<input type="checkbox"/> Consult and Comanage <input type="checkbox"/> Take over care	
<input type="checkbox"/> Authorized for _____ visits	
Section 5 – Information Relevant to Consult	
<input type="checkbox"/> Recent labs	<input type="checkbox"/> History & Physical /Consults /Progress Notes
<input type="checkbox"/> Radiology	<input type="checkbox"/> Available electronically
<input type="checkbox"/> Current Medications	<input type="checkbox"/> Attached
Section 6 – Response Requested from Referring	
<input type="checkbox"/> Call A.S.A.P. after seeing the patient	
<input type="checkbox"/> Change medications as appropriate	
<input type="checkbox"/> Initiate treatment as appropriate	
<input type="checkbox"/> Consult with other sub-specialist as appropriate	
<input type="checkbox"/> Fax letter to my office before mailing	
<input type="checkbox"/> Please let me know if member did not keep appointment	
<input type="checkbox"/> Follow-up information available electronically	
<input type="checkbox"/> Follow-up information attached	
<input type="checkbox"/> Other _____	

Specialist Name: _____ Phone: _____ Fax: _____	
Date of Referral Appointment (initial appointment is made by PCP's office) _____	
Requesting Provider Signature: _____ Date: _____	
Specialist Signature: _____ Date: _____	

Exceptions to Referral Protocol

➤ Well Woman Visit

Female members are eligible to self-refer to a participating OB/GYN.

- One (1) routine gynecological examination per Calendar Year and other such services provided by a participating obstetrician/gynecologist in the ordinary course of his or her practice as defined by the published recommendations of the accreditation council for graduate medical education. The member is not required to obtain a referral from his/her primary care provider or prior authorization from Community Health Plan for this covered service.
- For a woman age forty (40) years of age and over, one (1) mammography screening per calendar year provided by a participating provider. The member is not required to obtain a referral from his/her primary care provider or prior authorization from Community Health Plan for this covered service.

➤ Chiropractic Care/Manipulative Therapy

- A member with chiropractic benefits may access a participating chiropractor for care without a referral by the member's PCP. Chiropractic care may have limited benefits according to the specific group benefit plan.

➤ Vision Exams

- Benefits for routine vision exams are specific to the group benefit plan.

➤ Dental

- Benefits are specific to the group benefit plan.

Referral Limits and Conditions

- Prior authorization from Community Health Plan may be required in addition to a referral from the PCP. See Prior authorization list provided.
- Referrals are subject to denial for reasons such as, but not limited to:
 - Not a covered benefit
 - Duplicate services
 - Non-participating providers, etc.
 - Retroactive service
 - Has not seen PCP for problem
 - Benefits limit reached
 - Member requested
 - Convenience only
 - Member eligibility
 - Medical necessity

IX. REQUESTS FOR OUT OF NETWORK CARE

If at any time a provider requires assistance as to where a member may be referred for care, the provider should contact Customer Service at (816) 271-1247 select Provider Option 3 then Option 1 or (800) 447-5819 select Option 1 or Care Management at (800) 447-5819 selection Option 2 or Behavioral Health Management selection Option 4.

To enhance our referral system and assure a complete array of provider services, Community Health Plan has a referral network in place. If Community Health Plan cannot provide services within the primary network, the provider may request services from nonparticipating providers by doing the following:

- A letter of medical necessity must be completed by the PCP and submitted to Community Health Plan as specified by the group benefit plan.
- Information in the letter should include member demographics, name of the referral provider, services requested, reason for request (please provide clinical information and treatment history), name, address, phone number and fax number.
- The letter of medical necessity may be submitted by fax, mail, or courier to the attention of CHP Care Management.

NOTE: Behavioral Health requests must **not** be faxed, for reasons of confidentiality.

- The letter of medical necessity will be presented for medical review. A decision on coverage for urgent care will be made within one (1) business day of receipt or two (2) business days for non-urgent care, unless more information is required to make a determination. The PCP will be notified of approval or denial.

Approval is required from Community Health Plan's Medical Director before services are approved for payment. Requests for non-participating provider services may have limits on the approval at the discretion of the Medical Director.

X. REQUESTS FOR EXPERIMENTAL/INVESTIGATIONAL SERVICES

If a provider requests care for a member that is considered:

- New technology, experimental
- Not a standard of care
- Not typically a covered benefit

The provider must complete a letter of medical necessity that will be reviewed by the Medical Director in the same manner as other special services.

XI. CASE MANAGEMENT

Licensed Registered Nurses within Community Health Plan provide case management services for the members who are experiencing medical conditions or injuries that may require complex, high-intensity, or long-term health care. Case management establishes a one-to-one relationship between a Case Manager and a member (and the member's family) and demonstrates a dedication to the coordination of healthcare and enhancement of the quality of life.

The role of the case manager involves identifying immediate and ongoing needs of the patient and planning a course of care, including measurable goals and objectives, with the patient, providers, family, caregivers, and payers. The case manager compares the plan to evidenced-based guidelines, approved clinical pathways, or protocols to determine variance from expected outcome. When variance exists, the case manager can suggest possible solutions and adjustments. The Case Manager is responsible for monitoring quality measures and processes to promote high quality, cost-effective outcomes.

The overall responsibilities of the case manager at any level of care include patient assessment, planning to meet specific needs, coordination of resources to meet the needs and patient advocacy across the continuum of care.

The role of a Case Manager includes:

- Ensuring continuity of care by coordinating efforts and involving each member's health care team in developing and revising comprehensive treatment plans for home and/or hospital. The health care team may include physicians, nurses, physical therapists, dietitians, etc.
- Contacting specialists to evaluate medical options.
- Facilitating communication between health care providers, members, and their families.
- Making arrangements with health care providers and specialized facilities as needed.
- Identifying community, state, and federal resources as needed.
- Monitoring members' progress.
- Facilitating changes in members' treatment plans when appropriate.
- Offering support and guidance to our members and their families.

XII. HIGH RISK CARE PROGRAM

For Community Health Plan members, identified with a complicated or chronic health condition, Community Health Plan offers a team approach to assist these members, and their families, understand their disease process and help in receiving health care services. Health conditions associated with this program could include (but are not limited to) diabetes, asthma, congestive heart failure, oncology, organ transplants, and mental health disorders.

Members can be referred to the Community, Access, Resource and Education (CARE) Management Program through multiple points of access including:

- Primary Care Providers
- Case Management (within a facility or employer group setting)
- Utilization Review

Members receive:

- An introductory phone call with information on how to access their personal CARE Manager, who is a Licensed Registered Nurse. This phone call will describe the program and provide contact telephone numbers.
- Regular contact with their CARE Manager to check on their health status, design and follow up on a plan of care, and answer the member's health questions.
- Information on access to Community Health Plan's participating provider services.
- Education and mailings related to the member's illness and plan of care.

Providers will receive:

- Notification letter of member's participation in the CARE Program.
- Telephone contact with CARE Manager for exchange of information and coordination of care.
- Assistance with authorizations needed for health services.
- Coordination of health services following hospital discharge.
- Notification letter of member discharge from program.

If you would like more information about the CARE Program at Community Health Plan, please call (816) 271- 4019 or (800) 990 - 9247.

XIII. DISEASE MANAGEMENT

Community Connections includes Community Health Plan's disease management programs designed to help members, who have been diagnosed with a chronic disease, manage their condition by partnering with their provider. Disease management programs focus on member education and instruction on how to self-manage a chronic disease. The goal is to promote overall health and increase quality of life.

Diabetes Connections is available to members with type 1 or type 2 diabetes. This program includes educational phone calls, mailings and guidelines for managing diabetes.

Cardiac Connections is available to members who have been diagnosed with heart disease and congestive heart failure. This program provides calls, mailings and cardiac management guidelines.

Asthma Connections is a program for members diagnosed with asthma. The clinical staff provides phone calls to members and their physicians, asthma care management, and member and provider education.

COPD Connections is a program for members with airflow obstruction due to chronic bronchitis, emphysema or asthma. The COPD program staff provides phone calls to members and providers, care management, and provider education.

CARE Connections is designed for members diagnosed with depression. Behavioral health nurses provide support to members over the phone, send educational mailings and coordination care.

Community Connections Program participants will receive:

- An information packet in the mail, including a Calendar/Workbook
- A detailed program description
- Materials to help them better understand their condition
- The nationally recognized evidence-based Standards of Care
- A progressive, ongoing evaluation of the member's health status

Participants will be contacted periodically by phone and/or by mail:

- To assist in answering questions
- To assist in identifying self care goals
- To remind of important tests and exams
- In response to requests for information

Health educators and specialists are available to discuss the individual's condition Monday through Friday toll free, 1-800-447-3617 from 8:00 am to 8:00 pm CST.

The provider directs their patient's treatment plan with the added support of a Disease Management Team to reinforce the provider's efforts to achieve optimal clinical outcomes and patient satisfaction.

You are welcome to contact Community Health Plan Customer Service to refer a patient or for further questions regarding any of Community Health Plan's Disease Management programs.

XIV. PHARMACEUTICAL MANAGEMENT

The Prescription Drug Program offered by Community Health Plan is administered through PharmaCare. This program encourages our members to use a network pharmacy to obtain medications, for acute conditions, up to a 30-day supply. Community Health Plan members, who take medications for chronic conditions, may utilize their mail-order benefit which allows up to a 90-day supply. The program uses a formulary, which list the preferred brand name drugs to be used, where clinically appropriate. It also encourages members to utilize generic medications where appropriate. If you need a copy of the most recent formulary, please contact customer service or visit our website www.mychp.com.

Pharmaceutical Management involves the use of sound clinical evidence supporting a pharmacy benefit for Community Health Plan's members and the application of that benefit in an appropriate manner based on the needs of individual patients. This can include but is not limited to quantity limits per prescription, step-therapy protocols and prior authorization for certain conditions or disease states.

Community Health Plan, in conjunction with its Pharmacy Benefit Manager (PBM), may communicate directly with members regarding prescription drugs. This includes, but is not limited to, utilizing generic drugs where appropriate, promoting the use of formulary agents, specialty pharmacy utilization and promotion of mail-order fulfillment of prescriptions for chronic conditions.

The following is a list of reasons that a medication may require a prior authorization.

- Multiple indications for a single chemical entity.
(Examples: Bupropion HCL, Wellbutrin SR 150mg/Zyban)
- Age specific drugs.
(Example: Tretinonin or Growth Hormone therapy)
- Specialty drugs for treatment of chronic conditions including, but not limited to
 - Multiple Sclerosis: Avonex, Betaseron, Copaxone, or Rebif
 - Rheumatoid Arthritis: Enbrel, Humira, Kineret, or Remicade
 - Hemophilia: Factor VIII (Recombinate, Humate-P), Factor IX (Benefix)
 - Hepatitis C: Intron, PEG-Intron, Pegasys, Rebetrone, Interferons
 - Respiratory Syncytial Virus (RSV): Synagis
 - Joint Disease: Synvisc, Supartz
 - Immune or Blood Disorders: Epogen, Neupogen, Neulasta, Procrit, Immunoglobulins
 - Hormonal Therapies: Lupron, Depot Lupron
- Medication supply for vacation.
- Replacement of lost or stolen medication.
- Step-Therapy Protocols
- Migraine Headache Medications ("Triptans:" Amerge, Axert, Frova, Imitrex, Maxalt, Relpax, Zomig)

- Medications, which are not a Plan benefit: Hormone Replacement Therapy (prescribed for a medical reason other than fertility)
- Medications that may be used for cosmetic or medical reasons.

Specialty Pharmacy

See the prior authorization list in this section for a complete listing of medications that require prior authorization. Specialty pharmacy medications must be obtained through Specialty Pharmacy for Community Health Plan members. Specialty Pharmacy is a service provided by CHP's Pharmacy Benefit Management (PBM) vendor. All high-cost medications and injectibles listed on the prior authorization list are to be obtained through Specialty Pharmacy instead of the retail pharmacy or provider's office.

The process for prior authorization with CHP for specialty pharmacy medications can be obtained by telephone at (816) 271-1247 select Provider Option 3, then Option 4 or (800) 447-5819 select Option 4.

Prior authorization with CHP for specialty pharmacy medications can be obtained by telephone at (816) 271-1247 or (800) 447-5819. Once the authorization is obtained, simply fax the prescription, accompanied with a patient specialty pharmacy prior authorization form to CHP at (816) 271-1266 or (800) 447 3894. A copy of the prior authorization form can be found in the Provider section of our web site at mychp.com or the forms section of the Provider's Reference Manual.

XV. DENTAL TRAUMA AND DISEASES OF THE MOUTH

While Community Health Plan does not provide coverage for routine dental care and basic restorative dentistry, members who require services for dental trauma may seek care from any dentist or oral surgeon within our network. Dental trauma may include, but is not limited to blunt trauma and penetrating trauma that impacts the mouth, teeth and/or gums. It is necessary to seek these services from a Community Health Plan participating provider, and a prior authorization is required.

Members who require services for disease of the mouth may seek care from a Community Health Plan network provider. Diseases of the mouth may include, but are not limited to, oral cancer, oral lesions and infections.

Requests for services to treat diseases of the mouth will be handled in the same manner as other requests requiring prior authorization. Dental trauma will be treated as emergent/urgent services.

Procedure

Please follow the same procedure as for a prior authorization

XVI. DURABLE MEDICAL EQUIPMENT SERVICES & SUPPLIES

DME may be supplied without a prior-authorization number if:

- DME is supplied through a participating DME provider, and
- The purchase price is less than \$1000, and
- The member has a physician's order.
- A participating provider can provide DME if the purchase is under \$200, for example crutches, splints, slings or small braces.

Prior authorization is required for:

- All rental DME
- All DME priced over \$1000
- All DME repair
- All DME replacement if the equipment is over \$1000

(Maintenance, repair, or replacement that is the result of the member's neglect, misuse, or abuse will be the member's responsibility.)

DME Rental vs Purchase

- Purchase: All custom DME (braces, AFO's, diabetic shoes) will be purchased along with DME under \$1000. Other DME (CPAP, O2 concentrators, etc.) will be rented to purchase. Nebulizers qualify for purchase only.
- Rental: Some DME (CPAP, etc) will be rented for a trial of one month to assure efficacy and patient compliance, and then be rented until a purchase price has been satisfied. Any DME over \$1000 to be used for a short time (less than 6 months period of time – wheelchairs, beds, etc) will be rented, but if the purchase price is reached before the rental period is completed, the item will be considered purchased at that point.

XVII. PLASTIC AND RECONSTRUCTIVE SURGERY

The following are covered services:

- Surgery that substantially improves functioning of any malformed body part; repair of disfigurement resulting from an injury (other than mastectomy), provided the surgery occurs within one (1) year of the date the injury occurred or of the date of a subsequent surgery to repair the disfigurement if authorized by Community Health Plan; reduction mammoplasty if authorized by Community Health Plan; and reconstruction incidental to surgery if authorized by Community Health Plan. The member is not required to be an enrollee at the time of the injury for these services to be covered.
- Reconstructive surgery or prosthetic devices related to mastectomy necessary to restore symmetry as recommended by the participating provider.

ALL COVERED SERVICES MUST HAVE PRIOR AUTHORIZATION

XVIII. COMMUNITY HEALTH LINE

Community Health Line, a health advice telephone service, is available to all Community Health Plan members and all people within our service area, twenty-four (24) hours a day, seven (7) days a week. Callers have access to licensed registered nurses that direct callers to the appropriate source of care and provide them with health information. The telephone number is (800) 455-2476 or (816) 271-4000.

Objectives:

- Empower consumers by providing a single point of contact for health information designed to match their needs with the appropriate level of care.
- Provide patient education at the “teachable moment.”
- Offer a quality information healthcare option to the community.
- Provide access to health professionals seven (7) days a week, twenty-four (24) hours a day.

XIX. BEHAVIORAL HEALTH MANAGEMENT

Introduction

Community Health Plan provides behavioral health benefits and services for its members by contracting with behavioral health providers throughout Northwest Missouri and Northeast Kansas. Behavioral health providers are considered either consulting providers or ancillary providers. Both require a referral from the Primary Care Provider for care, with the exception of members who have Point-of-Service benefits they wish to use. Missouri Law allows for two (2) behavioral health visits per year without a referral. The first two behavioral health visits that occur at the beginning of the calendar year will be counted as these two visits. If a referral is already in place for these two visits, this benefit will be expended regardless of existing referral status. Kansas's law allows members and residents to obtain the first three (3) behavioral health visits of the calendar year without a co-pay being collected, and no coinsurance or deductible will apply.

Behavioral health services operate under the direction of the team leader of Care Management and the Medical Director of Community Health Plan. Services are coordinated by licensed registered nurses with special training in behavioral health. Behavioral Health Care Managers serve as liaisons between the Primary Care Provider, facilities, and behavioral health providers. They coordinate all aspects of behavioral health services involving Community Health Plan members. Behavioral health services as well as chemical dependency/substance abuse services are provided according to the benefit plan of each respective member.

Goal

The goal of behavioral health services is to provide objective and systematic monitoring of the quality, accessibility, appropriateness and cost of outpatient, inpatient, day hospital, and partial hospitalization services. Care Management ensures treatment of diagnosed behavioral health illness and substance abuse conditions.

Objectives

Provide effective behavioral health/chemical dependency care management for identified members, assuring that the member is receiving the appropriate level of care in the least restrictive setting using nationally accepted treatment criteria.

Conduct concurrent review of all inpatient and day hospital behavioral health/chemical dependency admissions.

Monitor the medical appropriateness of the length of stay based upon the application of *The Milliman Care Guidelines*[®] and the *Oak Group MCAP Clinical Review Criteria*[™], both based on nationally recognized developed criteria.

Conduct quality assurance audits to objectively measure quality of care provided by provider, facility, and any ancillary providers contracted with Community Health Plan.

Coordinate initiatives and communication between the Member, primary care provider, and behavioral health provider.

Requests For Out Of Network Care

If at any time a provider requires assistance as to where a member may be referred for care, the provider should contact Customer Service at (816) 271-1247 select provider Option 3 then Option 1 or (800) 447-5819 select Option 1 or Behavioral Health Department of Care Management at (800) 447-5819 select Option 3.

To enhance our referral system and assure a complete array of provider services, Community Health Plan has a referral network in place. If Community Health Plan cannot provide standard treatment for their diagnosis within the primary network, the provider may request services from nonparticipating providers by doing the following:

A letter of medical necessity must be completed by the PCP and submitted to Community Health Plan as specified by the group benefit plan.

Information in the letter should include member demographics, name of the referral provider, services requested, reason for request (please provide clinical information and treatment history), name, address, phone number and fax number.

The letter of medical necessity may be submitted by mail, or courier.

NOTE: Behavioral Health requests must not be faxed, for reasons of confidentiality.

The letter of medical necessity will be presented for medical review. A decision on coverage for urgent care will be made within one (1) business day of receipt or two (2) business days for non-urgent care, unless more information is required to make a determination. The PCP will be notified of approval or denial.

Approval is required from Community Health Plan's Medical Director before services are approved for payment. Requests for nonparticipating provider services may have limits on the approval at the discretion of the Medical Director.

Out of network inpatient services require a call for prior authorization to the Behavioral Health Department of Community Health Plan.

Prior Authorization Procedure for Inpatient Psychiatric and Substance Abuse Services

To prior authorize services, please call Community Health Plan at (816) 271-1247 provider Option 3, then Option 3 or 1-800-447-5819 Option 3. It is recommended that the provider/facility be prepared with the following information when requesting prior authorization for inpatient behavioral health services.

- Member name
- Member ID number/Date of Birth
- Diagnosis, symptoms and severity of illness (DSM IV-TR)
- How long the condition or symptoms have been present
- Previous treatment for this condition or similar problems
- Name of the behavioral health specialist who has previously treated this member for outpatient services
- Type of service being requested

The information is evaluated, and if admission criteria is met, prior authorization is completed. The criteria used is The *Milliman Care Guidelines*[®] and/or the *Oak Group MCAP Clinical Review Criteria*[™]. The caller is provided with a prior authorization number if approved. On-site concurrent or telephonic review will be conducted throughout the duration of the inpatient confinement. Extensions of the length of stay will be approved if acute care criteria continues to be met.

For after-hours and weekend inpatient authorizations, Behavioral Health in-patient facilities should call to leave a confidential voice mail message with clinical information for Behavioral Health Care Management. The authorizations will be processed on the next business day. Please call Community Health Plan at (816) 271-1247 provider Option 3, then Option 3 or 1-800-447-5819 Option 3.

NOTE: The providers of service must submit the authorization number on all claims to Community Health Plan.

Adverse Determinations

In the event that the information provided does not meet clinical guidelines for medical necessity, the Case Manager will review with the Community Health Plan licensed Board Certified Consulting Psychiatrist and Medical Director. The Community Health Plan Case Manager will notify the provider rendering the service by telephone within 24 hours of making the adverse determination, and generate written or electronic confirmation of the telephone notification to the member and provider within one (1) additional business day from the initial telephonic notification of the adverse determination. Such notification shall include:

- A general description of the reason that the service is denied.
- Information regarding the appeal rights.
- Instructions on how to obtain the written clinical rationale that was used in making the determination.
- Instructions on how to request a peer review with the Community Health Plan consulting Psychiatrist.
- Instructions on expedited review.

All neuropsychological testing and admissions not prior authorized will be subject to denial of payment.

Behavioral Health Follow Up After Discharge From Inpatient Mental Health Stay

The Behavioral Health staff will attempt to contact each member, or their legal guardian within seven (7) days after discharge from inpatient mental health/ substance abuse services. If unable to reach the member within seven (7) days, the Behavioral Health staff will coordinate care and make two (2) further attempts within thirty (30) days post discharge.

If the Behavioral Health staff finds special needs in the course of the phone call, the staff person will coordinate care and offer any coordination of care to the member to access necessary outpatient services.

At the time of discharge, the Behavioral Health staff will also ascertain the dates and times of scheduled outpatient mental health appointments. He or she will contact the provider designated as the aftercare practitioner to determine if the patient was able to comply with the outpatient appointment.

Care Connections

Community Health Plan identifies members who have a behavioral health diagnosis and due to symptoms are at high risk of being hospitalized or in need of significant assistance in accessing Behavioral Health Care.

Members can be referred to CARE Connections through multiple points of access:

- Primary Care Providers
- Behavioral Health Providers
- Inpatient treatment facilities
- Behavioral Health Case Managers within the facility or employer group settings
- Access/Triage

Members receive:

- An introductory mailing including information on how to access their personal Behavioral Health Case Manager.
- Program description with important contact numbers Educational material on depression – signs, symptoms, and treatment
- Reminder calls before follow-up appointments
- A personalized plan of care developed with the help of a Behavioral Health Case Manager

Members will have scheduled follow-up calls to assist in:

- Rating symptoms of depression
- Assist in medication compliance
- Optimizing quality of life
- Communication of care options

Care Managers will assist with communication between Primary Care Providers and Behavioral Health specialists as needed to assist in providing a seamless continuum of care to program members.

If you would like more information about the CARE Program at Community Health Plan, Please call Community Health Plan at (816) 271-1247 provider Option 3, then Option 3 or 1-800-447-5819 Option 3.