

Care Management

Regence provides a wide range of care management programs and resources designed to support our members at any stage of health. Care management programs may be targeted to specific conditions, such as our core care management programs, or designed to improve or maintain overall health, such as our health and wellness programs. Regardless of their focus, all care management programs are intended to supplement and reinforce the care and guidance you provide to our members. Most feature clinical one-on-one member support. Program availability may vary by group and benefit plan.

Core care management programs

Our core care management programs include:

- Utilization management
- Case management
- Regence Disease Management *
- Special Beginnings® *

Health and wellness programs

Programs aimed at improving the overall health and wellness of our members include:

- Regence Health Coach *
- CareEnhance® *
- **myRegence.com**, powered by the Regence Engine
- Regence Advantages

*Not all Regence members are eligible for these programs. AdvicareSM disease management is also available for larger groups.

Identifying Members

Members are identified or referred for care management programs through a number of sources. Referrals may come from an internal department at Regence, such as Claims, Medical Services, Provider Services, Customer Service or Sales. Referrals may also come from an external source, such as the member's family, physician or other health care professional or facility.

- To refer a Regence member for case or disease management, please contact central triage at 1 (866) 543-5765 or complete an online Case Management Referral Request at **www.regence.com/orreg/forms/redesign/caseManagementReferral.html**.
- To refer a pregnant member to the Special Beginnings® program, contact 1 (888) JOY-BABY (569-0229). Members may also enroll online.
- Members can self-refer to Regence Health Coach, CareEnhance, **myRegence.com** and Regence Advantages.

Utilization Management

Regence's compensation plan for employees, physicians, other health care professionals and facilities does not contain direct or indirect incentives to deny coverage or services. Utilization management includes prospective, concurrent and retrospective review. Decision-making is based on appropriateness of care, service, benefits and eligibility.

Pre-Authorization and Prior Authorization (Prospective Review)

Pre-authorization is a prospective determination performed by licensed health care professionals and trained pre-authorization analysts working under the direction of licensed registered nurses. The intent is to determine medical necessity and appropriateness of proposed treatment, level of care assessment, benefits and eligibility, and appropriate treatment setting. Pre-authorization pertains to medical necessity only and does not guarantee payment. It is not a treatment recommendation or a guarantee that the member will be insured or eligible for benefits when services are performed.

The pre-authorization process is not complete until the member's benefits and eligibility have been verified. Approved pre-authorizations obtained for services on the *Medical Pre-authorization Lists* are valid for 90 days from the time the pre-authorization is completed. Member eligibility must be verified through Customer Service within five days of the service.

Approval or denial of requests for services is determined by review of all available pertinent medical information including complications, comorbidities and/or discussion with the requesting physician.

Administrative Review Criteria

The following administrative checks are performed during the prospective review process.

- Member eligibility
- Requested care, service or supply is a covered benefit
- Physician or other health care professional or facility is contracted with Regence
- Requested service is at the appropriate setting or modality
- Requested service or item is consistent with medical policy and practice guidelines

Medical Review Criteria

In addition to an administrative review, Regence employs various criteria and policies in determining medical necessity. We obtain relevant clinical information, including complications and comorbidities, when making a determination of coverage based on medical necessity. At any time in the utilization review process, the medical director or his or her designee may determine that the use of a board-certified consultant is appropriate. In addition:

- Qualified medical professionals perform the review
- Criteria used for approval or denial of services or supplies can be found in Regence's *Medical Policy Manual* available online in the Library section of our Web site at <http://www.regence.com/trgmedpol> or can be mailed upon request
- Length of stay is assigned based upon medical necessity, plan guidelines, medical policy and community standards
- Medical necessity denials are determined by a physician

Definition of Medical Necessity, Medically Necessary

"Medical necessity" or "medically necessary" relates to those services and supplies that are required for diagnosis or treatment of illness or injury, which if omitted, would adversely affect the member's condition. In addition, "medical necessity" or "medically necessary" relates to those services and supplies which, in the judgment of Regence, are:

- Appropriate by treatment setting and level of care in amount, duration and frequency of care and consistent with the symptoms or diagnosis and treatment of the condition
- Appropriate with regard to widely accepted standards of good medical practice
- Not mainly custodial
- Not primarily for the convenience of the member, the member's family or a physician or other health care professional
- Not for research
- Not regarded by the medical director or utilization review program as investigational
- The most cost effective of the treatment settings, alternative supplies or levels of service that can be safely provided to the member. This means, for example, that care rendered in a hospital setting is not medically necessary if it can be provided in a less expensive setting, such as a skilled nursing facility, without harm to the member.

Medically necessary care does not include care that helps a person conduct activities of daily living and that can be provided by people without medical or paramedical skills (e.g., assistance with bathing, eating, dressing or getting in and out of bed). This also includes care that is primarily for the purpose of separating a member from others or maintaining safety in the home.

The fact that a physician or other health care professional prescribes, orders, recommends or approves a service or supply does not make the service or supply medically necessary or a contract benefit. The final decision on whether a service or supply is medically necessary or a contract benefit rests with the Regence medical

director and may be appealed using the Provider Appeal Process found in the Provider Agreements section of this manual at <http://www.or.regence.com/provider/library/manual/providerOfficeManual/docs/agreements.pdf>.

Guidelines for Selecting *Medical Pre-authorization Lists* Services

The *Medical Pre-authorization Lists* contains medical procedures, services and supplies that require pre-authorization. These lists are updated annually, at a minimum. The criteria for selecting medications, devices, procedures and other medical services for pre-authorization are listed below. To be included on the *Medical Pre-authorization Lists*, one or more of the criteria must be met.

1. There is significant debate, disagreement or lack of accepted standards among providers or in the clinical literature regarding indications for use, clinical effectiveness, cost-effectiveness or the place or stage in therapy.
2. There is significant deviation from established professional practice guidelines or standards of care based on documented utilization patterns **or** for new technologies, there is potential for deviation from established or provisional practice guidelines or standards.
3. There is a need to ensure access to an adequate level of care at an affordable cost.
4. There are significant documented marketing and sales strategies in use designed to influence physician treatment patterns and member service demand patterns in a way that may result in significant costs and/or increased utilization with little or no therapeutic gain and little or no enhanced member health outcomes.
5. The medication, device procedure or service is new and emerging and the safety, effectiveness and/or utilization is unknown or not fully documented.
6. There is a need to direct the member to a contracted provider or less costly alternative setting or service source.
7. The medication, device, procedure or service is prone to inappropriate, unsafe and/or excessive utilization.
8. The medication, device, procedure or service has limited indications, definable utilization patterns, and/or efficacy parameters requiring periodic reevaluation to determine if physician-defined outcomes and endpoints are being met.
9. The medications, devices, procedures or services are excluded by contract once clinical information is discerned within the context of the member's contract benefits.
10. The diagnosis and treatment plan is complicated and the medical situation of the member necessitates intensive management or condition-based care management to facilitate benefit administration within the context of the care provided and the member's contracted benefits.

In addition to pre-authorization requirements, the *Medical Pre-authorization Lists* may also list services and supplies for which notification is requested as part of a care management program. These notifications are identified as such on the lists and do not follow the above criteria for inclusion.

Using Your *Medical Pre-authorization Lists*

Pre-authorization nurses are available to pre-authorize services as defined in our *Medical Pre-authorization Lists*. They also screen for medical necessity, length of stay, appropriate treatment setting (e.g., inpatient or outpatient) and concurrent review. Current *Medical Pre-authorization Lists* can be found online at www.or.regence.com/provider. These lists include phone and fax numbers to use for each line of business and type of service being pre-authorized. Because revisions are periodically made to the lists, **it is imperative that you replace your lists whenever you receive notice of a revision.**

Pharmacy Prior Authorization

Pharmacy requirements are separate from the *Medical Pre-authorization Lists*. Prior authorization requirements apply to most members whose prescription claims are processed through Argus. Pharmacists will be alerted when the prescription is filled if a prior authorization or medication dispensing limit (MDL) applies. Please see the RegenceRx section of this manual for additional information or visit the RegenceRx Web site at www.regencerox.com/physician.

Prospective Review Provider Appeal Process

The Provider Appeal Process outlined below exists for contracted and non-contracted providers who disagree with a denial for a prospective service.

1. Every effort will be made to resolve a provider complaint without a formal appeal. However, a provider may request a formal appeal in writing if a pre-authorization has been denied. After eligibility and benefits are confirmed and all pertinent clinical information is received for a pre-authorization request, the appeal will be responded to in writing within the following time frames:
 - Standard appeal – two business days.
 - Urgent appeal – one business day. An appeal is considered urgent if the standard process might seriously jeopardize the member's life, health or ability to regain maximum function.
2. All documentation associated with the initial request will be gathered and submitted to the medical director or the director's designee for a final determination.
3. The final decision will be communicated both by phone and in writing.

Concurrent Review

Concurrent review is the process of reviewing health care services at the time they are being rendered to verify medical necessity and compliance with medical policy and practice guidelines. Concurrent review includes discharge planning and may be conducted on-site, by phone or by fax.

Retrospective Review

Retrospective, or post-service, review is a process for the evaluation of services for medical necessity and appropriateness based on medical and reimbursement policy criteria. It also helps Regence identify, monitor and evaluate professional community practices and to ensure appropriate resource utilization.

Retrospective claim reviews are completed within time frames established by the Blue Cross and Blue Shield Association and applicable state and federal regulations. Claims processing notification is made through claims vouchers and explanation of benefits.

Case Management

Case Management is a process directed toward assessing needs, coordinating resources and creating flexible, cost-effective options for identified members to facilitate quality care and individualized treatment plans. Our case managers have a wide variety of clinical experience as registered nurses and social workers. These case managers can act as liaisons and refer the member, physician or health care professional to available community, commercial and/or social service resources. Early intervention may result in additional resources for physicians in managing patient care.

Our internally-administered case management is broken down into two broad categories: complex and specialty. Complex case management focuses on catastrophic illness or injury. This team is the liaison between all interested parties, enhancing communication and promoting teamwork for the most positive outcomes possible. They target care coordination for members who may need more hands-on assistance with issues such as level-of-care changes, discharge planning or outpatient services coordination. Specialty case management programs consist of pediatrics, oncology/end of life, transplants and mental disorders. These specializations were developed to link members and providers with case managers familiar with specific issues, treatment options and resources related to their specialty areas. For example:

- Pediatric specialty case managers assist our younger members (birth-18 years) and their families with targeted education, support and guidance through the health care system.
- Oncology/end of life specialty case managers understand the unique issues faced by cancer/end stage patients and keep abreast of the latest clinical trials, community resources and support groups.
- Transplant case managers strive to smooth the transition between pre- and post-transplant care and to improve emotional, physical and financial outcomes.

Disease Management

Disease management programs offer both early intervention and long-term management of chronic conditions. This can help reduce the need for expensive procedures, hospitalizations and emergency room visits. Most disease management programs focus on chronic illnesses such as diabetes, cardiac and respiratory conditions. Regence currently offers two disease management programs. Regence

Disease Management (administered internally) as well as AdvicareSM, a program administered through Healthways, Inc.

We can help your patients with chronic conditions understand and follow your care recommendations and make the most of their office visits. Below is an overview of how both disease management programs work:

- Members who could benefit are identified, contacted and encouraged to enroll in the programs.
- Enrolled members receive tailored interventions, including care reminders, newsletters, educational materials, clinical support and other outreach as needed, based on unique individual needs.
- Members are educated about their condition so they better understand the care plan their physician recommends.

Regence Disease Management

Our internally-administered programs focus on conditions that most impact on our members' quality of life and are highly integrated with other medical, pharmacy and behavioral health programs.

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Anxiety
- Depression

AdvicareSM Disease Management

AdvicareSM provides disease management services to members with chronic conditions through a partnership with Healthways, Inc. Conditions covered vary by group. Currently three separate packages are offered. Advicare offers personalized education and support from experienced nurses and dietitians to enhance members' physician/patient relationship. We began offering Advicare disease management programs in 2004 to large groups.

Special Beginnings[®]

Special Beginnings[®] is an internally-administered maternity management program that provides pregnant women with prenatal education and support for a healthy pregnancy and a healthy, full-term baby. A nurse is assigned to each member, and the physician or midwife is notified of the member's participation in the program.

Members enrolled in Special Beginnings receive:

- A book or DVD about pregnancy (including options in Spanish)

- Packets of tailored educational material
- Regular contact by an assigned program nurse
- Toll-free 24-hour access to a maternity nurse advisor
- Reward points for completing the program at **myregence.com**

Regence Health CoachSM

Regence Health CoachSM is an internally-administered program that targets eligible members' specific health concern(s) and supplies them with tools to reach healthy lifestyle goals through regular coaching and motivational interaction. Personal health coaches are trained in motivational interviewing and readiness to change theory at Oregon Health Sciences University (OHSU) in Portland, Oregon. They help participants one-on-one with diverse goals such as getting more sleep, reducing stress, improving nutrition or increasing exercise. Enrolled members receive:

- A free pedometer and walking journal
- Toll-free and e-mail access to a personal health coach
- **myRegence.com** points for participation

CareEnhance[®]

The CareEnhance[®] nurse advice line is offered through McKesson Health Solutions. This program helps eligible members make more informed health care decisions. With CareEnhance members receive:

- Toll-free access 24-hours a day, seven days a week, to registered nurses providing algorithm-based symptom assessment, general health information, appropriate care advice and follow-up as necessary
- Audio Health Library with more than 1,100 health topics (500 in Spanish)
- Quarterly member mailings to raise awareness and encourage utilization of the nurse line services. These mailings feature refrigerator magnets and wallet cards.

Regence Advantages

Regence Advantages offers our members discounts from a number of leading health-related companies. A full list of discounts available can be found online at <http://www.or.regence.com/member/discountServices/>. Some examples of discounted services include fitness centers and weight loss programs.