

BlueAdvantage Health Management

BlueAdvantage member benefits include access to a comprehensive Health Management program that is designed to encompass total health needs and promote access to individualized, appropriate, quality and cost-effective care while improving the quality of life. The program assists members in achieving quality outcomes by equipping and guiding them through the entire health care process without delay or interruption of services. Through these processes, treatment options and barriers to optimal outcomes are identified.

Some objectives of the program include:

- Maximizing opportunities to positively influence health status and health outcomes
- Facilitating practitioner collaboration
- Facilitating member agreement and participation, member education and empowerment
- Facilitating family and community support
- Promoting quality care in the most appropriate setting
- Empowering members to make informed health care decisions

The program focuses on changing health behavior relative to risk identification through member engagement, enrollment into appropriate program(s), health coaching, follow-up, outcomes reporting, and integration of services. Once a member is enrolled in a program, a member of the BlueAdvantage Health Management team will work with him or her for the entirety of the program.

The program includes:

- Outreach
- Self-management Support
- Lifestyle Management
- Care Coordination
- Disease Management
- Transplant Management
- Complex Care Management
- Behavioral Health Management
- Palliative Care
- Utilization Management

The BlueAdvantage Health Management team consists of Medical Directors who are Physicians, Pharmacists, and Registered Nurses with various health care settings experience. Staff who assist with outreach activities, education efforts and make referrals to appropriate Health Management programs supports these team members.

The BlueAdvantage Health Management team is experienced in coordinating health care needs and developing management plans specific to the individual health care needs and the treatment plan ordered by a member's doctor. The Health Management program is implemented through telephonic, written, or web-based communication. Additionally, the Health Management team works closely with family members or caregivers, a member's doctor and any other health care provider to help a member have better control of their health and care, and achieve maximum outcomes.

Outreach

All BlueAdvantage members receive health resources through the Outreach program. The Personal Health Manager is a single online source for members to receive wellness services information, health information and interact with the BlueAdvantage Health Management team. BlueAdvantage members receive the Healthwise for Life book, preventive services reminders, *Your BlueAdvantage* newsletter, and have access to health information links on BCBST.com and a Health Information Audio Library with more than 1200 topics related to health available in English and Spanish. BlueAdvantage members also have access to BluePerks discount program for a selection of health and wellness services that are not covered benefits under their health plan.

Member safety is an important component of health management and safety risks are continually assessed and identified throughout the Health Management program. To promote safety precautions and educate members regarding potential risks, all members receive information regarding home and other safety practices.

Health and Wellness surveys are completed by mail, telephone, or online within 90 days of a member's effective date. The information from the survey is an effective strategy to identify individuals who can benefit from behavior change programs. Additionally, claims data and gaps in care analyses are an important component in the identification of members who may benefit from Health Management programs. Significant outreach activities are performed to meet or exceed a return rate goal of 75%. Survey results provided by the member are documented in a web-based application that assists in care coordination and self-management. A member receives their individual results and plan with a copy provided to a member's physician if the member so chooses. The results are used to recommend appropriate programs to address identified risks factors to members who may benefit from health management.

Self-Management Support

BlueAdvantage provides tools and information that a member can use to help improve their quality of life related to health. The web-based application referenced above also assists with the delivery of individualized health information and serves as an avenue for communication among BlueAdvantage Health Management team, members and providers. The system includes and allows for:

- Identification and stratification of members for appropriate intervention
- Personalized health surveys
- Individualized automated care plans
- Health Management care plan customization ability
- Automated personalized member and provider communication
- Secure messaging with members and providers
- Personal Health Manager

Lifestyle Management

Disease specific brochures, educational materials and the use of the Personal Health Manager provide BlueAdvantage members information to promote healthy lifestyles. However, Lifestyle Management is more than just providing primary prevention by mailing relevant brochures to members. Lifestyle Management assists members in achieving improved health status through behavioral modification related to lifestyle habits. BlueAdvantage members are initially assessed during outreach activities through a series of questions that identify readiness for change. Behavior change readiness and modification is then assessed continually throughout a member's health management.

Lifestyle Management topics include weight management, smoking cessation, hypertension management, cholesterol management, stress management, and more.

Care Coordination

The Health Management program involves the full spectrum of care coordination. Care Coordination is intended to stabilize members' health condition/disease, promote self-management by providing tools and education to allow them to make informed decisions about their health care, encourage and provide tools for active participation in managing their condition(s), and assist with arranging for care in the most appropriate setting and care that is necessary for self-management.

For BlueAdvantage's membership, this program is particularly helpful since many members in this population have multiple chronic diseases. Members are provided access to the highest quality care with optimal utilization of benefits and resources, including appropriate utilization of treatment, services and community resources. Care Coordination is designed to decrease the need for crisis intervention through symptom management and decrease the incidence of emergent care and acute care hospitalization. Members or family members/caregivers are actively involved in determining program goals and objectives specific to a member.

Disease Management

Disease Management involves the same interventions as Care Coordination; however, it is disease specific. It is a system of coordinated health care interventions and communications for the population's members with conditions in which patient self-care efforts are significant. Disease Management emphasizes prevention of exacerbations and complications through education and monitoring, and evaluation of clinical outcomes on an ongoing basis with the goal of overall health. Currently, disease states being managed through this program are diabetes and congestive heart failure.

The primary goal is to stabilize the member's health condition/disease and assist them with tools, education and care necessary for self-management. The program promotes member and caregiver's active participation in management of the disease process resulting in an increased knowledge of the disease process, prevention and treatment. Additionally, the member increases their knowledge of healthy lifestyle changes and co-morbid management. The treating physician's involvement is an integral part of the program and development of an individualized plan of care and desired outcomes. The program supports the physician by reinforcing education, monitoring and reporting.

Other important components of the program include evaluation of clinical, humanistic and economic outcomes, population identification processes using predictive modeling strategies, evidence-based guidelines, collaborative practice models to include physician and support service providers, and outcomes measurement, evaluation and management.

Transplant Management

Transplant Management focuses on the entire spectrum of transplant care. Member participation in transplant case management is mandatory. The care of the member is managed from the time the possibility of a transplant need is identified and continues up to 12 months post-transplant.

Complex Care Management

Members with complex health care needs, unstable multi-disease states, and conditions where a longer period of management will be required are managed through Intensive Management. Complex and catastrophic conditions such as trauma, AIDs, extensive burns, and Guillain-Barre' syndrome are managed through an intensive approach of assessing, planning,

coordinating, implementing and evaluating care through multiple health and psychosocial needs of the member are met.

Behavioral Health Management

This program focuses on behavioral needs of the member as well as physical needs. Members with behavioral health diagnoses are monitored closely to identify immediate and ongoing needs of the member and plan a course of care in collaboration with treating physicians, family members, and other members of the health care team.

An important component of Behavioral Management is providing education regarding medication compliance, recognizing symptoms and understanding when to contact his or her physician, and when to seek emergency treatment. Identifying triggers that exacerbate symptoms is discussed with a member and/or family and assistance is provided to determine strategies for avoiding these triggers. Other program components include substance abuse strategies, various assessment tools (i.e., suicide risk) as well as identifying and facilitating appropriate alternatives to admissions (i.e., individual or group treatment on an outpatient basis, self-help group referral, day treatment, partial hospitalization).

Palliative Care

A Palliative Care program focuses on symptoms control and supportive care early in a patient's illness and is designed to both improve quality of life for patients while they fight their disease and potentially increase life expectancy. Palliative care includes the prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems.

The Palliative Care program addresses chronic pain management, however, with this population end of life management is crucial. Program participants are anticipated to likely include members who are eligible for hospice, but have refused those services for various reasons. While these members have significant needs, refusing hospice intervention may be a direct correlation to fear of being placed in a hospice program as acceptance of their terminal condition. The objective of our Palliative Care program is to engage those members and assist the member and family in coordinating their end of life care in the most appropriate setting, providing pain control support, providing information regarding living wills, advance directives, medical power of attorney, and other related forms, providing bereavement counseling for family members prior to the member's death, and facilitating hospice referrals if the member chooses to transition to a hospice program.

Contact Numbers for All of the Above Programs

Phone 1-800-800-841-7434

Fax Numbers 1-888-535-5243

1-423-535-5243

Utilization Management

BlueAdvantage Health Management programs adhere to CMS' Medicare Advantage rules and regulations promulgated in 42 CFR § 422 and CMS' Internet Only Medicare Managed Care Manual. CMS' requirements for Medicare Advantage vary from the requirements for Original Medicare. Chapter 13 of the Managed Care Manual is a significant reference utilized to implement BlueAdvantage's Utilization Management programs.

Utilization management includes services that require prior authorization, services that require notification, advance determinations that may be requested by a member, practitioner or provider, and retrospective review. CMS' Medicare Advantage reconsideration process is available in cases of dissatisfaction with the review decision.

These utilization management strategies are additional effective mechanisms for identifying members who may benefit from Health Management programs.

The Utilization Management program follows the CMS hierarchy for both decisions and references in making medical necessity determinations.

The hierarchy of decision is that the service must:

1. Be a benefit (refer to the Evidence of Coverage or call Customer Services 1-800-841-7434)
2. Not be excluded according to CMS National and Local coverage guidelines
3. Be appropriate and medically necessary

The hierarchy of references includes:

1. The law (Title 18 of the SSA)
2. The Regulations (Title 42 CFR part 422 and 476)
3. National Coverage Determinations (Pub 100-03 of the Internet Only Manual)
4. Other coverage guidelines in Interpretive Manuals (Internet Only Manual (IOM), sub manuals Pub 100-04 Claims Processing, Pub 100-02 Benefit Policy Manual, Pub 100-08 Program Integrity Manual, Pub 100-10 QIO manual, Pub 100-16 Medicare Managed Care Manual)
5. Local Coverage Determinations (<http://www.cms.hhs.gov/mcd/search.asp>)
6. Milliman Care Guidelines[®]
7. Modified Milliman Care Guidelines[®] (http://www.bcbst.com/providers/UM_Guidelines/)
8. BCBST policy
9. Durable Medical Equipment Medicare Administrative Contractor (DMEMAC) associated Program Safeguard Contractor (PSC) local coverage determinations (LCD)
10. Other major payer policy and peer reviewed literature

Prior Authorization Requirements

Prior authorizations are performed to allow members and providers to receive a medical appropriateness determination before services are rendered to ensure members are receiving medically necessary services in the most appropriate setting and allow providers to receive a coverage determination prior to performing a service and requesting reimbursement. Prior authorization is a requirement under the Terms and Conditions of Plan Payment. However, providers will not be penalized for non-compliance with prior authorization requirements and claims submitted for services not authorized prospectively will be reviewed retrospectively for medical appropriateness to determine coverage and reimbursement. If claim information alone does not provide sufficient information to make a medical appropriateness determination, the provider will receive a written request for medical records. If additional clinical information is requested, the review and claims processing will be completed when the requested information is received.

Prior authorization is required for the following:

- All acute care facility, skilled nursing facility, rehabilitation and behavioral health facility inpatient stays
- Home health services/skilled nursing visits including those for home infusion therapy
- Part B Specialty Pharmacy Medications with a line item price greater than \$200
- Durable medical equipment-for purchase or rentals if the purchase price is greater than \$500
- Orthotics and prosthetics if the purchase price is greater than \$200

- Speech therapy, occupational therapy and physical therapy.

Authorization will be issued when care and treatment are determined to be medically necessary and medically appropriate. Effective February 1, 2007, BlueAdvantage will not require prior authorization for home health *evaluations* in order to allow the provider to obtain sufficient information before requesting prior authorization for home health *visits*, as well as expediting the review process.

Requests for Notification:

- All emergency admissions within 24 hours or one (1) business day after services have started.

Notification is especially important for members who required emergency admissions as they would likely benefit from Health Management programs.

Prior authorization/notification reviews can be initiated by a member, designated authorized member representative, practitioner, provider or facility. However, it is ultimately the facility and practitioner's responsibility to contact BlueAdvantage to request an authorization and to provide clinical and demographic information that is required to complete the authorization/notification. Scheduled admissions/services must be authorized up to 24 hours prior to admission/service.

Specific Medical Review Guidelines for prior authorization are located in the BCBST Commercial Provider Administrator manual, section XXIV Medicare Advantage and subsection (H) Utilization Management at:

http://www.bcbst.com/providers/manuals/Commercial_Core_Dec06.pdf

Advance Determination Review

A member or provider has the opportunity to seek a determination of coverage before receiving or providing services by requesting an Advance Determination. Information required for processing Advance Determination Reviews is found on a specific form located at http://www.bcbst.com/providers/manuals/Commercial_Core_Dec06.pdf

Retrospective Claims and Clinical Record Review

Retrospective claims reviews are conducted to provide a determination of medical necessity, as well as verification of eligibility and benefits. Claims are targeted for review based on National Coverage Determinations, Local Coverage Determinations and BCBST Medical Policy. Reviews are performed prior to claims payment using CMS' processing guidelines (i.e. postacute care transfer policy, low utilization payment adjustments, outlier payments, etc.).

Retrospective clinical record reviews may be conducted to meet our CMS contractual requirements. Record review results support CMS and other regulatory agencies audits, applicable accreditation audits, quality improvement activities, QIO and IRE review processes, and CMS' risk-adjusted payment processes.

Utilization Management Decision Notification

Written notification of the outcome of medical necessity reviews is provided to members, practitioners and facility.

CMS requires a Detailed Notice (DN) be distributed to a member or authorized representative requesting an appeal of discharge from an inpatient facility or when BCBST no longer intends to continue coverage of an authorized hospital inpatient admission BCBST

delegates to Providers the responsibility for developing and delivering the DN for provider discharge determinations and for delivery of the DN for BCBST discharge determinations. CMS requires the DN to be delivered as soon as possible, but no later than noon of the day after the QIO's notification or BCBST's request for delivery. Providers are required to fax a signed copy of the DN to BlueCross BlueShield of Tennessee UM Department at 1-888-535-5243 or 1-423-535-5243. *Providers must be able to demonstrate compliance with the delivery of the DN in accordance with applicable CMS regulations.*

CMS requires a Detailed Explanation of Non-Coverage (DENC) be distributed to a member or authorized representative requesting an appeal of discharge from a SNF, HHA or CORF or when BCBST no longer intends to continue coverage. BCBST delegates to Providers the responsibility for developing and delivering the DENC for provider discharge determinations and for delivery of the DENC for BCBST discharge determinations. CMS requires the DENC to be delivered as soon as possible, but no later than close of business the day of the QIO's notification or BCBST's request for delivery. Providers are required to fax a signed copy of the DENC to BCBST UM Department at 1-888-535-5243 or 1-423-535-5243. *Providers must be able to demonstrate compliance with the delivery of the DENC in accordance with the applicable CMS regulations.*

Contact Numbers for Utilization Management Programs

Phone 1-800-924-7141

Fax Numbers 1-888-535-5243

1-423-535-5243

Reconsideration Process

A reconsideration consists of a review of an adverse determination or termination of services decision, the evidence and findings upon which it was based, and any other evidence submitted or obtained.

A standard reconsideration of an adverse determination or termination of services decision may be requested by a Member or a Member's authorized representative (further described below). A Physician may be appointed to act as a Member's representative and file an appeal on his or her behalf. Both the Member and Practitioner must sign, date and complete a representation form. CMS-1696 Appointment of Representation form is located on CMS' website. A written request for a standard reconsideration must be submitted within 60 calendar days from the date of the notice of the determination.

If a member or authorized representative shows good cause in writing, including the reason why the request was not filed timely, BlueAdvantage may extend the time frame for filing a request for reconsideration. Examples of circumstances where good cause may exist include (but are not limited to) the following situations:

- The member did not personally receive the adverse determination notice, or he/she received it late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The member had incorrect or incomplete information concerning the reconsideration process; or
- The member lacked capacity to understand the time frame for filing a request for reconsideration.

If BlueAdvantage denies a member's request for a good cause extension, the member may file a grievance with BlueAdvantage.

Reconsideration requests should be sent to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage
Appeals Department
PO Box 180205
Chattanooga, TN 37402-7205

A standard reconsideration of the denial of a request for service will be determined no later than 30 calendar days from the date the request of a standard reconsideration is received. The timeframe may be extended up to 14 calendar days at the member's request or if BlueAdvantage determines extending the timeframe is in the best interest of the member (i.e., requesting specific information that could potentially change a previously denied decision).

A member or physician may submit a verbal or written request for an expedited reconsideration in situations where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function. If BlueAdvantage approves a request for an expedited reconsideration, the review will be completed no later than 72 hours after receiving the request. The 72-hour timeframe may be extended up to 14 calendar days at the member's request for an extension or if BlueAdvantage determines extending the timeframe is in the best interest of the member.

A request for payment of a service already provided to the member is not eligible to be reviewed as an expedited reconsideration.

A reconsideration request will be reviewed by a physician reviewer other than the one who performed the initial review. If the reconsideration is upheld, the reconsideration request will be sent to an Independent Review Entity (IRE) contracted by CMS to review Medicare health plans' adverse reconsiderations. A copy of all information related to the reconsideration request is submitted to the IRE as expeditiously as the member's health condition requires, but no later than 30 calendar days from the date BlueAdvantage received the member's request for a standard reconsideration (or no later than upon expiration of an extension). Expedited reconsiderations requiring independent review will be submitted to the IRE as expeditiously as the member's health condition requires, but no later than within 24 hours of affirmation of BlueAdvantage's adverse expedited determination.

The IRE is required by CMS to complete its reconsidered determination as expeditiously as the member's health condition requires and observes the same timeframes as described above. The IRE is responsible for notifying all the parties of the reconsidered determination and sending a copy of the reconsidered determination to the CMS Regional Office.

Authorized Representatives

An authorized representative is an individual appointed by a member or other party to act on behalf of a member or other party involved in the appeal. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member in dealing with any of the levels of the appeals processes (reconsiderations, independent reviews, Administrative Law Judge hearings, Medicare Appeals Council reviews, and judicial reviews).

A member may appoint any individual such as a relative, friend, advocate, an attorney, or any physician to act as his or her representative and file an appeal on his or her behalf. Also, a representative may be authorized by the court or act in accordance with State law to file an appeal for a member. Either the signed representative form or other appropriate legal papers supporting an authorized representative's status, must be included with each appeal. Unless revoked, an appointment is considered valid for one year from the date that the appointment is signed by both the member and the representative. The representation is valid for the duration of the appeal. A photocopy of the signed representative form must be submitted with future appeals on behalf of the member in order to continue representation. Any appeal received with a photocopied representative form that is more than one year old is invalid to appoint that person as a representative and a new form must be executed by the member.

A reconsideration request will not be considered until the appropriate documentation is provided. The timeframe for processing a reconsideration request begins when appropriate documentation is received.

A provider, physician, or supplier may not charge a member for representation in an appeal. Administrative costs incurred by a representative during the appeals process are not reasonable costs for Medicare reimbursement purposes.

A representative may:

- Obtain information about the member's claim to the extent consistent with current Federal and state law;
- Submit evidence;
- Make statements of fact and law; and
- Make any request, or give or receive any notice about the appeal proceedings.

A non-deemed provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the provider will not bill the member regardless of the outcome of the appeal.

Quality of Care

A quality of care complaint may be filed through BlueAdvantage's grievance process and/or a Quality Improvement Organization (QIO) under contract by CMS to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for members receiving care in acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities.

A QIO will determine whether the quality of services meet professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Members have the right to an expedited review by a QIO when they disagree with their BlueAdvantage's decision that Medicare coverage of their services should end. The member (or representative) is responsible for contacting the QIO (within the specified timelines) if he or she wishes to obtain an expedited review.

The appeals processes described above comply with CMS' requirements and more detailed information is located in 42 CFR 422 Subpart M and CMS' Internet Only Managed Care Manual Chapter 13.

CFR:

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=e731b1406de886c6e41ea4d3b78497ff&rgn=div5&view=text&node=42:3.0.1.1.9&idno=42>

Managed Care Manual:

<http://www.cms.hhs.gov/manuals/downloads/mc86c13.pdf>

Member Rights

Relative to coverage determinations and appeals, member rights include, but are not limited to:

The right to a timely determination;

The right to request an expedited determination, or an extension and, if the request is denied, the right to receive a written notice that explains the member's right to file an expedited grievance.

The right to a written notice from BlueAdvantage of its own decision to take an extension on a request for a determination that explains the reasons for the delay and explains the member's right to file an expedited grievance if he or she disagrees with the extension.

The right to receive information from BlueAdvantage regarding the member's ability to obtain a detailed written notice from BlueAdvantage regarding the member's services; and

The right to a detailed written notice of BlueAdvantage's decision to deny, terminate or reduce a payment or service in whole or in part, or to reduce the level of care in an ongoing course of treatment which includes the member's appeal rights.

The right to request an expedited reconsideration;

The right to request and receive appeal data from BlueAdvantage;

The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE);

The right to automatic reconsideration by an IRE contracted by CMS, when the BlueAdvantage upholds its original adverse determination in whole or in part;

The right to an Administrative Law Judge (ALJ) hearing if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy meets the appropriate threshold requirement, as set forth in CMS' Internet Only Managed Care Manual Chapter 13 section 100.2;

The right to request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the member in whole or in part;

The right to judicial review of the hearing decision if the ALJ hearing and/or MAC review is unfavorable to the member, in whole or in part, and the amount remaining in controversy meets

the appropriate threshold requirement, as set forth in CMS' Internet Only Managed Care Manual Chapter 13 section 120;

The right to file a quality of care grievance with a QIO;

The right to request a QIO review of a termination of coverage of inpatient hospital care. If a member receives immediate QIO review of a determination of non-coverage of inpatient hospital care, the above rights are limited. In this case, the member is not entitled to the additional review of the issue by BlueAdvantage. The QIO review decision is subject to an ALJ hearing if the amount in controversy meets the appropriate threshold, and review of an ALJ hearing decision or dismissal by the MAC. Members may submit requests for QIO review of determinations of non-coverage of inpatient hospital care in accordance with the procedures set forth in CMS' Internet Only Managed Care Manual Chapter 13 section 160;

The right to request a QIO review of a termination of services in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities. If a member receives QIO review of a SNF, HHA or CORF service termination, the member is not entitled to the additional review of the issue by BlueAdvantage. Members may submit requests for QIO review of provider settings in accordance with the procedures set forth in CMS' Internet Only Managed Care Manual Chapter 13 section 90.2;

The right to request and be given timely access to the member's case file and a copy of that case subject to federal and state law regarding confidentiality of patient information. BlueAdvantage has the right to charge the member a reasonable amount, for example, the costs of mailing and/or an amount comparable to the charges established by a QIO for duplicating the case file material;

The right to challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are reviewed by the DAB of the Department of Health and Human Services. Challenges concerning LCDs are reviewed by ALJs.