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## CHAPTER 9 – CARE MANAGEMENT SERVICES

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### CARE MANAGEMENT SERVICES

The following services are managed in the Care Management Department:

- Prior Authorization
- Utilization Review (including pre-certification and concurrent review)
- Case Management
- Intensive Case Management for Disease Management Programs

#### Prior Authorization

Prior authorization means obtaining permission from CHNCT prior to rendering the service/procedure. It is the review of specified services/procedures for medical necessity prior to and/or throughout the episode of care.

Prior authorization can be obtained by calling the Care Management Department at 800-440-5071 or by faxing a request to 203-265-3994. The following information is necessary before a prior authorization can be given:

- Member name
- Member ID
- Member date of birth
- Diagnosis or reason for treatment
- Treatment plan including number of visits or proposed treatment

The Care Management staff will review the request against established criteria and will respond to the provider within 2 business days of receipt of all clinical information by sending an authorization or a denial letter to the PCP office, the specialist office and the member.

Following is a chart illustrating the prior authorization requirement:

#### PRIOR AUTHORIZATION REQUIREMENTS:

<b><i>HUSKY Risk</i></b> – These require prior authorization:	<b><i>Charter Oak</i></b> – These require prior authorization:
Elective Inpatient Admissions – at least 48 hours prior to admission.	Elective Inpatient Admissions – at least 48 hours prior to admission.
All services performed at non-par facilities	All Services performed at non-par facilities
DME Rental to purchase and DME equipment over \$1,000	DME Rental to purchase and DME equipment over \$1,000
Home Health Services will be allowed two prenatal and two postpartum nursing visits without prior authorization	Home Health Services
PT, OT, Speech Therapy	PT, OT, Speech Therapy
Cardiac Rehab	Cardiac Rehab
Transplants	Transplants
Chiropractic	

Admissions to skilled nursing and rehabilitation facilities – at least 48 hours prior to admission.	Admissions to skilled nursing and rehabilitation facilities – at least 48 hours prior to admission.
<ul style="list-style-type: none"> <li>• All the following procedures:</li> <li>• Lipectomy</li> <li>• Otoplasty</li> <li>• Keloid excisions</li> <li>• Rhinoplasty</li> <li>• Silicone Implants</li> <li>• Abdominoplasty</li> <li>• Mammoplasty</li> <li>• Genitoplasty</li> <li>• Reconstructive surgery (including breast reconstruction following mastectomy)</li> <li>• Carpal tunnel release</li> <li>• Stripping &amp; ligation of varicose veins</li> <li>• TMJ related procedures/treatments</li> <li>• Treatment of obesity</li> </ul>	<ul style="list-style-type: none"> <li>• All the following procedures:</li> <li>• Lipectomy</li> <li>• Otoplasty</li> <li>• Keloid excisions</li> <li>• Rhinoplasty</li> <li>• Silicone Implants</li> <li>• Abdominoplasty</li> <li>• Mammoplasty</li> <li>• Genitoplasty</li> <li>• Reconstructive surgery (including breast reconstruction following mastectomy)</li> <li>• Carpal tunnel release</li> <li>• Stripping &amp; ligation of varicose veins</li> <li>• TMJ related procedures/treatments</li> </ul>

**MATERNITY ADMISSIONS: (HUSKY and Charter Oak Health Plan)**

Effective in March 2009, CHNCT participating hospitals in Connecticut, are no longer required to notify CHNCT of a routine, uncomplicated, normal maternity admission.

This applies to an admission for a vaginal delivery where the patient and newborn remain in for the hospital for 2 days or for a cesarean delivery when the patient and newborn remain in the hospital for the 4 days.

Any stays beyond the 2 or 4 days, or any stays related to a complicated pregnancy or delivery, preterm labor admissions, sick newborn stays, etc. require notification to the plan.

*Please note that we will be following up with the delivering OB offices to obtain birth weight information and any other delivery information we may need to gather for reporting purposes.*

**The following services do not require a referral or prior authorization regardless of provider participation status:**

- Emergency Department Care
- Family Planning
- Lab
- Radiology
- Emergent Labor Room Related Services

**Note:** In the event a covered specialty service is not available for a member within CHNCT’s provider network, CHNCT may authorize a referral to a non-participating provider. The appropriate

number of visits and the duration of the referral will be determined by CHNCT.

Referral forms may be obtained by calling the Care Management Department at 800-440-5071 or from the website at [www.chnct.org](http://www.chnct.org).

## ***Utilization Review***

### **Pre-certification (elective admissions)**

Pre-certification is a form of prior authorization. **Pre-certification is required for:**

- **All elective hospital inpatient stays**
- **All inpatient admissions to skilled nursing facilities or rehab facilities**

The provider admitting the member for an elective admission needs to request a pre-certification prior to admission. The following information is necessary:

- Member name
- Member ID
- Member date of birth
- Diagnosis and ICD-9 code
- Procedure and CPT-4 code
- Place of service
- Date of service
- Admitting physician
- Length of stay

CHNCT requests the provider to notify us within 2 business days but no later than 10 calendar days of the admission by calling 800-440-5071 or faxing 203-265-3994. Notifications greater than 10 calendar days from the admission date are subject to denial of services.

### ***Certification (urgent/emergent admissions)***

- **Certification is required for emergent hospital admissions**

The provider admitting the member needs to notify CHNCT by calling (800-440-5071) or faxing (203-265- 3994) the request to CHNCT within 2 business days of the admission.

Utilization Management staff will review the admission on the first business day or sooner after being notified of the admission. All information necessary for CHNCT to determine medical necessity and medical appropriateness must be documented in the member's medical record. If necessary, the Utilization Management staff will contact the attending physician to obtain additional information. The Utilization Management staff will assist in the discharge planning process, working with the discharge coordinators at the facilities, and are available to assist in locating and arranging alternatives to hospital care. For assistance, please contact the Care Management department at 800-440-5071.

### ***Concurrent Review/Continued Stay Review***

Utilization Management staff will follow the case concurrently while the member remains inpatient. Concurrent review is performed to:

- Determine medical necessity and medical appropriateness for the member's continued stay in the hospital
- Monitor and assess the plan of treatment and continuity of care
- Determine whether the level of care is still appropriate for the member's medical needs

- Discover duplication of services or service delays
- Coordinate and establish timely discharge planning and services

## ***Case Management***

CHNCT provides case management services to CHNCT members across the continuum of the healthcare delivery system. CHNCT systematically identifies members with complex healthcare needs and refers them to the Care Management department for case management services.

Types of cases that may be evaluated for case management include:

- Multi/Head Traumas
- Spinal cord injuries/disorders
- HIV (AIDS)
- Neoplasms
- Major burns
- Neuromuscular dysfunctions
- Asthma
- Cardiac anomalies
- Chronic renal failure
- Congenital defects
- High Risk Pregnancy
- Organ or bone marrow transplants
- Neonates admitted to NICU
- Children with special health care needs

Following are some of the sources used to identify Members for case management:

- Welcome Calls: Welcome call forms are forwarded to the Care Management Department. These forms assist in the identification of members with special healthcare needs and contain information obtained from new members regarding their current health status and services being received.
- Referral Forms from PCPs: Referral forms for specialty services are faxed to CHNCT from Members' PCPs. These forms are screened for trigger diagnoses.
- Emergency Department and Inpatient Admissions: Emergency Department and inpatient admissions are faxed to CHNCT on a daily basis by the contracted hospitals. These are also screened for trigger diagnoses.
- BHP Referrals: CHNCT's Behavioral Health liaison is contacted by CTBHP when it is determined that a Member treated by their clinician also presents with medical issues/concerns, whether due to the behavioral health diagnosis or not. These Members are referred to Care Management for case management review.
- Outreach Phone Calls: Members identified through Outreach phone calls are referred to Care Management for Case Management review.
- DSS Eligibility Files: DSS eligibility files identify Members on SSI and/or DCF and are reviewed by the Care Management department for case management opportunities.
- Other Referrals: Referrals from providers, state agencies (DCF, DMR), self-referrals, etc. are reviewed by Care Management for case management opportunities.
- Claims Data: Claims data is mined and analysis is done for identification of members with complex health care needs.

Members not meeting criteria for Case Management are contacted by telephone and provided information regarding other resources and services available to assist them within the community.

The RN Case Manager assesses each case and in collaboration with the member or legal guardian, the primary care physician and other involved health professionals, conducts an assessment and creates a plan of care. The assessment is completed within 30 calendar days and includes an evaluation of the member's health status, environment, support system, financial and community resource needs, specific treatment goals, barriers to care, specific services to be provided and their expected duration, and current providers. The clinical assessment is done to determine any existing physical, behavioral, nutritional, social and developmental conditions warranting case management. Members and their PCPs are contacted within 3 days of the receipt of the referral.

The Case Manager also provides health education during many communications with the member. The member may also be referred to a specific agency or website that can assist in providing additional information. Educational mailings are also sent as appropriate, i.e., EPSDT educational mailing.

The Case Manager re evaluates each case on a regular basis to assess responses to interventions and to identify new risk factors that may warrant an adjustment to the initial care plan. The plan is then modified to address new risk factors or changes in health status. The frequency of follow up is based on the member's individual needs and adheres to the guidelines for the acuity level of the case. All cases are reassessed until all goals have been met, the member is able to function independently, case management services no longer benefit the member, the member declines case management services or the member is no longer eligible for benefits.

## **Intensive Case Management for Disease Management Programs**

The following Disease Management Programs are available for CHNCT members:

### **Healthy Airways**

This program offers informative mailings to all members with asthma, along with support and intensive case management of high-risk members. It also includes periodic mailings designed to educate, facilitate compliance with the provider's treatment plan and encourage participation in the program. In addition, depression screening for assessment and referral to the states' Behavioral Health Program is provided as needed.

### **Healthy Beginnings**

This program promotes healthy pregnancies and birth outcomes by encouraging the early entry of CHNCT's pregnant members into prenatal care. All pregnant members are enrolled in a program that includes educational mailings throughout the pregnancy and postpartum period, telephonic interventions, intensive case management of all high-risk members and ongoing reassessment of risk factors with appropriate referrals as needed. Because each disease management team member is empowered to provide the most appropriate services, they establish exceptional rapport with the member.

Healthy Beginnings has shown to increase:

- The frequency of prenatal care; and
- The frequency of postpartum care.

Healthy Beginnings has shown to decrease:

- The number of members who receive no prenatal care;

- The incidence of low birth-weight infants; and
- Neonatal intensive-care unit admissions, lengths of stay and other costs.

### **Healthy Living with Diabetes**

This program is designed to educate and support members in caring for Diabetes. This program offers informative mailings to all members with diabetes, along with support and intensive case management of high-risk members. It also includes periodic mailings designed to educate, facilitate compliance with the provider's treatment plan and encourage participation in the program. In addition, depression screening for assessment and referral to the Behavioral Health Program is provided as needed.

Members' with diabetes are stratified based on laboratory and claim information. Members with high lab values and/or high utilization for diabetes will be contacted by a nurse case manager. This nursing support will be provided telephonically, with in-home assessments and teaching being done as needed.

General information mailings will be sent to all members in the program which includes but is not limited to information about blood glucose and cholesterol levels, foot care, medications, at-home glucose monitoring, diet and exercise. Additionally, focused information such as mailings and referrals to community resources will be offered based on member-specific needs.

### **Healthy Cells**

Healthy Cells is CHNCT's disease management program for all members with a primary diagnosis of Sickle Cell Disease. It also is an intensive case management program wherein a registered nurse contacts all identified members for inclusion into the program. The goals are to prevent Sickle Cell crisis and consequential Emergency Department utilization and inpatient hospitalization by promoting appropriate care.