

UTILIZATION MANAGEMENT

Utilization Review Criteria

Physicians Plus uses evidence-based criteria to assist in making utilization management review determinations. Plan-developed criteria are created, adopted and reviewed with the input of appropriate practicing network providers and specialists. InterQual is a nationally recognized criterion set used in making inpatient coverage determinations for the Plan. Utilization management (UM) criteria are available to practitioners upon request. You may:

- 1) obtain a copy of case-related criteria;
- 2) discuss UM issues or the UM process with staff;
- 3) discuss a UM denial or potential denial; or
- 4) contact a UM reviewer by calling the Health Services Department at (608) 282-8900 or (800) 545-5015.

Plan-developed criteria are also made available to practitioners on our website www.pplusic.com.

UM Decision Making

UM decision making is based only on appropriateness of care, type of service and member's current coverage.

Physicians Plus does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives are not provided to UM decision makers to encourage decisions that would result in under-utilization.

UM staff is available during normal business hours (8:00 a.m – 5:00 p.m) for calls regarding UM issues. Voice mail, fax and e-mail is available for UM staff to receive inbound communication regarding UM issues after normal business hours.

Evaluation of New Technology

It is the responsibility of Physicians Plus to recognize and evaluate emerging new medical and behavioral health care procedures, devices, and pharmaceuticals to address the incorporation of such technologies as covered benefits.

Physicians Plus considers expert opinions, current medical

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literature including clinical trials, recognized clinical guidelines, and governmental requirements and regulations in their review. New technology reviews may be completed for member specific cases as requested by a provider or member. Please contact the Health Services Department for questions or a new technology request at (608) 282-8900 or (800) 545-5015.

CONCURRENT REVIEW AND DISCHARGE PLANNING

The purpose of the concurrent review function is to ensure that a member who is admitted to a hospital, rehabilitation facility, long-term acute care facility, or skilled nursing facility receives the correct intensity of services for his or her condition.

Concurrent review activities are conducted telephonically or via fax by a Physicians Plus Healthcare Advocate in conjunction with care management staff at the facility. It is the responsibility of the facility or the attending physician to notify and provide all necessary information to the Health Services Department for continuation of stay authorization.

Concurrent review begins after admission of a member to an inpatient facility. Established evidence-based criteria (InterQual) are used to determine medical necessity for requested services. If it appears that an admission will not meet criteria for approval or that a member's length of stay will exceed the number of days for which prior authorization was given the admission will be reviewed by to the Medical Director or Vice President and Chief Medical Officer (VP & CMO) if there is a potential for denial. The Medical Director or VP & CMO approves or denies the extension of care request. If the Medical Director or VP & CMO denies further inpatient coverage, the member, hospital and attending physician will receive a denial letter and the remainder of the member's hospitalization will not be covered by Physicians Plus.

An aspect of the concurrent review process is discharge planning. This process is conducted by the Healthcare Advocates in conjunction with the facility's care management team, member, member's family and significant others, involved practitioners and by Physicians Plus case management staff. Discharge planning occurs prior to or upon admission to the facility and is monitored by the Healthcare Advocates. During the discharge planning process, the Healthcare Advocates educate members, significant others and care givers about benefit administration, community resources and alternative care options if necessary.

CASE MANAGEMENT

Case management is a systematic, problem-solving process designed to provide cost-effective forms of care and access to resources to improve or maintain the quality and continuity of services. Case Managers (Licensed Practical Nurses and Registered Nurses) assist in activities to provide a comprehensive, coordinated continuum of care for members.

The purpose of **complex** case management is to provide personalized services to members with multiple or complex conditions to obtain coordinated access to care and services. Eligible members are identified through the following methods:

- routine utilization management functions
- hospital data
- claims or encounter data
- the health information line
- pharmacy data
- hospital discharge planners
- other internal departments
- providers and members

Case Managers monitor and facilitate the member's care by communicating with the member, member's family and significant others and providers to develop an individualized case management plan including long and short-term goals. Assistance with compliance to the case management plan and access to necessary services is a core function of Physicians Plus' CareEnhance Clinical Management Software (CCMS) system from McKesson.

The **chronic illness** management programs including case management for diabetes and heart and vascular disease are designed to assist at-risk members in achieving their optimal level of health by encouraging self-management skills, facilitating access to available services, and strengthening the patient-provider relationship. The following components are defined and documented for each chronic illness program:

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- Evidence-based care guidelines
- Clinical care management and outreach
- Collaborative practice models
- Informed decision making
- Outcomes measurement

If there is a potential need or benefit of Case Management, please contact a Physicians Plus Case Manager at (608) 282-8900 or 1-800-545-5015 for assistance in coordinating care or services for your Physicians Plus patient.

NursePlus

NursePlus is a 24-hour, seven-day-a-week member resource for professional support from a registered nurse. This service is available to Physicians Plus members and accessible through a toll-free phone call to 866-PPLUSRN (866-775-8776). Members also have the option to send a secure message from the Physicians Plus website to NursePlus and receive an email reply within 24 hours.

Members are urged to contact NursePlus with any medical questions when they are unable to reach their physician or physician's office staff. Available any time, NursePlus nurses use world-class clinical guidelines to provide advice regarding medical problems/questions and also help callers access the recorded health information available from an Audio Health Library.

When your patients connect to NursePlus, a Medical Service Representative greets them, determines their reason for calling and immediately forwards the call to a registered triage nurse or into the Audio Health Library system. If the member has concerns about a medical situation, the triage nurse collects a brief health history, asks specific questions that help in assessing the problem and may recommend care options. Depending on the situation, nurses may advise members to hang up and dial 911 immediately, to proceed promptly to an immediate care facility or to schedule an appointment with their primary care physician (PCP). In other cases, nurses may simply answer questions or provide home care guidelines.

When the call ends, NursePlus faxes a Triage Encounter Document (a transcript/record of a member's call) to the office of the member's PCP. This helps ensure continuity of care and informs the PCP of any treatment advice a patient receives from NursePlus. Please call Physicians Plus Health Services at 608-282-8900 or 800-545-5015 if you have any questions about a patient's NursePlus encounter.

Members should use NursePlus as a supplemental tool to help manage their health, not as a replacement for the patient-PCP relationship.

MobileNurse

Physicians Plus now offers our members MobileNurse — a free smartphone application that can help members make appropriate decisions on what level of care (if any) they need when they or their family get sick.

As you know, health problems can arise at any time, and MobileNurse is a quick and convenient way for users to determine the severity of a sickness and determine the appropriate response. The care guides are medically reviewed and derived from nurse advice line telephone protocols.

Some of the features of MobileNurse include:

- Support available 24 hours a day, 7 days a week
- Quickly determines the severity of sickness
- Determines the appropriate response, and if/when they need to call: their doctor; a nearby Urgent Care center; 9-1-1; or a nearby Emergency Room.
- Teaches users how to relieve symptoms of minor illnesses
- Provides Pediatric Dosage Tables – including easy access to the recommended dosage for common over-the-counter medications.
- Users GPS system in mobile device to locate a nearby medical facility – once facility is selected, all contact information for that facility is displayed, including point-by-point driving directions and estimated drive time to facility.

MobileNurse is now available through the iTunes and Android App store. For more information, visit www.pplusic.com.

MobileNurse is not being marketed as a substitute for consultation with a physician. It is the first of a series of planned mobile tools being planned by Physicians Plus to more actively engage individuals in their health.