



## 2022 Utilization Management Program

Blue Shield of California and Blue Shield of California Life & Health Insurance Company operate a Utilization Management (UM) Program to direct and monitor the appropriateness of healthcare services provided to our plan members. The UM Program evaluates the utilization of services provided to members before, during, and after services are performed. The program coordinates the cooperative participation of members, network hospitals, physicians, and other healthcare providers to deliver a timely and effective program focused on improved outcomes and quality care.

A designated Blue Shield senior-level medical director is actively involved and oversees the development and implementation of the UM Program and its policies and procedures. Actively practicing healthcare providers in Blue Shield networks provide additional input. Blue Shield regional medical directors, medical management managers, care/case management nurses, and non-clinical staff support these providers in sufficient numbers to ensure timely interventions and interactions with providers and members.

At least annually, the statewide Blue Shield Utilization Management Committee reviews, revises, updates, and approves the UM Program's plan, policies, and procedures.

The program ensures that UM decision-making is based solely on appropriateness of care and services, and the existence of benefit coverage. Blue Shield does not reward practitioners, vendors, or other individuals for issuing denials of coverage of care or service. There are no financial incentives for UM decision-makers to encourage decisions that result in underutilization.

Medical decisions are made by qualified individuals, and with the use of criteria that is evidence-based and supported by clinical principles and processes, without undue influence of plan management concerned with Blue Shield's fiscal operation. The UM Program also ensures that contracting physicians are not penalized for authorizing appropriate medical care and referrals.

In some cases, Blue Shield may delegate the implementation of the UM Program to an Independent Practice Association (IPA), medical group (MG) or vendor contracted with Blue Shield. Blue Shield's team of Delegation Oversight nurses monitors the IPA, MG, or vendor to ensure a timely and effective program, consistent with Blue Shield's internal program. Prior to delegation, the IPA/MG or vendor must demonstrate the ability to implement Blue Shield's UM Program.

The Delegation Oversight nurses perform audits and an annual evaluation of the IPA/MG's performance of UM functions, decisions, and operations against accreditation and regulatory standards. These standards include Blue Shield internal standards, the National Committee for Quality Assurance (NCQA) standards (HMO), Centers for Medicare & Medicaid Services (CMS) regulations for Medicare Advantage (HMO), Knox-Keene regulations 1300.70, Health Care Service Plan Quality Assurance Program (Department of Managed Health Care), URAC standards (PPO), and Department of Labor standards, in accordance with Employee Retirement Income Security Act (ERISA).

## Scope

The Blue Shield UM Program includes management and evaluation of care and services in all settings, including doctors' offices and clinics, day surgery centers, hospitals, skilled nursing facilities, rehab centers, and care provided in the home. The program includes activities such as pre-authorization of services; the review of member care while in a facility setting (such as a hospital, a chemical dependency treatment center, a skilled nursing facility, or a rehab center); and a post-service review of care including but not limited to facility, outpatient or office care, and prescription drugs. The program also includes member support through case management of complex medical care, chronic condition management (also called disease management), and the health advocacy program. The UM Program uses care coordination, referrals, and member education to help ensure the members receive medical care at the right time, in the right location, and by the right caregiver for the best clinical outcome and within the benefits available.

UM activities include the following:

- Monitoring and assessing the delivery of care, including review and evaluation of medical necessity and appropriateness, under- and over-utilization of services, continuity and coordination of care, timeliness, cost effectiveness, quality of care and service, and outcomes
- Ensuring that members have access to the appropriate care and service within their health plan benefits that is consistent with accepted standards of medical practice
- Retaining the ultimate responsibility for the determination of medical necessity for Blue Shield members
- Ensuring that denials related to utilization issues are reviewed and handled efficiently according to Blue Shield UM timeliness standards
- Evaluating the effectiveness of the UM Program, utilizing member- and provider-specific data which includes member and provider satisfaction surveys
- Identifying, educating, and managing members with select chronic conditions, promoting increased member participation in disease self-management, improving quality of life for members, and reducing acute exacerbations of their illness
- Through Delegation Oversight, monitoring Independent Physician Associations and medical groups delegated for UM activities and reporting time frames determined by Blue Shield, and conducting regular provider audits with follow-up as needed to ensure continued compliance with Blue Shield standards
- Monitoring performance to ensure qualified healthcare professionals perform all components of the UM Program
- Maintaining a process for a licensed physician to conduct reviews on cases that may not meet medical necessity criteria
- Maintaining a process that promotes UM staff and Blue Shield medical directors' access to appropriate board-certified specialists as needed in determining medical necessity
- Defining and monitoring the process used to avoid conflict of interest by staff reviewers and committee members
- Ensuring the confidentiality of member and provider information

## Staffing

Licensed medical professionals supervise all UM Program activities. The program is supported by a staff of non-licensed employees. These employees perform a variety of non-clinical/administrative functions, such as providing support to the professional clinical staff; data entry; creation of letters, reports, and files; verification of member eligibility and benefits; and serving as the initial point of contact for members and providers for UM activities.

All clinical activities, such as review of care for medical necessity, are performed by a licensed nurse with an active professional United States license, or other appropriate medical professional, such as a physical therapist or pharmacist licensed in California. If the medical professional has any questions about the medical necessity of services to be rendered, or appropriateness of the setting for service based on review criteria and guidelines, the case is forwarded to a Blue Shield medical director for case review. The Blue Shield medical director contacts the attending physician to discuss the case, if necessary. Only a Blue Shield medical director licensed in the state of California is authorized to make a denial for coverage based on medical necessity.

Blue Shield members can call the customer service phone number, or the TTY number, that appears on their Blue Shield member ID card with questions or comments about the UM Program and to ask to speak to a utilization manager, and also to request interpreter services. Members may call during regular business hours. Additionally, messages may be left after hours on a dedicated, confidential voicemail message line, to be reviewed the next business day.

## Confidentiality

Due to the nature of routine UM operations, Blue Shield has implemented policies and procedures to protect and ensure the confidential treatment of personal and health information of our members and privileged medical record information. Upon employment, all Blue Shield employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality. In addition, all UM staff and committee members are required to sign a confidentiality agreement on an annual basis.

A secured password system controls both the Blue Shield UM staff voicemail phone message line for utilization review information and the staff's computer network system.

All faxes are received in digital format and only staff with appropriate credentials have access to ensure medical record confidentiality.

## Goals

The UM Program promotes the delivery of high-quality care in the most cost-effective manner for Blue Shield's members. Supporting this mission, the program:

- Ensures effective and efficient use of appropriate medical services
- Analyzes and reviews data to identify patterns and trends regarding over- and under-utilization of services



- Establishes a process for medical necessity review; care before, during, and after is provided
- Promotes and maintains cost-effective quality care through use of established, evidence-based clinical guidelines
- Promotes early identification, intervention, and referral to the appropriate level of care
- Identifies members with special care needs and facilitates the delivery of appropriate care
- Promotes preventive care and health promotion programs
- Identifies actual and/or potential quality issues during utilization review activities and refers to internal Blue Shield staff for investigation, follow-up, and resolution
- Ensures compliance with accrediting and regulatory agencies
- Recommends and formulates changes in medical policy, guidelines, and procedures as a result of utilization-pattern analysis and industry trends

## Integration with the Quality Oversight Program

The UM Program works together with the Quality Oversight Program. The goals and performance in utilization management are monitored and measured as part of the impact on quality outcomes.

In addition:

- The Blue Shield Utilization Management Committee evaluates and approves the UM Program annually
- The Blue Shield Utilization Management Committee reviews aggregate UM data, satisfaction surveys, member grievances, denials, and appeals

The Blue Shield Utilization Management Committee reports to the Quality Oversight Committee (QOC). The UM staff may identify actual and/or potential quality issues during utilization review activities. These issues are referred to staff dedicated to addressing quality issues for further investigation, follow-up, and resolution.

Recommendations for revisions and improvements are made as deemed necessary. The Blue Shield Quality Oversight Committee updates and approves the UM Program annually.

External reviews of the program are conducted by other agencies, such as the National Committee for Quality Assurance (NCQA) and URAC, the state Department of Managed Health Care (DMHC), and the federal Centers for Medicare & Medicaid Services (CMS). Blue Shield of California is an HMO and PDP plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.