blue california
Promise Health Plan

Policy Title: Data Identification Process for Complex Case Management		POLICY #: 70.2.67 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 2/08	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 3/21**	

PURPOSE

The purpose of this policy is to describe the mechanisms Blue Shield of California Promise Health Plan (Blue Shield Promise) utilizes to identify potential members for referral to Complex Case Management. This process is achieved through multiple data sources identified via specific criteria and categories of disease states. This is in accordance with NCQA Standard Q.I.7, Element "B".

POLICY

The Case Management Department through prospective, concurrent or retrospective review will identify members who have experienced a critical event(s) or diagnosis requiring extensive use of resources needing assistance to facilitate appropriate delivery of care and services to optimize outcomes. The identification process is achieved through multiple data sources. Specific member reports are generated in collaboration with the Blue Shield Promise Health Plan Health Informatics Department. This report is based on the following but not limited to:

- Hospital/SNF Utilization
- Referral Utilization
- Outpatient Utilization
- Age
- Line of Business
- Pharmacy Data
- Costs PMPM

The data sources used to identify members for Complex Case Management is delineated into two types:

- Administrative/Electronic Data
- UM Processes

Electronic identification sources include but not limited to the following:

- Claims Data
- Encounter Data
- Hospital Discharge Data
- Pharmacy Data
- Laboratory Data

UM Management identification sources include but not limited to the following:

- Precertification Data
- Inpatient/Concurrent Review Data
- Prior Authorization Data
- Hospital Data
- QM Referrals
- Member Services Referral
- Providers
- Member or Caregiver

Indicators for Complex Case Management

- Major Organ Transplant
- Major Trauma
- 4 or More Chronic Conditions
- 3 or more Admits within a 12-month period
- Readmission with thirty (30) Days with the Same/Similar Diagnosis/Condition
- Polypharmacy Utilization Consisting of > 30 Prescriptions per Quarter
- Diagnosis of cancer requiring multiple modalities of treatment with complex coordination of care across multiple disciplines

Chronic Conditions

- Diabetes
- Renal Failure
- Hypertension
- Pulmonary: COPD, Pneumonia, Asthma, Respiratory Failure, Pulmonary HTN, Guillain-Barre Syndrome
- Cardiac: CHF, Cardiomyopathy, CAD
- Osteomyelitis
- Rheumatoid Arthritis
- SLE
- Multiple Sclerosis
- Parkinson's Disease
- Cirrhosis of Liver/Chronic Liver Disease
- Pressure Ulcers
- HIV
- Metastatic Cancer

PROCEDURE

1. The Health Information Department generates reports specific to meet requirements to identify members eligible for Complex Case Management as outline above on a monthly basis
2. Pharmacy Data reports will be generated on a quarterly basis.
3. The Chief Medical Officer and Director, Medical Services will complete the following steps:
    a. Review the data reports provided above to determine member's meeting initial selection criteria
    b. Stratify members based on risk/acuity and utilization
    c. Determine level of ambulatory monitoring indicated per member and assign to appropriate Case Management Program.
    d. Evaluate reports for improvements opportunities

e. Meet quarterly with the Health Informatics Department to review Data Report efficacy.

REFERENCES