**BLUE CROSS AND BLUE SHIELD OF ILLINOIS**
**PROCEDURE**

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| **DEPARTMENT: Provider Network Performance** | **POLICY NUMBER: Administrative 71A** | **ORIGINAL EFFECTIVE DATE: 1/1/2009** |
| **POLICY TITLE: Complex Case Management** | | **EFFECTIVE DATE:06/01/2022** |
| | | **LAST REVISION DATE: 06/01/2022** |
| **EXECUTIVE OWNER: DSVP, IL Health Care Delivery** | **BUSINESS OWNER: Manager Clinical Operations** | **LAST REVIEW DATE: 06/01/2022** |

## I. SCOPE

This Procedure applies to the following lines of business and products:

| Line of Business / Product Scope / Plan Scope/Contract Number (if applicable) | In Scope [x] |
|---|---|
| HMO Commercial | X |
| HMO Exchange | X |
| Health Care Delivery QI HMO Commercial | |
| Health Care Delivery QI PPO Commercial | |
| Health Care Delivery QI HMO Exchange | |
| Health Care Delivery QI PPO Exchange | |

## II. PROCEDURE

**Complex Case Management Requirements:**

Members and Primary Care Physicians (PCPs) are to be made aware of the ability to refer to ***Complex Case Management*** (CCM). The IPA will communicate the program using printed materials***,*** but are not limited to, the Member Welcome Letter, PCP newsletters, and/or a web site.

CCM documentation must be maintained in the IPA ***Provider*** Portal. Any IPAs that do not use the IPA ***Provider*** Portal must have prior HMO approval for an alternative process.

A minimum annual average of ***0.15%*** of IPA's total membership must be enrolled in a ***CCM or Tier 2 Condition Management (Asthma or Diabetes) program.*** Annually, IPAs must submit a written Policy & Procedure describing their Complex Case Management (CCM) program with their annual Utilization Management (UM) and Population Health Management (PHM) Plan. This should include, but is not limited to, ***m***ember identification and engagement strategies; and identification of CCM team structure and processes. Physician oversight of the program is required.

The IPA must have a Physician Champion for Case Management who is an Illinois-licensed physician who provides leadership for the Case Management program and promotes the IPA Case Management program within the organization by educating peers and discussing the program's relevance.

Each IPA is required to have a clinician (RN, NP, PA, MD/DO, LCSW, LCPC, Pharmacist, or other professional approved by the HMO) who may be certified in Case Management performing complex case management services. The IPA Case Manager must perform and document at least one monthly bi-directional contact between the member and Case Manager.

**Member Identification and Enrollment**

To assist in the identification of potential CCM Members, the HMO will provide the IPA with an integrated data report showing a list of Members who should be evaluated for CCM. and This list will be posted to the IPA portal and will be updated monthly. The IPA should determine if these Members are clinically appropriate for CCM services.

The IPA can additionally identify Members for CCM using data obtained from PCP and/or Member self- referrals, hospital discharge data, utilization management activities and claims/encounter information. The IPA uploads their referral report to the IPA portal monthly.

Candidates for CCM are identified on a monthly basis, by utilizing the following sources:

- BCBS HMO integrated data report which includes:
  - Medical, behavioral, pharmacy claims and encounter data
  - Lab results from LOINC[1] code data
  - Health Appraisal results
- IPA-identified referrals which include:
  - Medical management program referral:
  - UM/Condition Mgmt./Health Information Line referral)
  - IPA Discharge planner referral;
  - Member or Caregiver referral; and
  - IPA Practitioner referral.

**HMO Monthly Oversight**

The HMO ***Clinical Delegation Coordinator (CDC)*** will provide monthly oversight of CCM cases and determine if they are appropriately stratified into CCM based on current year CCM guidelines and requirements.

The IPA must document required elements in the BCBSIL HMO IPA ***Provider*** Portal database.

An Initial Assessment (IA) must be initiated within 30 days and completed within 60 days of determined member eligibility. Over a two-week period, the IPA must attempt to contact the ***m***ember at least three times, at varying times of the day, through at least two of the following contact mechanisms: ***T***elephone, regular mail, email, or fax to begin the IA. The case should be closed if unable to contact the member after three unsuccessful attempts within the two-week timeframe within the first thirty-day eligibility period.

Required elements for the IA are documented in the Utilization Management Plan.

[1] Logical Observation Identifiers Names and ***Codes*** (***LOINC***®) is clinical terminology that is important for laboratory test orders and results and is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information. https://www.mayocliniclabs.com/test-catalog/appendix/loinc-codes.html

Members may decline participation or opt-out of CCM services at any point in time, and this date must be documented in the BCBSIL HMO IPA ***Provider*** Portal.

1. The IPA case manager must develop a case management plan in collaboration with the ***m***ember and PCP or BH Specialist which includes:
    a. Prioritized goals (at least two being medical or mental health-related and one-member self-management goal).
    b. PCP and/or BH Specialist approval for all active goals upon enrollment and every six months thereafter.
    c. Documentation of timeframes for goals to be met, revision, or completion dates, when applicable.
    d. Development and communication of a self-management plan must be documented.
2. IPA must perform and document monthly member contact between the ***m***ember and Case Manager which meets the following criteria:
    a. Monthly contact clearly documented as a contact between the ***m***ember and ***C***ase manager.
    b. Contact can be face-to-face or telephonic but must be bi-directional. Voicemail and e-mail are NOT considered bi-directional.
    c. Documentation of ***m***ember contact with identified ***m***ember ID, date, time, and duration of meeting to confirm the contact.
    d. Documentation of assessment of barriers to existing goals (including environmental barriers).
    e. Documentation of the three-member centric goals relating to member's specific current needs. Goals must be prioritized, numbered, attainable, measurable, current, reviewed and revised before the expiration date and consider member and caregiver preferences and desired involvement;
    f. Documentation of member progress toward meeting goals with each member contact. Achievement of goals, revision of goals or goal dates, if applicable.
    g. Revision of goals or goal dates, if applicable
    h. Documentation of progress towards self-management
    i. A schedule for follow-up and communication with the Member, including the date for the next contact.
3. Members enrolled in CCM must have at least one face-to-face visit with the PCP or a specialist every six months.
4. The ***m***ember must be notified if their case is being closed and this must be documented in the member CCM file.
5. The HMO will conduct quarterly CCM surveys for all ***m***embers discharged during that quarter and who were continuously enrolled in the Complex Case Management (CCM) program for 60 days or more. IPAs will be required to present the CCM Survey results to their IPA UM ***c***ommittee ***m***eeting annually.
6. Oversight of the IPA CCM process will be performed on an ongoing basis and scored as a part of the case file review portion of the Population Health Management Adherence Audit

## III. CONTROLS/MONITORING

| Line of Business and/or Area | Control Requirements |
|---|---|
| HMO | Controls are detailed in the Policy itself. |

## IV. PROCEDURE REVIEWERS

| Person Responsible for Review | Title | Date of Review |
|---|---|---|
| Deidre Meyers | Clinical Delegation Coordinator | 05/10/2022 |
| | | |

## V. PROCEDURE REVISION HISTORY

| Description of Changes | Revision Date |
|---|---|
| Percentage of member enrollment in CCM per IPA changed, Nurse Liaison title change to Clinical Delegation Coordinator, grammar changes | 05/10/2022 |
| | |

## VI. PROCEDURE APPROVALS

| Company, Division, Department and/or Committee | By: Name | Title | Approval date |
|---|---|---|---|
| BCBSIL P&P | | | 5/26/2022 |
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## VII. PROCEDURE ATTACHMENTS / ADDITIONAL INFORMATION

# APPENDIX A

Assessment and evaluation each require the case manager or other qualified individual to draw and document a conclusion about data or information that has been collected. The process for collecting information and summarizing its meaning or implications with regard to the Member's situation is performed in the Initial Assessment (IA) so the information can be used to formulate the Member case management plan.

IPA Complex Case Management Requirements

I. Initial Assessment

The Initial Assessment (IA), documented in the HMO Provider Portal, must include the following:

a) Document the date the member's eligibility for CCM was determined. The eligibility date is the date the member was identified by either data or referral source. The IA must be initiated within 30 days of eligibility;

b) Document the date the Initial Assessment was completed. The IA must be completed within 60 days of eligibility/identification. If the Initial Assessment is initiated greater than 30 days after eligibility, user must attest that the information is current and complete;

c) If an IA is not initiated within 30 days after member is determined by the IPA to be eligible for CCM, the IPA must demonstrate they attempted to contact the member at least three times over a two-week period within the first 30 days of eligibility, to complete the Initial Assessment. Case should be closed if unable to contact the member after three attempts are documented;

d) Document the following required elements for the Initial Assessment:

1. Initial assessment of the member's health status and condition specific issues (including the Case Managers conclusion regarding the members health status and the members self-reported health status);
2. Diagnoses – acute and chronic conditions;
3. Procedures – historical and current, including inpatient stays, or document "none";
4. Current status of diagnoses documented, include mental health and/or Substance Use Disorder diagnoses;
5. Clinical and treatment history – include disease onset, history from the onset of the condition(s) leading to the current health status;
6. Medications including dosage, schedule and history of discontinued medications;
7. Ability and/or barriers to perform activities of daily living including, at minimum, the following assessment: bathing, hygiene, dressing, toileting, transferring or functional mobility and eating; If a member needs assistance with any ADL, the documentation must describe the type of assistance and reason for the need for assistance.
8. Current mental health status including any mental health conditions or substance use disorders.

9. Assessment of cognitive functioning including the member's ability to communicate and understand instructions and the member's ability to process information about an illness;
10. Language Assessment including primary language member uses to communicate;
11. Assessment of Cultural Preferences and cultural health beliefs or practices or limitations. Documentation must identify potential barriers to effective communication or care and acceptability of specific treatments;
12. Assessment of Behavioral Health status. Assess if the member with Behavioral Health/SUD diagnosis has signed a Release of Information allowing communication Initial Assessment between the PCP and Behavioral Health Specialist;
13. Initial assessment of Social Determinants of Health (housing, housing security, access to food markets, exposure to crime/violence, personal safety, discrimination, access to media, social support, access to transportation and/or financial barriers, economic stability, education) and their potential impact on the member's ability to meet their goals;
14. Assessment of life planning activities and documentation of collaboration with PCP if appropriate. If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason.
15. Documentation of hearing or vision limitations and identification of potential barriers to care, or "no limitations";
16. Evaluation of linguistic needs or preferences including health literacy. Documentation must include specific needs to include in the case management plan and barriers to effective communication of care.
17. Evaluation of the adequacy of caregiver resources, involvement, and understanding of care plan. Documentation must describe the resources in place, whether they are sufficient for the member's needs, and note any specific gaps to address.
18. Documentation of benefits, and benefit limitations including an assessment of the adequacy of the member's benefits to fulfill the treatment plan (Available benefits must be specific and adequate to meet the member needs and documentation must state member's understanding of the benefit). Example: member with a diagnosis of acute CVA with secondary hemiplegia. Documentation of available benefits should reference whether the member's benefits cover the required treatments and prescriptions. 60-session limitation of PT/OT and ST per calendar year. Documentation must state that the member is aware of this;
19. Documentation must include the case manager's evaluation of the member's eligibility for community resources, the availability of those resources and

which resources the member may need. At minimum, the following community resources must be assessed: community mental health programs, transportation, wellness programs, nutritional support and palliative care programs; (ex.- Meals on wheels, township services, legal aid), or not (document reason if not needed);

20. Assessment of life planning activities; and
21. Member self-management plan. The member self- management plan is verbally communicated to and agreed upon by the member.