BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual - Disease Management Programs, Case Management Program and Clinical Practice Guidelines

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health.** These specific requirements will be noted with the plan/network name. If a plan/ network name is not specifically listed or the "**Plan**" is referenced, the information will apply to **all** HMO products.

In this Section

The following topics are covered in this section:

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Disease Management Programs, Case Management Program and Clinical Practice Guidelines

Capitated Medical Groups - Important Note

Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and prior authorization processes, contracting, and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/ affiliated with a capitated Medical Group are subject to that entity's procedures and requirements for the Plan's provider complaint resolution.

Condition Management/ Disease Management Program Overview

The Blue Cross and Blue Shield of Texas (BCBSTX) **Plans'** Disease Management Program provides chronically ill **Plan** members with the resources to remain healthy and maintain their quality of life. The program is available to members diagnosed with asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease and cardiovascular condition clusters, diabetes, low back pain, metabolic syndrome, oncology, weight management, and/or those who need assistance with tobacco cessation. Member enrollment is voluntary; candidates are identified through continuous recruitment.

The **Plan** takes a comprehensive approach to Condition Management by involving the member, the Plan and the attending physician in the education and counseling process. The **Plan** will notify physicians in writing of their patients' enrollment in the program and provide periodic updates on member progress as needed. When appropriate, the **Plan** will notify physicians of changes in their patients' health status and encourage patients to maintain open communication with their physician.

Program Goals – Condition Management/ Disease Management Program

The **Plans** have established the following goals for the Disease Management Program:

- Enhance member self-management skills
- Reduce intensity and frequency of disease-related symptoms
- Enhance member quality of life, satisfaction, and functional status
- Improve member adherence to the physician's treatment plan
- Improve communication among member, physician, and health plan

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Disease Management Programs, Case Management Program and Clinical Practice Guidelines

Program Goals – Condition Management/ Disease Management Program, cont.	• Facilitate appropriate health care resource utilization • Reduce avoidable hospitalizations, emergency room visits, and associated costs related to the disease; and reduce work absenteeism and medical claim costs • Enhance member closure of condition specific gaps in care
Condition Management/ Disease Management Program and Compliance	Periodic assessments are conducted to identify diseases that have a significant impact on members. To identify members appropriate for disease management, risk stratification is performed using pharmacy, lab and medical claims as well as the predictive modeling tool. Based on stratification results, targeted interventions are offered to address members' levels of disease severity. Members with mild severity may receive educational materials and other self-management tools to support their physician's treatment plan. Each member with the condition receives a seasonal mailer and an outbound call. Members with a moderate or severe condition are eligible for extended program components. The staff coordinates all chronic condition participant services and collaborates with specialty staff to ensure continuity and coordination of care for those members with a moderate or severe condition. The focus of the condition management program includes the management of chronic conditions; Asthma, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) and Cardiovascular Condition Clusters, Diabetes, Low Back Pain and Oncology. A hierarchy is used to determine which of multiple conditions a member is experiencing has the highest priority to include the management and support of comorbid conditions. In addition, the staff has experience and processes in place to manage chronic conditions, such as hypertension, metabolic syndrome, cancer and oncology related diagnosis, migraine headaches, gastroesophageal reflux disease and osteoarthritis.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Disease Management Programs, Case Management Program and Clinical Practice Guidelines

Physician Integration/ Collaboration

The Blue Care Connection program plan of care is designed to support the physician's treatment plan. The physician may be contacted by the clinician and/or Plan medical director for clinician to clinician consultation as follows:

- Clarification of the member's treatment plan including open gaps in care;
- Clarification of medications;
- Member is non-compliant with treatment;
- There are concerns related to member safety and/or quality issues;
- Behavior or lifestyle is detrimental to the condition being managed;
- Clinician cannot reach the member and has information that could be vital to share with the provider.

Blue Care Connection resources can help a member plan and manage their health, but does not replace the care of a physician. The intent of the physician collaboration is to alert the physician to gaps in health care and outreach to the physician to involve them in facilitating condition specific gap closure. The physician collaboration is designed to respect the physician's knowledge and strengthen the relationship between the physician and their member.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Disease Management Programs, Case Management Program and Clinical Practice Guidelines

Gap Closure

Gap closure focuses on showing improvement in the member's care through engaging them and their physician in better management of health outcomes. The clinical staff can identify opportunities from claims data that a physician may not be able to identify during a normal office visit. To identify gap closure and health improvement opportunities, the clinician researches a member's claims history through review of claims history available in the medical management system platform. Gap closures and health improvement opportunities may include the following:

- **Diabetes**
  - No physician office visit in 6 months
  - No HbA1C in the past 12 months
  - No low density lipoprotein in the past 12 months
  - No microalbuminura in the past 12 months
  - No ACE inhibitor or ARB in the past 6 months for diabetes with hypertension
- **Asthma**
  - Not on controller medications
- **Chronic Obstructive Pulmonary Disease (COPD)**
  - Bronchodilator adherence
- **Congestive Heart Failure (CHF)**
  - No physician office visit in the past 6 months
- **Coronary Artery Disease (CAD) and Cardiovascular Condition Clusters**
  - No low density lipoprotein in the past 12 months
- **Low Back Pain**
  - No evidence of medication adherence or compliance with therapy

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Disease Management Programs, Case Management Program and Clinical Practice Guidelines

Case Management Program Overview and Compliance

Complex Case Management Programs focus on the highest risk population with late stage chronic or catastrophic conditions such as: transplants, major trauma, rare diseases, and end of life issues. The Utilization Management and Blue Care Connection staff members are trained on medical events that may trigger a referral to complex Case Management.

Care Coordination and Early Intervention Program is a transition of care model that fosters clinical improvement. The program provides pre-admission, inpatient, and post-discharge outreach designed to provide educational and safety support to members having an admission for a targeted diagnosis or procedure code that has been identified as having a high potential for readmission and/or post discharge complications. The program focus is to reduce readmissions, emergency room visits, and improve member health outcomes.

NICU. The NICU program is administered internally by specialty R.N.s along with an assigned neonatologist. The assigned specialist is not an employee of BCBSTX, but is a credentialed, practicing specialist. The focus of the programs is on enhancing and supporting the physician's treatment plan and on assisting the member with navigation through the medical care system while maximizing their benefit dollars.

Program components include the following:

- Weekly telephonic case review with the Plan medical director, an assigned neonatologist, and the NICU R.N.
- Ongoing telephonic contact between the Plan medical director and the attending neonatologist to discuss the appropriate level of care and treatment
- Coordination of home health and DME
- Social service support for assistance in addressing barriers to discharge

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Disease Management Programs, Case Management Program and Clinical Practice Guidelines

Outcome Measures	The Case Management Program meets state regulatory requirements for case management. Standard reports are produced periodically and summarize: • Resource utilization • Goals met • Overall member satisfaction • Quality of life and functional status

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Disease Management Programs, Case Management Program and Clinical Practice Guidelines

Women and Family Health

Childbirth-related expenses have become one of the largest components of health care costs today. To maintain costs and to assist female members in achieving healthy pregnancy outcomes, BCBSTX offers the Maternity/Fertility program to **Plan** members.

Whether you are pregnant or planning to get pregnant, BCBSTX provides the following resources:

- Ovia Health™ apps feature health trackers and provide videos, tips, coaching and more.
- Well onTarget® has self-management programs about pregnancy that members can take online, covering topics such as healthy foods, body changes and labor.

Our maternity specialists will support members by phone from early pregnancy until six weeks after delivery if your pregnancy is high-risk.

Note: *To ensure* ***Plan*** *members have the opportunity to participate in these programs, physicians must contact the* ***Medical Care Management Department*** *at* ***1-800-441-9188*** *or access Availity Authorizations & Referrals immediately, with notification of any pregnancy for their* ***Plan*** *members. Members may also call* ***1-888-421-7781*** *directly to enroll.*

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Disease Management Programs, Case Management Program and Clinical Practice Guidelines

Clinical Practice Guidelines Overview

Clinical Practice Guidelines will be reviewed and revised annually as appropriate. Guidelines may be reevaluated and updated more frequently, depending on the availability of additional data and information relating to the guideline topic.

Clinical Practice Guidelines are reviewed and adopted as the foundation for its Disease Management Programs, quality initiative and provider tools. The guidelines are based upon nationally recognized clinical expert panels, and are available to assist Physicians in clinical practice.

Preventive Care Guidelines

Promotion of preventive health is a major objective of the BCBSTX Quality Improvement Program. The Adult, Infant, Child and Adolescent, and Prenatal Wellness Guidelines have been adopted by BCBSTX and are provided to **Plan** members. The Wellness Guidelines are available on the BCBSTX Provider website under Clinical Resources: http://www.bcbstx.com/provider/clinical/tx_preventivecare.html

Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are also available for asthma, cardiovascular disease, chronic kidney disease, COPD, diabetes mellitus and heart failure. To assist in member education, these guidelines are available to Physicians by calling the Disease Management Department at **1-800-462-3275**, or you may access the guideline references on the BCBSTX Provider website under Clinical Resources: http://www.bcbstx.com/provider/clinical/cpg.html