

Quality Assurance

Our Medicare Advantage Plans have a number of programs designed to help ensure that our members receive appropriate health care that meets their needs.

Medical Utilization Management Programs

Members of our professional medical staff will review some of the medical care proposed by your doctors to determine whether it meets criteria for covered health care benefits as defined in your Evidence of Coverage and by applicable Medicare and Anthem guidelines.

Additionally, our staff may help you coordinate your care in order to maximize your benefits and help you access the care you need. These activities are called “utilization management.” For our Medicare Advantage plans, our Utilization Management (UM) programs include:

- Preadmission Certification
- Concurrent Review and
- Case Management.

Preadmission Certification

Preadmission certification is the process of obtaining approval in advance of care. Advance approval may be necessary to receive coverage for certain medical care, such as non-emergency hospital admissions, outpatient tests, outpatient surgery, visits to specialists, home health visits, or nursing home admissions.

Your primary care physician plays a central role in this process. Your physician may request preadmission certification from our precertification department by calling, faxing, or mailing the request to us. One of our precertification nurses will then review the diagnosis and procedures for medical appropriateness under the terms of your coverage.

If the nurse can certify the service, the request will be authorized. If the service cannot be initially certified, the nurse will refer your physician’s request to one of our physician reviewers for a decision. The physician reviewer may consult with your physician during the review process.

Our precertification decisions are made using Medicare coverage criteria and guidelines. In addition, we use nationally recognized clinical guidelines, such as Milliman Care Guidelines, for medical necessity review, as well as internally developed clinical criteria. The Medicare guidelines, national clinical guidelines, and internally developed criteria are available to physicians upon request for specific precertification decisions.

Concurrent Review

Our Utilization Management staff monitors hospital care during an inpatient stay. This is designed to help make sure that our members receive care that is medically necessary, as defined in their Evidence of Coverage.

During the concurrent review process, the nurse may review patient charts and conduct face-to-face interviews with the patient (if appropriate), family members (if available) and hospital staff. Concurrent review also facilitates discharge planning for the member. In addition, the nurse may help arrange post-hospital care, including help with nursing home placement, home health care, and obtaining durable medical equipment.

Case Management

Case management is a collaborative process between the member, the member's physician(s) and other individuals involved in the member's care. Case management works to assess, develop, implement, coordinate, monitor and evaluate plans designed to optimize the member's health care benefits.

Through phone calls and written communication, the case manager empowers the member to exercise benefit options appropriate for the member's individual health needs. The Case Managers help the primary care physician coordinate benefits and care for members with complex and serious medical conditions.

A Case Manager:

- Collects and analyzes data about actual and potential member benefit needs, to help develop a case management plan. This is accomplished through interaction with the provider(s) and family members.
- Makes an assessment by gathering not only benefit information, but also information about cognitive status, medication management, social support, nutritional status, emotional status, and environmental and care access issues.
- Develops a case management plan in collaboration with the member and provider and specifies individualized goals and interventions to meet the needs of the member based on the member's benefits.
- Monitors the interventions to ensure that the case management plan is effective and to determine whether revisions or modifications are needed. Evaluation is ongoing during the coordination and monitoring phases to determine whether the plan is being implemented and if desired outcomes are being achieved.

Case management seeks to contribute to the optimal health, function, coverage and satisfaction of our members.