8 Integrated Health Management

Description This chapter provides an overview of Integrated Health Management, which offers products, programs, and services designed to help members take a more active role in managing their overall health, while supporting safe, high quality care.

Topics

Provider Portal Resources

- You can find comprehensive information about these programs under Health Management in the online Library, as well as all Care Management contact information.
- Medical Policies are available in the Library under Reference Info.
- All Care Management forms can be found in the online Library under Provider Forms.
- Prospective Review tool at premera.com/provider (under Utilization Review) tells you if medical necessity review is recommended for a specific service or procedure.
- Pharmacy information and resources are located at premera.com/pharmacy.

Section 1: Care Management Program

Overview

The Premera Care Management program is designed to work in collaboration with physicians and providers to offer admission notification, pre-admission screening, re-admission prevention, complex case management and Utilization Management (UM), to provide members with peace of mind.

Integrated Case Management

Integrated Case Management provides effective assistance for your patients who are experiencing health complexity resulting from acute or chronic medical or mental health conditions including, substance use disorders, inadequate social support, and/or limited or poorly coordinated access to healthcare services.

Our case managers partner with patients, their caregivers and providers to identify and eliminate clinical and non-clinical barriers to optimal health. Case Management interventions support the provider-patient relationship, identify and facilitate removal of barriers to good self-management and promote adherence to the prescribed treatment plan.

Referrals to or questions about our Integrated Case Management program can be made by calling 888-742-1479 Monday – Friday 8 a.m. to 7 p.m. PST or by faxing the following information to 877-468-7377:

- Patient (Premera member) name
- Premera ID number and suffix
- Telephone number and contact name if contact is not the member
- Reason for the referral

Care Transition Management

Care Transition Management interventions are designed to support patients during the transitions from home to hospital and hospital to home through:

- Preadmission patient outreach to patients undergoing targeted elective procedures to verify understanding of preadmission orders and post-discharge support at home
- Outreach to assist facilities with discharge planning for serious illness or injury that may require intensive follow-up care
- Post-discharge patient outreach to identify barriers to optimal recovery, promote treatment adherence, and encourage recommended follow-up care
- Assessment for and referral to Case and Disease Management when needed

Disease Management

Condition support is available to eligible health plan members with one or more of the following conditions:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary artery disease
- Diabetes
- Heart failure

Participant identification is based on claims data or healthcare provider referral. High-risk patients are offered an opportunity to participate in regular pre-scheduled phone calls from a personal health support coach.

For referrals or questions about our Disease Management program call 877-342-5258, option 6, Monday – Friday 8 a.m. to 7 p.m. PST or fax the following information to 888-742-1486:

- Patient (Premera member) name
- Premera ID number and suffix
- Telephone number and contact name if contact is not the member
- Reason for the referral

Section 2: Medical Review Criteria

Overview

Medical policies are developed to assist Premera staff in managing over, under, and inappropriate utilization of healthcare services, and to establish coverage for new and developing medical and behavior health procedures, devices and pharmaceutical agents. We use these policies as guidelines to evaluate the medical necessity of particular service or treatment or to determine if they are investigational or experimental.

Provider Portal Resources

Medical policies are available at premera.com/provider; click on Medical Policies under Reference Info. If you would like a copy of a particular medical policy and are unable to obtain it online, email your request to medicalpolicy@premera.com.

Medical Policy Development

Many of our policies are adopted from policies approved by the Blue Cross Blue Shield Association's (BCBSA) Medical Policy Panel (MPP). The MPP is composed of medical directors representing 37 Blue Cross and/or Blue Shield plans across the United States.

Premera makes its own determinations whether to adopt the national medical policies and may make changes to represent regional variations in practice when appropriate. We also develop unique policies as needed.

A corporate Medical Policy Committee composed of licensed physicians and nurses meets regularly to adopt and update all policies. Policies are reviewed and updated annually or more frequently if new relevant studies are published.

The following sources of information are used in developing and updating medical policies:

- BCBSA Medical Policy Reference Manual
- BCBSA Technology Evaluation Center Assessments and other national sources of technology assessments (including AHRQ)
- Hayes, Inc. (Knowledge Center and Technology Assessment Services)
- Published, credible scientific evidence in peer-reviewed medical literature
- Milliman Care Guidelines
- National guidelines developed by medical specialty organizations
- Independent external advisory groups
- Practicing physician input
- Independent Review Organization materials

Premera polices are also informed by practicing physicians who participate in our Pharmacy and Therapeutics Committee, our Oncology Advisory Panel, our regional physician advisory committees, and contracted local practitioners. All policies are published on our external website.

We notify contracted physicians and providers of any medical policy change at least 90 days prior to the effective date of the policy. This notification generally takes place through publication in our *Network News* newsletter, and occasionally notifications are sent by direct mail.

When there are differences between the member's contract and medical policy, the member's contract prevails. The existence of a medical policy regarding a specific service or treatment does not guarantee that the member's contract covers that service.

A contracted physician or provider can request specific criteria related to a medical decision for his/ her patient. To request a copy of the criteria, contact Care Management.

Definitions of Contract Terminology

Medical Necessity

Medical necessity is a term used in health plan contracts to describe services that will be covered. The following definition is used in most of our contracts: those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that meet all of the following criterion:

- In accordance with "generally accepted standards of medical practice"**
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician, or other healthcare provider
- Not more costly than alternative services or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

** For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Experimental and Investigational Services

This term is used in healthcare coverage plan contracts to describe which services are likely to be excluded from coverage. Most of our contracts use the following language: Experimental and/or investigational services may include a treatment, procedure, equipment, drug, drug usage, medical device or supply which meets one or more of the following criteria as determined by Premera:

- The U.S. Food and Drug Administration has not granted approval (on the date of service) for a drug or device that cannot be lawfully marketed without its approval.
- Reliable scientific-based evidence does not demonstrate effectiveness of the service nor does it define a specific role for the service in clinical evaluation, management or treatment of the member.
- Credible scientific-based evidence does not demonstrate effectiveness of the drug or device with or without FDA approval.
- The service is subject to oversight by an Institutional Review Board.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or effectiveness.
- Evaluation of credible scientific-based evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable scientific-based evidence includes, but is not limited to, published randomized controlled trials, case reports and articles in peer reviewed medical and scientific literature, and BCBSA Technology Evaluation Center assessments. Member contract language may vary in defining what is considered experimental and investigational.

Note: The fact that services were furnished, prescribed, or approved by a physician or other qualified practitioner does not in and of itself mean that the covered services were medically necessary.

Access to Review Criteria

Distribution of Medical Necessity Criteria to Physicians and Providers

Physician and nurse reviewers at Premera apply a variety of criteria to assist in the determination of medical necessity. The following medical necessity criteria are available to contracted physicians and providers upon request:

- Company Medical Policy
- Milliman Care Guidelines
- American Society of Addiction Medicine (ASAM) Guidelines for Chemical Dependency
- Durable Medical Equipment Regional Carriers (DMERC).

A contracted physician or provider can request specific criteria related to a medical decision for his/her patient. To request a copy of the criteria, contact the Care Management department at 877-342-5258, option 3. Copies of individual medical policies are available at premera.com/medicalpolicies or email medicalpolicy@premera.com.

Peer to Peer Conversation

Coverage decisions are based on standards of care and medical necessity. Providers who receive an adverse decision (denial) related to clinical review for medical necessity or experimental/investigational status can discuss the decision with a physician reviewer. The request may be made by calling 877-835-5672 within seven days of the decision to ensure timely discussion.

Requestors must provide the name of the member, member ID, and specific services that were denied. Our Medical Services Department will arrange for a conference call between the requesting provider and a plan medical director. The phone conversation will not necessarily be with a peer matched specialty reviewer. This discussion does not represent an appeal.

Utilization Management Disclosures

All requests for coverage of services that do not appear to meet medical necessity criteria are reviewed initially by a clinician (nurse or behavioral health specialist). If the service does not meet medical necessity criteria, or if it is considered experimental/investigational, the case is referred to a Premera physician for review. A physician is the final arbitrator of any denials based on medical necessity or experimental/investigational status.

Ensuring Appropriate Service and Coverage

We are committed to covering our members' care and encourage appropriate use of healthcare services. Physicians, providers and Premera staff who make utilization-related decisions must comply with the following policy statement:

- Utilization management decisions are based on appropriateness of care and services, and existence of coverage.
- We do not compensate physicians, providers or other individuals conducting utilization review for denials of coverage or services.
- We do not provide financial incentives for utilization management decision-makers to encourage denials of coverage or services.

Provider Portal Resources

Providers can significantly improve claims payment timeliness by following the Prospective Review recommendations available at premera.com/provider (under Utilization Review). Simply enter the date of service and procedure code to determine if a medical necessity review is recommended.

Section 3: Clinical Review

Overview

Clinical Review activities support medical quality and encourage cost-conscious action through collaboration with Premera internal departments and external organizations. Clinical Review includes utilization review activities for prospective, concurrent, and retrospective review of inpatient and outpatient medical and behavioral healthcare and services, ancillary and alternative care and treatments, and pharmaceutical products and services.

Member Protected Personal Information

Our confidentiality policy protects the confidentiality and privacy of our members' protected personal and medical information by preventing the unauthorized use and disclosure of such information by our associates and business associates.

Protected Personal Information

We are committed to maintaining the confidentiality of individuals' protected personal health and financial information (collectively referred to as "protected personal information" or PPI). Premera collects, uses, and discloses PPI solely for routine business functions as required or permitted by law or regulation. We strictly prohibit the unauthorized disclosure of PPI by our associates and business associates, unless we have first obtained the member's written authorization.

We understand that you value standards of confidentiality as a healthcare professional. As a contracted physician or provider, you are required to maintain the confidentiality of all PPI concerning any current or former patients (our members). In addition, you are also bound to observe certain state and federal privacy laws. At a minimum, each clinic should have each staff member sign a confidentiality statement upon employment in which the employee acknowledges the importance of maintaining the confidentiality of PPI. This is a Premera office site standard used in our credentialing and recredentialing process.

Release of Medical and Clinical Records

The "authorization for treatment" that you obtain from Premera members prior to rendering services, authorizes you to disclose general health information to us. The validity of such an "authorization for treatment" is not limited to 90 days, and such disclosures do not need to be documented in the member's medical chart. State and federal privacy laws allow physicians and providers to disclose PPI to Premera without the patient's authorization for payment purposes and healthcare operations such as:

- Determining eligibility
- Paying claims
- Coordinating benefits with other insurance carriers
- Utilization and medical necessity reviews
- Healthcare operations activities (e.g., case and care management, quality reviews)

Protected Personal Information

Any and all information created or received by the company that identifies or can readily be associated with the identity of an individual, whether oral or recorded in any form or medium, that directly relates to the:

- Past, present or future physical, mental or behavioral health or condition of an individual
- Past, present or future payment for the provision of healthcare to an individual
- Past, present or future finances of an individual, including, without limitation, an individual's name, address, telephone number, Social Security Number, subscriber number or wage information.

Routine Business Function
Any activity undertaken by the company, or by a business associate on behalf of the company, for healthcare operations and payment activities, including, but not limited to:

- Carrying out the management functions of the company, including, but not limited to, underwriting, actuarial, care management, case management and quality reviews
- Obtaining subscription charges or
- Determining or fulfilling its responsibility for coverage under the health plan and for the provision of benefits under the health plan, including, but not limited to, member benefit eligibility, payment of member claims, customer service, and coordination of member benefits.

Medical Records Requests

Occasionally, we request medical records to help us make a determination or to process a claim. We need to receive copies of medical records within the timeframe specified in our request for the following reasons:

- A provider or member appeals the decision and more information is needed to support the request.
- A claim is rebilled with different diagnosis/procedure code (e.g., CPT, HCPCS, ICD-9) or date-of-service (not required if year is accidentally keyed incorrectly).
- A procedure requires Medical Director review.
- A determination of a pre-existing condition.

When responding by mail to a medical records request, include only those records specified in the request

- Include a copy of the original request, noting the:
  - ✓ Member's name
  - ✓ Date the medical records were requested
  - ✓ Name and mailstop (MS) of the associate requesting the records
- Enclose your "Copying Fee" invoice* (can be on your letterhead) that includes:
  - ✓ Physician or provider and clinic name and address
  - ✓ Member's name and ID number
  - ✓ Number of pages copied at 25 cents per page
  - ✓ Total pages and cost
- Records may be transmitted via fax to the fax number noted in the request.

Premera reimburses a "reasonable fee" of 25 cents per page for medical record copies necessary to perform appropriate medical necessity determinations and/or prospective reviews.

There is no reimbursement for copies when the medical record information is:

- Necessary to adjudicate appropriate claims payment
- Required to perform due diligence in the resolution of a quality of care issue
- Required in resolving a member's complaint, appeal or grievance

Quality Review
The terms of the Practitioner Agreement address cooperation with health plan requests for copies of medical records needed to evaluate quality of care or in response to other quality auditing activities. When we request this type of data, we routinely notify medical offices five to 10 business days prior to the review. Practitioner reimbursement is not provided for patient records requested for quality purposes.

Note: For Utilization Management reviews, when we request copies of a member's medical record, reimbursement is 25 cents per page, and only for those records specified in the request letter. We do not reimburse for records sent beyond the scope of the request letter.

Utilization Review Activities

Clinical review includes prospective, concurrent and retrospective components.

Admission Notification

Hospitals routinely notify Premera of all inpatient admissions, which allows us to verify benefits, link members to other programs and assess the need for case management. Some plans may be subject to prior authorization. Please refer to back of member ID card.

Services requiring admission notification:

- Inpatient admissions – Non-emergent, elective or scheduled admissions (including mental health and chemical dependency)
- Skilled nursing facility and acute rehabilitation admissions
- Acute care hospitals
- Inpatient hospice
- Behavioral health and chemical dependency, residential treatment centers and intensive outpatient treatment centers (IOP)

Admission notification policies and procedures:

- Premera should be notified of urgent/emergent admissions within 48 hours of the admission.
- Maternity admissions related to delivery do not require admission notification for the first 48 hours for vaginal delivery or the first 96 hours for C-section. Inpatient stays beyond the first 48 hours for vaginal delivery or the first 96 hours for C-section require admission notification.
- Other elective/scheduled admissions should complete the admission notification process prior to admission.
- Policies DO NOT apply to members covered by Medicare Supplement.

Submit Admission Notification:

- By fax: Submit Admission Notification Request
- By phone: 877-342-5258**,** option 3

Benefit Level Exception

Sometimes it is reasonable for a member to receive services from a provider or facility not in his/her network. Depending on the member's contract provisions, out-of-network services may be covered at a lower rate, or not at all. A benefit level exception is a request for services to be paid at in-network level for an out-of-network provider and must be requested **prior** to the service. If the request meets the criteria, Premera may allow out-of-network services to be reimbursed at the member's in-network benefit level.

Concurrent Review and Discharge Planning

Premera uses internal guidelines when reviewing cases. They may need to contact the attending physician or specialist for additional information about the case and care decision. Contracted physicians are expected to provide pertinent clinical information in response to these requests (see your contract for more information).

Premera guidelines are established from internal and external sources, primarily from the Milliman Care Guidelines, internal medical policy, and other national sources. A copy of any guidelines used for a specific case is available on request through the assigned Care Transition Manager.

Prospective (Pre-Service) Review for Medical Necessity

Prior-authorizations are **not** required in most member contracts. However, we recommend you request a prospective review known as a "Benefit Advisory" for the procedures and services that we routinely review for medical necessity (e.g. considered cosmetic, experimental or investigational), contract exclusions, or contract limitations).

Utilization Review *(cont.)*

Retrospective Review

We review claims for services that are potentially cosmetic, experimental or investigational, not medically necessary or have benefit limitations. To prevent an unexpected retrospective denial, we recommend requesting a Benefit Advisory for procedures that may be considered cosmetic, experimental or investigational or not medically necessary.

Retrospective review results in review of claims for benefit determination and/or medical necessity after receipt of a claim and prior to making a payment decision. Potential denials are sent to a Premera medical director when determination is based on medical necessity, correct assignment of benefit, or the use of experimental/investigative services/procedures.

Delegated Functions

We may delegate part of the case management or clinical review functions to qualifying entities. This does not include delegation of benefit quotes, technology assessment, benefit exceptions, member/provider satisfaction with health plan, over- and under-utilization of services, pharmacy benefit management, or appeals.

Benefit Advisory

A Benefit Advisory is a review to determine if a service meets medical necessity criteria and if the member's plan includes the benefit. Any services listed in the "Practitioner Clinical Review Guideline" or "Clinical Review Code List" (below) can be reviewed prospectively as a Benefit Advisory.

A Benefit Advisory is recommended for procedures or services that typically suspend for retrospective review of medical necessity (e.g., considered cosmetic, experimental or investigational). A Benefit Advisory is not a requirement nor is it a guarantee of payment.

If a Benefit Advisory has not been requested for a service or procedure on the Clinical Review lists, we will do a retrospective claim review before payment. The review will determine if the service or procedure is a covered benefit and if it is medically necessary.

If you have a change to a request previously submitted for a Benefit Advisory, call Care Management for instructions. A change or update to a service or procedure will need to be reviewed by a clinician.

Provider Portal Resources

The following are links to the lists of services that are reviewed for medical necessity:

- Clinical Review Code List WA (.pdf)
- Clinical Review Code list – Monthly Updates WA (.pdf)
- Practitioner Clinical Review Guidelines WA (.pdf)
- Advanced Imaging Services subject to review: CPT Code List (.pdf)
  Radiology requests for CT, MRI, MRA, and Nuclear Cardiology must be submitted through American Imaging Management.

Contact Information

Benefit Advisory requests:

- Fax Benefit Advisory request form (recommended method): 800-866-4198
- Call 877-342-5258, option 3

Prospective review requests:

- Fax: to 800-866-4198 (recommended method)
- Call: 877-342-5258, option 3

Note: Select plans have prior authorization requirements. Prospective review includes Benefit Advisories and prior authorization. The difference is that a Benefit Advisory is not required in the member contract where prior authorization is required by the member contract. Call Customer Service to determine if a member's plan has this requirement.

Premera Blue Cross
Notification Processes

Our role is to support you as you care for your Premera patients. The notification processes noted below are either required based on the specific contract or recommended for review prior to the service being rendered.

Note: Actual payment is subject to Premera's payment policies, the subscriber's benefits and eligibility at the time of service, and the application of certain industry standard claims adjudication procedures. Please contact Customer Service to determine if a member's plan has this requirement.

	Inpatient Admission Notification		Authorization		Benefit Advisory	
Service	**Action**	**Requesting Party**	**Action**	**Requesting Party**	**Action**	**Requesting Party**
Organ Transplants & Related Travel Expenses	Recommended	Facility	Not Required	N/A (Transplant facility)	Recommended	Facility
Non-maternity Hospital Admissions	Recommended	Facility	Not Required	N/A	N/A	Provider
Inpatient Mental Health	Recommended	Facility	Not Required (***Note***: subject to medical necessity review)	N/A Facility	Recommended	Provider
Maternity Hospital Admission	Contact Customer Service for benefits & eligibility	Facility	Not Required	N/A	N/A	N/A
Blue Card/ Out-of-area	Recommended	Facility	Not Required	N/A	Recommended	Provider
Outpatient Services	N/A	N/A	Not Required	N/A	Recommended if on RMN list	Provider

Provider Portal Resources

Providers can significantly improve claims payment timeliness by following the Prospective Review recommendations available at premera.com/provider (under Utilization Review). Simply enter the date of service and procedure code to determine if a medical necessity review is recommended.

Section 4: Pharmacy

Overview

Our pharmacy programs promote choice, savings and safety for our members. We focus on minimizing our members' out-of-pocket expenses, maximizing their safety when prescription drugs are required, and supporting your care recommendations for them.

Generics Program

The Premera generics program is designed to address rising pharmacy costs and keep healthcare affordable for everyone.
Consider the following:

- Over 80 percent of all brand medications are now available as generics.
- The average Premera member can save up to $192 a year by using generic medications instead of brand medications.
- Members save money with a generic prescription because these drugs are available at the lowest copay through the member's health plan.
- When a generic equivalent is not available, there may be a generic in the same class of drugs that is a good alternative.

To learn more about our generics program, visit our website at premera.com/generics.

Prior Authorization Program

Our pharmacy prior authorization program focuses pharmaceutical care for selected member contracts. This program promotes appropriate utilization of specific drugs. Point of sale edits occur at the pharmacy if our medical necessity guidelines are not meet. Our Pharmacy and Therapeutics Committee approves these edits, and the criteria development is based on one or more of the following resources:

- Premera clinical practice guidelines
- Premera medical policy
- A reputable clinical source including drug package inserts, peer-reviewed journal articles, and clinical trials
- Accepted treatment standards based on our clinical pathways and/or medical and pharmacy best practices.

If a prescription does not meet the Premera clinical criteria, the computer system alerts the pharmacist. The prescription will not be filled until it has been reviewed with the Prior Authorization Fax-back Form available at premera.com/pharmacy.

Note: Drugs may be added or deleted from the prior authorization program at any time without prior notification. If you have questions about the Pharmacy Prior Authorization Program, please call Pharmacy Services at 888-261-1756, option 2, or visit our website at premera.com/pharmacy.

Dose Optimization Program

As part of the dose optimization program, we work with you and the member, with your approval, to replace multiple doses of lower strength medications with a single dose of a higher strength medication. Taking a medication once a day in a higher strength instead of multiple lower dose medication results in the same daily dose and increases the member's compliance with his/her drug therapy.

About 50 medications are selected for the program. Only drugs that are approved by the Food and Drug Administration (FDA) for once daily dosing and have different strengths available at similar costs are included in the program.

How the Dose Optimization Program works:

- It includes medications that have similar pricing across multiple strengths and can

be taken as a single daily dose.
- When a prescription for an eligible drug is filled or refilled, the member receives a letter letting him/her know that he/she has the option of taking just one pill, once a day.
- We ask members to contact you or the pharmacist to discuss changing the prescription.
- On the third refill attempt, the pharmacist can perform a one-time override; the prescription must be changed or an exception granted prior to next fill.

To learn more about the Dose Optimization program, please call Pharmacy Services at 888-261-1756, option 2.

Electronic Formulary ePocrates

ePocrates is a palm-based and desktop health plan formulary guide. The software can be downloaded to a computer, Personal Digital Assistant device (PDA) or smartphone. ePocrates offers the following benefits for physicians:

- Free download of our formulary for ePocrates users
- Access to the Premera formulary while in the exam room or at a patient's bedside
- Multiple plan formulary access from one device (for any other plans that have also signed up for the service)
- Quarterly formulary updates
- Automatic updates
- Access to drugs by name or class
- Drug tier, for tiered formularies
- Drug alternatives
- Detailed drug information (dosing, precautions, interactions, adverse reactions) in pop-up windows
- Drug- drug interactions, including multiple medications.

For more information on ePocrates Rx, visit its website at ePocrates.com

Specialty Pharmacy Program

The Specialty Pharmacy Program reduces costs of specialty drugs, eases administrative burden, and facilitates quality care. Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions including multiple sclerosis, rheumatoid arthritis and hepatitis C. Specialty pharmacies focus in the delivery and clinical management of specialty drugs.

They are staffed by pharmacists, nurses and patient care representatives who are trained to meet the unique needs of people taking specialty drugs. Besides arranging for delivery of the specialty drugs, they also provide members with clinical services including drug and disease information, support and counseling. They also coordinate benefit advisories directly with Premera.

Premera's Specialty Pharmacy Program helps you manage these medications through:

- Patient education
- Working with to assure you are taking your medications as you prescribe
- Clinical support potential side effects
- Medication ordering and delivery options

Member benefits may require the use of one of our contracted specialty pharmacies to fill specialty medications. View the Mandatory (Preferred) Specialty Drug List to see medications that are included in the Specialty Pharmacy Program. Prescriptions for these medications may be called to:

- Accredo Health Group (a Medco company): 877-244-2995
- Walgreens Specialty Pharmacy: 877-223-6447

Section 5: Quality Program

Quality Program Overview

The Quality Program provides a framework for ongoing measurement, evaluation and communication designed to improve members' health and the quality and safety of the care and service they experience.

The goals of the Quality Program are to assure that Premera:

- Engages in ongoing improvement of member health and wellness across the health continuum;
- Enhances the value of its service to customers;
- Promotes a sustainable healthcare delivery system by supporting the provision of appropriate, effective and efficient medical and behavioral healthcare services to members.

Collaborating with stakeholders and supported by a corporate program infrastructure, Premera works to achieve the following objectives through the Quality Program:

- Quality clinical care
- Quality service
- Safety in healthcare

The scope of the corporate Quality Program includes:

- All products and markets and the service provided to diverse internal and external customers. Preventive, acute and chronic care services to members, care provided to special populations and those with complex health needs
- Behavioral healthcare, health promotion, lifestyle behavior change interventions, ancillary and alternative care and treatments,
- Pharmaceutical products and services, home health services and medical equipment.
- Projects and initiatives may address all markets or focus on a particular population, product, process, customer, or market.

Health plan performance monitoring and improvement encompasses key indicators of service quality and efficiency, clinical quality and outcomes, patient safety, complaints, access to care and service, member and provider satisfaction, communication and decision support, and program effectiveness. Activities are planned and tracked using an annual quality work plan. The Quality Program is evaluated annually.

Practitioner and provider collaboration with the health plan’s quality improvement program is essential. Individual practitioner and institutional provider contracts require that:

- Practitioners cooperate with quality activities;
- Premera or its agent have access to practitioner medical records to the extent permitted by state and federal law; and
- Practitioners maintain the confidentiality of member information and records.

Subcommittees within Premera’s Quality Program include practitioner representation. This enables participating providers to provide regional clinical expertise and input to Premera’s Quality Program. These committees include:

- Clinical Quality Improvement Committee
- Pharmacy and Therapeutics Committee
- Value Assessment Committee
- Credentialing Committees
- Oncology Advisory Committee
- Work groups convened to address specific clinical initiatives.

For questions about membership on Premera’s quality committees, contact a Premera medical director.

Evidence-based Care

Premera adopts clinical practice guidelines for the provision of non-preventive acute and chronic services relevant to its member population and for preventive and non-preventive behavioral health services. Evidence-based guidelines from recognized sources are designed to guide practitioner and member decisions about appropriate healthcare for specific clinical circumstances. Performance on key guidelines is measured and analyzed annually.

Premera's adoption of a national guideline or the inclusion of any statement made within a clinical practice guideline, does not guarantee benefit coverage for services and is not authorization of payment for specific procedures. Members' benefits can be verified online at premera.com/provider.

Clinical Practice Guidelines

Clinical Practice Guidelines are available via links to national associations and guideline sources from our website at premera.com/provider.

Preventive Health Services Guidelines

Premera has adopted the United States Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services. The guideline is evidence-based, relying on current scientific studies.

Immunizations are part of USPSTF recommendations for Preventive Health Services, and Premera recommends the Centers for Disease Control & Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) for an up-to-date Immunization Schedule.

USPSTF "A" and "B" grade services, in addition to content from other recognized sources, have been selected and formatted in two quick reference guides for provider use. These resources are available to print or download from our website at premera.com/provider.

Recommendation and Approval

Guideline recommendations are made by network practitioners, the Pharmacy and Therapeutics Committee, the Utilization Management Committee, and medical directors representing Premera's clinical program activities. Guidelines are reviewed, updated and approved by the Clinical Quality Improvement Committee at least every two years.

The Committee's composition reflects a variety of medical and behavioral health specialties as well as the geographic regions served by Premera.

To view, print or download copies of the Clinical Practice or Preventive Health Guidelines visit premera.com/provider.

Provider Portal Resources

Clinical Practice Guidelines are available via links to national associations and guideline sources from our website at premera.com/provider.

This page was intentionally left blank.