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**Overview**

While the provision of health care services and the exercise of professional medical judgment is the purview of treating physicians and other health care providers, case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes.

Case management emphasizes continuity of care for the members through the coordination of care among physicians and other providers. Case management is not an episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single practice setting.

- Primary Care Physicians (PCPs) serve as the principal case manager and coordinator of care. The Plan's Case Management team serves a support capacity to the PCP and assists in coordinating care actively linking member to providers, medical services, residential, social and other support services, as needed. The Plan's Case Management team adheres to the Case Management Society of America (CMSA) standards of practice.
- The Case Management team is comprised of specially qualified nurses who assess the member's risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the treatment plan.
- The Plan has incorporated case management programs that manage members with specific health care needs such as catastrophic diseases (adult and pediatric), transplant and obstetrics. The physician may request case management services for any of the Plan members.

- The Plan has adopted practice guidelines that are based on valid and reliable clinical evidence from the American Society of Transplant Surgeons (ASTS) for the Transplant program and the American College of Obstetrical and Gynecology (ACOG) for the OB program. The Case Management Society of America (CMSA) standards of care and the Agency for Health Care Research and Quality (AHRQ) for the wound care program.

**Transplant Case Management**

The purpose of the Transplant Case Management Program is to support the delivery of quality transplant-related health care to members. In addition, this program works in partnership with our physicians and facilities in developing and coordinating the appropriate plan of care.

**Member Stratification**

Members are stratified within the program based upon their status relative to actual completion of organ transplantation.

**Evaluation Phase:** Members are being evaluated for possible organ transplantation but have not yet undergone a transplant procedure.

**Pre-Transplant Phase:** Member has been accepted as a candidate for transplant and is waiting for appropriate donor availability.

**Transplant Phase:** Members have been admitted to a hospital for the organ transplantation.

**Post-Transplant Phase:** Members have completed an organ transplant and are discharged from the acute care facility. They are followed for a minimum of one year thereafter or until they disenroll from the Plan. The Plan's Case Manager assists the member post-transplant to ensure

continuity of care/services, and all health related needs are met in the post-transplant phase.

The objectives of the Plan's Transplant Case Management Program are to:

- Educate members and providers about the services available through the Plan and NYSDOH throughout the entire transplant treatment plan.
- Ensure the successful transition of care for members being discharged from acute and sub acute care facilities.
- Support and educate physicians in providing appropriate care before and after the transplant event.
- Facilitate quality, cost-effective care before and after the transplant event.

### **Domestic Violence Screening**

The American College of Obstetricians and Gynecologists recommends that every woman and girl presenting to an OB/GYN provider be screened for domestic violence. Because the prevalence of domestic violence in the OB/GYN setting is high, and because many women use their OB/GYN provider as their primary provider of health care and do not access other providers in the health care system, screening in this setting is critical.

Like primary care, OB/GYN and family planning settings offer a woman the chance to have a private conversation with her health care provider, where screening can be done in a less hectic setting than in the emergency department, for example.

### **Hotline Telephone Numbers**

New York State Domestic Violence Hotline

English 1-800-942-6906

Spanish 1-800-942-6908

New York City Domestic Violence Hotline  
1-800-621-HOPE (4673) or call 311

New York State (OPDV) Office for the Prevention of  
Domestic Violence  
<http://www.opdv.state.ny.us/index.html>

For county hotlines/resources  
[http://www.opdv.state.ny.us/about\\_dv/fss/resource.html](http://www.opdv.state.ny.us/about_dv/fss/resource.html)

WellCare Domestic Violence Coordinator  
1-866-653-0980

## Obstetrical Care

In support of obstetrical care, the Plan has adopted Guidelines of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG). These clinical practice guidelines are based on valid and reliable clinical evidence.

The Plan contracts with participating providers for OB care that includes OB as well as midwife services. The OB or midwife must complete the Prenatal Notification form (found in the **Forms** section of this manual) at the first prenatal visit and fax the completed form to Plan's OB department. Upon receipt, the Plan will give comprehensive authorization for prenatal, delivery and postpartum care.

Additionally, the member will be enrolled in the Prenatal Program and is evaluated for enrollment in the High Risk OB Case Management Program. If a pregnant member is receiving care from a non-participating provider upon enrollment, the Plan will make special arrangements to reimburse the provider for the member's care though the postpartum period.

The provider is required to provide the most appropriate and highest level of quality care for pregnant women.

**Authorizations  
for OB Care**

The OB physician or midwife must complete the Prenatal Notification form (found in the **Forms** section of this manual) at the first prenatal visit and fax the completed form to the Plan's OB department to obtain an authorization for OB care.

The Comprehensive Obstetrical Authorization covers the following services for the duration of the pregnancy:

- Visits – up to 16 visits for a normal pregnancy, when care begins early in the first trimester and continues through the postpartum period. The postpartum visit includes a PAP smear and family planning/counseling, to be completed within 21 – 56 days (by HEDIS definition) following delivery. Additional visits and authorizations for beneficiaries joining the plan after delivery may be obtained from Utilization Management at 1-800-351-8777.
- Rhogam injection.
- Lab work – unless otherwise directed, all lab work should be sent to the preferred lab provider, LabCorp Diagnostics.
- Circumcision is covered when performed during the hospital stay or in the office within six weeks after delivery.

Providers are expected to follow the New York Department of Health Interpretive Guidance for Prenatal Care - Guidance for Prenatal Standards in accordance with 10 NYCRR Part 85.40, Prenatal Care Assistance Program (PCAP). A copy of these guidelines is available in the **Provider and Member Education Materials** section of this manual.

**OB Physician  
Functioning  
as the PCP**

The OB physician may function as the PCP during the pregnancy and may request referrals and authorizations for that member during their pregnancy.

**High Risk OB  
Case Management  
Program**

The High Risk OB Case Management Program provides assistance to members that are identified as potential high risk pregnancies. If the physician notifies the Plan of a member's non-compliance, the high risk OB case manager can support the physician with necessary interventions to encourage compliance.

The High Risk Program coordinated through Matria:

- Educates members on their medical condition;
- Coordinates care through the continuum; and
- Assists the member in being an active participant in their own health care.

**Women, Infants  
and Children (WIC)  
Office**

Participating physicians are required to refer all pregnant women, breastfeeding and postpartum women, infants and children/adolescents up to age five to the local Women, Infants and Children (WIC) office.

The physician must:

1. Complete the WIC Program Medical Referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment),
2. For subsequent WIC certifications, coordinate with the local WIC office to provide the above referral data from the most recent exam.
3. Give a copy of each WIC Referral form to the member and retain a copy in the member's medical record.

**WIC Referral****WIC Women Infants and Children**

- Screen all pregnant, breast-feeding and postpartum women and refer as necessary to your local county WIC office or department of health.

For WIC eligibility call 800-522-5006.

**Lead Level  
Screening  
Program**

The Plan provides case management services to all eligible children with blood lead levels (BLL) equal to or greater than 10 mcg/dl. Services include:

- Family education about lead poisoning;
- Assistance in obtaining lead abatement;
- Coordination of testing of siblings;
- Scheduling of appointments; and
- Coordination of transportation, when needed.

Those members with elevated blood lead levels will be identified through a monthly lead level report from contracted laboratories and from the Plan's exam.

**Disease  
Management  
Programs**

The Disease Management Program proactively identifies members with AIDS, diabetes, asthma and Congestive Heart Failure and provides education for these members and/or their caregivers to empower them to make behavior changes to ensure the choices they make will improve their health and reduce the complications of their disease(s). In addition, the program educates members and their caregivers regarding the standards of care for asthma or diabetes, triggers to avoid and to ensure they are receiving the appropriate medications.

The program also focuses on educating the provider with regards to the standards of care for AIDS, diabetes, asthma and congestive heart failure and current treatment recommendations. Intervention and education will improve the quality of life of members, improve health outcomes and decrease medical costs.

- Members are stratified according to the severity of their disease.

- All members receive educational mailings and have the opportunity to request additional educational material specific to their condition or needs.
- Members who are stratified in the most high risk categories receive telephonic intervention by a disease management nurse. The nurse conducts a telephonic disease-specific health risk assessment and provides education regarding the disease process.
- All members also receive periodicity letters to remind them of the preventive health care they need.
- Members receive flu and pneumonia reminders.
- Member newsletters that feature articles related to AIDS, diabetes, asthma and congestive heart failure are mailed to members.
- Providers receive clinical practice guidelines based on nationally-recognized, evidence-based guidelines.
- Providers also receive fax alerts that are designed to alert the physicians to unacceptable lab values and inappropriate medication usage, in addition to hospitalizations and ER visits.
- Providers receive newsletters that feature articles regarding the latest treatment guidelines.

**Delegated Entities**

The Plan delegates some case management activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for utilization management activities, the delegated entity must

demonstrate that ongoing, functioning systems are in place and that they meet the required case management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of the Plan and the delegated entities. Delegation of select functions may occur only after an initial audit of the case management activities has been completed and there is evidence that the Plan's delegation requirements are met.

These requirements include:

- A written description of the specific utilization management/case management delegated activities;
- Semi-annual reporting requirements and evaluation mechanisms; and
- Remedies available to the Plan if the delegated entity does not fulfill its obligations.

On an annual basis, or more frequently, audits of the delegated entity are performed to ensure compliance with the Plan's delegation requirements.