



# Medical Management Department

*Developed by the Provider Affairs Operations/Education/Communications Department*

The Blue Cross and Blue Shield of Illinois Medical Management department has restructured and standardized its utilization management program to better serve our customers. The new structure is a simple plan designed to increase administrative efficiencies.

Organization	PPO and BlueChoice Medical Review Process
<p>There are two clinical teams separated into geographic areas:</p> <ul style="list-style-type: none"> <li>▪ Metropolitan Chicago and Illinois (which includes NW Indiana)</li> <li>▪ Multi State</li> </ul>	<p><b>Inpatient care requires prenotification/precertification</b></p> <p><b>Prenotification/Precertification</b></p> <p>Standard care is managed through the precertification process. It is expected that the majority of all cases will be handled through the standard process:</p> <ul style="list-style-type: none"> <li>▪ The provider/member must call the customer services number listed on the member's card.</li> <li>▪ Demographic and clinical information is obtained at the point of precertification</li> <li>▪ If case can be certified, the case is certified.</li> </ul> <p><b>If an extension for care is needed, call customer service.</b></p> <p><b>Medical Management Services</b></p> <p>If customer service staff cannot assign additional days based on workflow criteria, cases are routed to a nurse. Registered nurses (RNs) are assigned to a hospital or geographic region. Cases are screened against Milliman USA criteria.</p> <ul style="list-style-type: none"> <li>▪ Designated days are certified and the next review date is established when appropriate.</li> <li>▪ RN facilitates and collaborates with any discharge plans of the member.</li> <li>▪ If the case cannot be certified, the case is routed to a Physician for Medical Review.</li> <li>▪ All determinations are made within one business day.</li> </ul>
	<p style="text-align: center;"><b>Non-Certification – Appeals</b></p> <p><b>Non-Certification</b></p> <p>Non-Certifications are determined by a BCBSIL Physician</p> <ul style="list-style-type: none"> <li>▪ The facility, attending physician and member are notified of all denials</li> <li>▪ Verbal and written notification of a Non-Certification is completed within 1 business day of a determination</li> </ul> <p>In the event of a non-certification, the provider is entitled to the following appeals:</p> <p><b>Reconsideration</b></p> <p>This provides the opportunity for the attending physician to discuss the case with the Medical Director that made the determination.</p> <ul style="list-style-type: none"> <li>▪ Verbal and written notification of a Reconsideration is completed within 1 business day of a determination</li> </ul> <p><b>Expedited Appeal</b></p> <p>Appeal of a Non-Certification while the patient is receiving services.</p> <ul style="list-style-type: none"> <li>• The Care Coordinator is the facilitator of the Expedited Appeal</li> <li>• Verbal and written notifications of an Expedited Appeal are completed within one (1) business day of a determination.</li> </ul> <p><b>Standard Appeal</b></p> <p>Appeal of a Non-Certification after the patient is discharged from services. This is a medical record review by a physician.</p> <ul style="list-style-type: none"> <li>• The Case Manager is the facilitator of the Standard Appeal.</li> <li>• A letter requesting a Standard Appeal accompanied by the medical record is necessary to initiate a Standard Appeal.</li> <li>• Verbal and written notifications of a Standard Appeal are completed within 30 days of receiving the all necessary information.</li> </ul> <p><b>iExchange:</b></p> <p>If your facility has iExchange, you can get instant responses to Authorizations &amp; Extensions at the push of a button. No more lengthy phone calls, complicated forms &amp; No more waiting. iExchange is BCBSIL's internet solution enabling providers to submit authorizations &amp; extensions with real-time instant approval based upon our auto-approval engine set up. Cases that are not initially approved and receive a PEND status, are automatically routed to a designated work queue for immediate review by our CCCC (customer care call center) or by a Care Coordinator based upon the PEND rationale. It allows providers to check the status of a case by performing various searches. Treatment searches allow you to view and extend existing certifications. In addition, you can track the status of an appeal by accessing the details of the case.</p>