*NOTE: This section was updated in November 2020 with only one change (title was changed from Utilization Management, Case Management, Wellbeing Management Programs to Medical Management).
The intent of the Blue Cross and Blue Shield of Illinois (BCBSIL) Medical Management Department is to help ensure our members have access to affordable, quality health care. Our programs are designed to promote the optimal use of health care resources to improve health care outcomes. We believe the efficient and effective use of health care service results in quality health care outcomes. We use various resources, including MCG™ care guidelines, which are evidence and consensus based guidelines to support effective care and efficient resource utilization. BCBSIL meets the Blue Cross Association Consortium, National Committee for Quality Assurance (NCQA) and URAC standards.

Medical Management does not make determinations about whether services are medically appropriate, only if benefits are available. The final determination about what treatment or services should be received is between the patient and their health care provider.

Utilization Management (UM)
Based in part on industry and national standard of care guidelines, the UM program helps identified members receive benefits for the appropriate level of care in the most cost-effective setting, through short-term discharge planning, facilitating transitions between levels of care or pre-admission and post-discharge calls. For additional information, you may refer to the Health Care Delivery Utilization Management and Reference policies and procedures located in the BCBSIL Provider Manual section on our Provider website.

Utilization Management Criteria
Utilization Management review criteria is available to BCBSIL contracted physicians or other professional providers upon request. To receive guidelines on a specific condition, please contact the Utilization Management Department.

Utilization Management Accessibility
Utilization Management: 800-572-3089
Available Hours: 8 a.m. to 5 p.m. (CT), Monday through Friday
Benefit Preauthorization/Pre-certification Requests: 7 a.m. to 5:30 p.m. (CT), Monday through Friday
- Outside of regular business hours, calls are received through a contracted answering service.
- BCBSIL provides Telecommunication Device for Deaf (TDD)/Text Telephone (TTY) services and language assistance for incoming callers.
- Toll-free and collect calls are accepted throughout Illinois and all states within the Continental U.S., as well as Alaska and Hawaii.
- An Automated Call Directing (ACD) system allows callers using touch-tone phones to self-direct to the appropriate area. Medical Management personnel will refer the caller or transfer the call to other appropriate departments as needed.
- Outbound calls to members and/or their authorized representatives, providers and vendors will be made during normal business hours.
- Service calls and messages are often responded to immediately during working hours, but no later than within one business day after receipt of a message.
Utilization Management Affirmation Statement
BCBSIL distributes an affirmation statement to all staff and practitioners involved in UM decision-making, affirming that:

- UM decisions are based on medical necessity, as defined in the member’s benefit plan, which takes into consideration appropriateness of care and services, and the existence of available benefits.
- The organization does not specifically reward health plan staff, providers or other individuals for issuing denials of coverage, care or service.
- Incentive programs are not utilized to encourage decisions that result in underutilization.

Case Management (CM)
CM services are available for many PPO and Blue Choice PPO℠ members. The services of CM help to facilitate benefits for clinically appropriate care. 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 and a cost-effective outcome.

Case Management provides education and assistance for members with chronic medical conditions. Assistance may include, but is not limited to, unexpected catastrophic occurrences, psychosocial issues, and proactive management of anticipated medical management situations.

The objectives of the Case Management Program are designed to provide an individualized approach to managing the member’s health care needs. The program is an effort to:

- Coordinate medically necessary health care services in a manner that enhances the member’s quality of life
- Coordinate medically necessary health care services that promote high quality, cost-effective services in a manner that achieves better outcomes
- Involve the member or an authorized representative and the health care team in the development of a plan of care
- Provide member and family education regarding the patient’s benefits, disease process and choices regarding services including the right to refuse services
- Offer support services and assist the member with the monitoring of his or her condition in an effort to prevent complications
- Protect the welfare and safety of members and Case Management Coordinators
- Increase member and provider satisfaction by providing excellent customer service
- Evaluate results of member and practitioner surveys annually and develop processes to improve as indicated
- Establish guidelines for reasonable CM caseload and maintain an adequate number of Case Management Coordinators to provide optimum service for the population served

CM referrals may originate from a member, their family, physician, employer, hospital discharge planner, Integrative Predictive Modeling, Condition Management/Wellness, Utilization Management, an account executive, private duty nurse or other provider of services. All Case Management Coordinators performing Case Management functions are Registered Nurses in the State of Illinois with current unrestricted licensure, with a minimum of three years clinical practice experience and one year minimum of Health Insurance/Managed Care experience preferred and practice Case Management within the scope of their licensure (based on the standards of the discipline).

For additional information providers may contact a BCBSIL Case Manager by calling 888-978-9034. You may also refer to the Case Management policy under the Policy and Procedure/Health Care Delivery section located in the BCBSIL Provider Manual on our Provider website.
Wellbeing Management Programs
Wellbeing Management is an all-new, comprehensive care management and wellness program that will replace the existing Blue Care Connection for Large Group 151+ ASO and Custom Fully Insured beginning January 1, 2019. This new program takes a more comprehensive approach to improving health outcomes and delivering cost savings through holistic health management, expanded utilization management, and increased digital engagement strategies.

- **Holistic Health Management:** A holistic health management approach that proactively engages the highest-risk, highest-cost members to ensure continuity and consistency of care. This clinical model is designed to address the problems and silos of traditional, episodic care management by offering a more comprehensive approach to preventive care, complex/chronic care management, and life-long wellness.

- **Expanded Utilization Management:** A more rigorous UM approach for inpatient, outpatient, and pharmacy services to align with evolving industry best practices regarding misuse and overuse. This pinpointed approach can help generate hard dollar savings for our clients and members.

- **Increased Digital Engagement Strategies:** Personalized engagement strategies meet members where they are and engage them through a variety of convenient channels, including the ability to engage with a health advisor beyond traditional telephonic channels or access to increased self-management resources and tools.

The health condition management programs are not a substitute for the sound medical judgment of a member's doctor. The final decision regarding any treatment or services is between the patient and their health care provider.

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Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member's ID card.