

EBS-RMSCO's Medical Management Program

Our Third Party Administrator, EBS-RMSCO, is unique in that case management, utilization management, disease management and prevention are integrated through one business partner, Corporate Care Management (CCM). CCM is a leader in managed care and customer service. With a team of nurses who are certified as Chronic Care Professionals, CCM offers a unique and personalized approach to controlling medical plan expenses. They assist in plan design review and target preventative cost control programs, limiting our future exposure and helping to control our rising medical expenses. CCM has been providing medical case management services to self-funded plans since 1986 and has worked with EBS-RMSCO since 2000.

CCM utilizes an evidence-based approach in all programs to ensure all policies and procedures have clinical credibility. Programs are designed to identify chronic and high-cost conditions that potentially can exceed \$15,000.

As a result of their partnership with EBS-RMSCO, CCM saved EBS-RMSCO clients over \$14 million dollars in 2008. With CCM's services, EBS-RMSCO clients' inpatient medical expenses were reduced by 17.8%.

Reduction of Medical Costs

Medical costs are a significant expense to all companies. Costs are controlled by services/programs organized to manage medical claims. The early review of members' most costly procedures ensures that procedures are covered by our medical plan before medical service is provided to members.

Utilization Review

Utilization review efforts are focused on those services that represent the highest cost to the Plan thus providing the greatest opportunity for savings. Pre-admission verification is recommended for:

- All Inpatient Admissions
- Specialty Facility Stays
- Transplants
- Home Care
- Durable Medical Equipment Over \$2,500
- Hospice Care

This, along with a pre-service review program which targets costly outpatient services will direct providers to verify insurance either before service is provided or within 24 hours of one business day of an emergency admission. Costly outpatient services include:

- Home Care
- High-Cost Durable Medical Equipment
- Hospice Care

The review ensures that service is appropriate and plan guidelines for coverage are met.

Through focused pre-review programs, members are notified of Plan coverage and limitations, opportunities for savings are assessed, and cases that would benefit from intensive case management are identified. Potential cases are forwarded to the Nurse Case Manager assigned to the Plan. The Nurse Case Manager evaluates the case and provides case management as needed.

Case Management

As opportunities for savings are continually sought, cases are identified that will benefit from personal, comprehensive case management.

For complicated and high-cost cases that require additional support, the nurses become patient advocates, guiding the family through the healthcare system. The specially trained nurses use a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs. They confer with the family to ensure the services meet the member's health needs. They communicate with the member, the providers and the plan administrator to outline the available resources needed to promote quality, cost-effective outcomes.

As cases are identified, the Nurse Case Manager contacts the member and offers an introduction to the case management services available. The Nurse Case Manager assesses the member's needs by discussing the member's current condition, treatment plan, Plan benefits and concerns. Arrangements are made with the member for the timing of the next contact. Contact is made with providers and facilities as necessary to understand the proposed treatment, cost of care, and to determine coverage under the Plan. The Nurse Case Manager coordinates services as necessary and helps direct the member to participating providers. The Nurse Case Manager maintains regular contacts with the member and providers as needed throughout the case management process.

Many cases are identified by claim edits or review of the Plan's high-cost claim reports. The claims payment system alerts the processor when certain utilization triggers, diagnostic codes or procedure codes are found which will trigger a referral for case management. High-cost claim reports are reviewed periodically by the Nurse Case Manager to assure that all high-cost cases have been screened by a nurse for case management.

Case management includes:

Potential High-Cost Diagnoses

- Acquired Immune Deficiency Syndrome (AIDS), HIV+, or Any Other Potential Lifetime Illness
- Ascites (with other complex diagnosis)
- Bacterial Illness (meningitis, encephalitis, osteomyelitis)
- Burns (second or third degree burns covering 10% or more of the body surface)
- Cancer (any type)
- Cerebral Vascular Accidents (stroke, subarachnoid hemorrhage)
- Chemotherapy
- Children with Neurological or Congenital Anomalies (e.g. Down's syndrome)
- Cystic Fibrosis
- Fractured Femur, Hip/Knee Replacement (requiring inpatient rehabilitation)
- Head and Spinal cord Injuries
- Hemophilia
- Liver Disease (chronic)
- Maternity (high risk only) (e.g. premature labor or birth, bleeding, hyperemesis gravidarum, eclampsia, pre-eclampsia, known fetal anomaly, etc.)
- Neonates with Medical Complications or Born Prematurely
- Organ Harvest (bone marrow aspiration/harvest)
- Organ Transplants (heart, kidney, liver, bone marrow, lung, heart/lung, cornea) or Potential Candidates for Transplant
- Paralysis (paraplegia/quadriplegia)
- Pulmonary Fibrosis, Pulmonary Hypertension
- Renal/End-Stage Renal Disease/Dialysis Cases
- Repeat Brain Scan (due to abnormality or any initial or repeat scan of any organ due to mass, neoplasm, staging or restaging of cancer)
- Terminal or Progressive Disease (multiple sclerosis, guillian- barre, ALS, etc.)
- Trauma (major trauma or multiple trauma) (e.g. MVA, amputation, multiple fractures, crushing internal injury)
- Ventilator Dependence

Any Condition or Claim That May Represent Unusually High Cost to the Plan, Such As:

- Any Condition Requiring Transfer to a Specialized Facility (psych, substance abuse, neuro or medical rehab, skilled nursing facility)

- Any Condition Requiring Intensive Home Care or Costly Durable Medical Equipment/Prosthesis (>\$2,500) (DME reviews are handled by intake)
- Sequential Admissions (2 or > Inpatient in 6 months)
- Hospital Admission (>10 days with no precert or charges greater than \$30,000)

Following the initial review, cases continue to be monitored to identify additional opportunities for medical cost savings while ensuring quality medical care for members. Medical review of claims is provided to verify coverage and recommendations are made for payment.

High-cost cases are periodically reviewed to ensure our awareness of the plan's current health state and expected future costs.