BOSTON MEDICAL CENTER
HEALTHNet PLAN

Instructional Sheet for Care Management Referral Form - MCO

BMC HealthNet Plan offers care management services to members with chronic and complex medical/ behavioral health conditions and identified socioeconomic barriers to assist members and their providers to manage their condition and follow the prescribed treatment plan. We partner with Beacon Health Strategies to offer integrated care management to those members with a dual diagnosis.

In an effort to better support our providers and members, BMC HealthNet Plan has instituted a Care Management Referral Form that providers may complete and fax directly to us when your office has determined that a member may benefit from the care management services we offer.

Care Management Services Offered

Population Management is an intermediate-level care management program with a focus on helping members develop self-management skills, arranging services and providing health education for members with specific medical, behavioral and social needs. In addition, Population Management interventions may include smoking cessation, diet and nutritional counseling, wellness and prevention, and others for the following targeted medical populations:

- Diabetes
- Heart failure (HF)
- Hypertension
- Pregnancy and high risk pregnancy
- Asthma
- Coronary heart disease
- Chronic obstructive pulmonary disease (COPD)
- Obesity

Complex Care Management targets the most complex, highest risk members, including those with special health care needs for which a multidisciplinary approach is utilized, focusing on helping members develop self-management skills, arranging needed services and providing education to meet the varied health needs of this population.

Medical conditions that may be appropriate for a care management referral include but are not limited to:

- Cancer
- Bariatric surgery
- HIV
- CVA or other degenerative neurological or neuromuscular disorders
- Spinal cord injury/ traumatic brain injury /anoxic brain injury
- Complex newborn/NICU stay
- Neonatal abstinence syndrome / shaken baby syndrome

Indications that a patient may benefit from a referral to Complex Care Management for **<u>any medical condition</u>** include but are not limited to

- An illness or event that has caused a change or decline in ability to self- manage
- 5 or more chronic condition medications
- 5 or more different Specialists
- An Acute Inpatient stay with LOS > 7 days
- Multiple admissions/readmissions
- Multiple or repeated Emergency department use
- Homelessness, poor or inadequate living environment

BOSTON MEDICAL CENTER
HEALTHNet PLAN

Potential Indications for Behavioral Health Community Partner (BH Community Partner)*

- **One Diagnosis of :** SUD, Bi-Polar, Schizophrenia, Mood Disorder, Psychosis, Trauma, Suicidal/Homicidal, Depression, Adjustment Reaction, Anxiety, Psychosomatic /Conduct Disorder or PTSD, **and;**
- **One utilization of:** ESP interaction, Detox, Methadone, 3 + Inpatient Admits or 5+ ED visits in past 12 months, 3 medical co-morbidities, high LTSS utilization, current DMH enrollment

Potential Indications for Long Term Services and Supports Community Partner (LTSS Community Partner)*

- Individual currently enrolled in, or who may benefit from functional assistance of ADLs/IADLs through Long Term Services and Supports, or who need assistance identifying social service needs
- Individual with LTSS needs who experiences frequent ED visits, inpatient admissions, or SNF stays, and may need assistance coordinating functional needs and medical complexities, or transitioning from one level of service to another
- Individuals with brain injury, cognitive impairments, physical disabilities, or intellectual/development disabilities, older adults (up to age 64), and children or youth (ages 3-21) who may benefit from integrated, comprehensive care coordination for their complex LTSS needs

Note: some populations are excluded from participation in the CP Program, as their current Masshealth program already includes care management supports. Excluded populations include:

- DMH Program for Assertive Community Treatment (PACT)
- One Care
- Senior Care Options (SCO)
- Program for All-inclusive Care for the Elderly (PACE)
- Members not enrolled in an ACO/MCO (with exception of ACCS)
- BH CP Identified members (for those with LTSS needs – you can only be assigned to one CP type)

**** Please note that members with the above indications may be better served through other care management and community based services*.**

How to Complete the Care Management Referral Form

Member Information

1. Include the member's most up to date demographic information.

Referring Provider Information

1. Include the referring provider's demographic information and NPI #.
2. Include any agency related involvement, if applicable.

Clinical Information

1. Indicate member's diagnosis.
2. Include any relevant clinical information.
3. Indicate reason for referral into the care management program.

Care Management Program

1. Please select the care management program that you are requesting for the member.

Once completed, please fax the Care Management Referral Form to 617-951-3426. If you have any questions about this form, please contact us at 888-566-0008.

BOSTON MEDICAL CENTER HEALTHNet PLAN

Care Management Referral Form - MCO

FAX TO: 617-951-3426

Member Information

Member Name:____DOB:_____________BMCHP ID #: ____________________

Gender: _____________________ Home Phone: ________________________ Mobile Phone: _____________________

Address: ____

____

Guardian: ____

Referring Provider Information

Referring Provider Name:_____________________________________NPI #: ____________________ PCP Specialist

Referring Provider/Group Name:______________________________/_____________________NPI #: ___________________

Individual's name and group name if affiliated with multiple groups

Referring Provider Phone #: ______________________________________ Fax #: ____________________________

Agency Involvement: ____

____

____

Clinical Information – *Please provide the below information to support the referral*

Diagnosis:

Pertinent Clinical Information:

Reason for Referral to Care Management: ***(i.e. Are there goals or outcomes that the member is trying to attain?)*****:**

Care Management Program - MCO

Asthma	Heart Failure	Complex Care Management
COPD	Hypertension	Behavioral Health Care Management
Coronary Artery Disease (CAD)	Obesity (Adults and Childhood)	Social Care Management
Diabetes	Pregnancy and High Risk Pregnancy	BH Community Partner
		LTSS Community Partner