

Case Management (CM) Workflow

Triggers (referrals) for CM:

- Diagnosis (see page 2)
- Client Referral (broker/client)
- Utilization Review Episode (ie: IP admission)
- High Cost Claimant
- Member Self-Referral
- PCP Referral

Referral received

Are they eligible for CM?

NO

End

YES

Review all member info

CM need identified

NO

Assigned to CM based on licensure

YES

Intro letter sent

Other outreach as appropriate

Initial member outreach attempt

Member engagement?

NO

YES

Continue member outreach attempts

Successful member engagement?

Steps for outreach:

- Two phone calls
- Intro letter
- If unable to reach - send a letter
- Final phone attempt

Create/Update care plan

Provider engagement?
Network Steerage done in this step if applicable

Continue CM actions ongoing goal development & completion

Ongoing CM needs?

YES

NO

Close case and send closure letter

Email Referral to:

HBHCM-CMReferralRequest@hlthben.com

Include in the referral:

- Member Name
- Member DOB
- Member ID
- Reason for Referral
- Clinical Information: ex:
- Admission/Discharge, ER, treatment plan, medications, etc

Luminare Health uses the below diagnosis codes for identifying Case Management needs. The list includes services for both adult and pediatric members and can be used as a trigger that represents an opportunity for Case Management intervention.

- Limb Amputations
- Burns, Major 30% or greater surface of the body
- Potential High-Cost Claimant including but not limited to:
 - NICU Admission
 - Complex Pediatric
 - Inpatient admissions/ICU for any of the listed conditions
- Chronic Kidney Disease
- Gender Dysphoria
- Behavioral Health Treatment/Substance Use Disorder
- Transplant



*Luminare Health Benefits reserves the right to modify this list at any time. This list is not inclusive and case management is available based on client/member needs.