EmblemHealth

Provider Manual

Chapter 15: SNF IRF LTAC

This chapter applies to EmblemHealth Members enrolled starting January 1, 2018. See Care Management chapter for rules that will apply to dates of services December 31, 2017 and prior, EmblemHealth and other excluded members.

Prior approvals do not guarantee claim payment. Services must be covered by the member's health plan and the member must be eligible at the time services are rendered. Claims submitted may be subject to benefit denial.

Transitional Care Services

eviCore will provide transitional care services for all applicable EmblemHealth members discharging from the hospital with Inpatient Post-Acute Care Services or Home Care Services. The members will be managed by the eviCore Transitional Care Program for 90 days post hospital discharge. The transitional care program comprising member support is based on identified risk factors. Core services include PCP appointment scheduling, disease coaching, social services support and member education.

Members Managed by eviCore

Starting January 1, 2018, eviCore will manage members who access the following networks:

- **Commercial and Child Health Plus**
  - Prime Network
  - Select Care Network
- **Medicaid/HARP**
  - Enhanced Care Prime Network
- **Medicare and Special Needs Plans**
  - VIP Prime Network

Exceptions to These Rules

- Health care professionals treating members whose care is managed by HealthCare Partners and Montefiore were required to contact those managing entities to verify coverage and procedures.

Prior Approval Process

eviCore healthcare (eviCore) handles prior approval requests for post-acute care and direct admissions for the following:

- Skilled Nursing Facilities (SNF)
- Inpatient Rehabilitation Facilities (IRF)
- Long Term Acute Care Facilities (LTAC)

Members should not be transferred from an inpatient hospital setting to a SNF, IRF or LTAC setting without an eviCore prior approval number. SNF, IRF or LTAC facilities receiving EmblemHealth-managed members without prior approval should contact eviCore to verify approval before admission. Servicing facilities may obtain SNF, IRF or LTAC prior approval details for EmblemHealth Members via the eviCore web portal or by calling eviCore at **866-417-2345**, option 3 for EmblemHealth, or option 5, then 2 for PAC.

eviCore only manages members in Skilled Nursing, Inpatient Rehab, and Long-Term Care for 90 days. Thereafter, please contact EmblemHealth at **888-447-2884** to address ongoing inpatient days.

After January 1, 2018: Members should not be transferred from an inpatient hospital setting to a SNF, IRF or LTAC setting without an eviCore prior approval number. SNF, IRF or LTAC facilities receiving EmblemHealth-managed members without prior approval should contact eviCore to verify approval before admission. Servicing facilities may obtain SNF, IRF or LTAC prior approval details for EmblemHealth Members via the eviCore web portal or by calling eviCore at **866-417-2345**, option 3 for EmblemHealth, or option 5, then 2 for PAC.

Who Requests Prior Approval

- Hospitals will be responsible for submitting the initial post-acute care prior approval requests directly to eviCore for members being discharged to a SNF, IRF or LTAC.
- SNF, IRF and LTAC will be responsible for submitting concurrent review requests to eviCore for existing admissions and new (initial) prior approval requests for community referrals.
- SNF, IRF and LTAC are responsible for submitting the initial Home Health Service requests for all EmblemHealth members discharging from a their facility with home health services.

How To Obtain a Prior Approval

All providers must verify member eligibility and benefits prior to rendering services at emblemhealth.com/Providers. The following sections describe the information you will need to submit to eviCore and the processes for submitting prior approval requests.

Required Information

The requesting provider should be prepared to submit:

- Appropriate eviCore request form - available at: https://www.evicore.com/resources/healthplan/emblemhealth
- Patient's medical records
- Details such as: admitting diagnosis, history and physical, progress notes, medication list and wound or incision/location

How to Request Prior Approval For SNF/IRF/LTAC

Managing Entity	Methods to Submit Prior Approval Requests
eviCore	eviCore offers two convenient methods to request prior approval, depending on the Program: 1. Call **866-417-2345**, option 3 for EmblemHealth members, then 5 for PAC or Transitional Care; then either 2 for PAC or 3 for Transitional Care. 2. Facsimile: Clinical documentation can be faxed to 855-488-6275.
HealthCare Partners	Call **(800) 877-7587** or fax your request to (888) 746-6433.
Montefiore CMO	Call **(888) 666-8326**.

Prior approval	Skilled Nursing	Inpatient Rehab Facility	Long Term Acute Care
Initial	3 calendar days	5 calendar days	5 calendar days
Concurrent	7 calendar days	5 calendar days	7 calendar days

Once clinical information is received, determinations will be made within 1 business day. If a peer to peer review is requested, an additional business day will be granted. However, eviCore's typical response time is less.

Once eviCore has made a determination, they will call the requesting facility with a notification. Determinations will be shared via Allscripts with hospitals that use Allscripts. A copy of the determination letter will also be faxed.

The service facility can obtain the prior approval details via the eviCore web portal or by calling **866-417-2345**. Use option 3 for EmblemHealth and Option 5, then 2 for PAC.

The Initial prior approval is valid for 7 days. During that timeframe, inpatient hospitals must transfer the member to a SNF, IRF or LTAC facility. If the member is not discharged within the 7 day approval period, new prior approval is required.

Date Extension (concurrent review) Requests:
Important: For date extension (concurrent review) prior approval requests, facilities should submit clinical information 72 hours before the last covered day. This allows time for Notice of Medicare Non-Coverage (NOMNC) to be issued. eviCore will issue the NOMNC form to the provider. The provider is responsible for issuing the NOMNC to the member, having it signed and returning it to eviCore.

SNF/IRF/LTAC Prior Approval Criteria

Criteria used by eviCore includes, but is not limited to:

- McKesson InterQual® Criteria
- Medicare Benefit Policy Manuals & Clinical Findings

Retrospective Reviews
eviCore will accept requests for retrospective reviews of medical necessity. Requests must be submitted within 14 calendar days from the date the initial service was rendered.

Concurrent Review
Facilities that fail to provide clinical updates and/or progress notes to the managing entity (concurrent review nurse or eviCore) will not be reimbursed for unauthorized days.

Permanent Placement Process for Medicaid Members
If a Medicaid member needs long-term residential care, the facility is required to request increased coverage from the Local Department of Social Services (LDSS) within 48 hours of a change in a member's status via submission of the DOH-3559 (or equivalent).

The facility must also submit a completed Notice of Permanent Placement Medicaid Managed Care (MAP Form) within 60 days of the change in status to the LDSS. The facility must notify EmblemHealth of the change in status. If requested, the facility must submit a copy of the MAP form to EmblemHealth for approval prior to facility's submission of the MAP form to the LDSS.

Payment for residential care is contingent upon the LDSS' official designation of the member as a Permanent Placement Member.

Hospital Transfers
If an emergency occurs, the SNF, IRF or LTAC facility should take all medically appropriate actions to safely transport the member to the nearest hospital, including the use of an ambulance, if necessary.

eviCore must be notified when a member temporarily leaves and returns to a SNF, such as when the member is readmitted to the hospital.

Discharge Planning
The discharge planning process from all facility settings should begin as early as possible. This allows time to arrange appropriate resources for the member's care.

Hospitals will be responsible for submitting the initial prior approval requests directly to eviCore for members being discharged to a SNF, IRF or LTAC. For post-acute care services after an inpatient hospital stay (acute rehabilitation, skilled nursing facility stay, home care, durable medical equipment, etc.), the eviCore concurrent review nurse will facilitate prior approvals of medically necessary treatments if the member's benefit plan includes these services.

For members in a SNF, IRF or LTAC, the discharging facility is responsible for submitting the initial Home Health Service requests.

Notice of Medicare Non-Coverage (NOMNC) for Medicare Members
Important: For date extension (concurrent review) prior approval requests, SNF Facilities should submit clinical information 72 hours prior to the last covered day. This allows time for Notice of Medicare Non-Coverage (NOMNC) to be issued. eviCore will issue the NOMNC form to the provider. The provider is responsible for issuing the NOMNC to the member, having it signed and returning it to eviCore.

In accordance with CMS guidelines, the Notice of Medicare Non-Coverage (NOMNC) will be issued by the servicing provider no later than 2 calendar days prior to the discontinuation of coverage or the second to last day of service, if care is not being provided daily.

If the member is cognitively impaired, the servicing provider is responsible for informing the health care proxy of the end-of-service dates and the appeal rights. If the proxy is unable to sign and date it, the staff member and witness who informed the proxy of the end date and appeal rights should sign and date the form, then fax it back to eviCore or send via the eviCore PAC Web Portal.

Denial and Appeals Process

Unable to Provide Prior Approval for Initial Request cases that do not meet medical necessity on initial nurse review will be sent to a second level physician for review and determination. If a potential adverse determination is made by an eviCore physician, they will reach out to the requesting facility and a Peer to Peer Review will be offered.

Peer to Peer (P2P) must be requested within 1 business day, or additional clinical information that supports medical necessity must be received within 1 business day, or the determination is final and the case will be closed. Note: P2P must occur within 1 business day or a denial letter will be issued.

If the P2P process does not result in a reversal of the recommendation of denial, eviCore will issue a denial letter. The physician reviewer may suggest an alternate level of care and/or the appeals process.

Once a service has been denied, members and providers must file an appeal to have the request reviewed again.

Medicaid or Commercial Members requesting to appeal a denial for initial PAC services should follow the instructions provided on the denial letter. Appeal requests must be submitted to eviCore via phone at **800-835-7064** (Monday through Friday, 8 a.m. - 6 p.m. EST) or faxed to **866-699-8128**.

Medicare Members may request an appeal of a denial for initial PAC services by following the instructions provided in the denial letter. Providers should follow the process outlined in the Dispute Resolution for Medicare chapter.

Unable to Extend Services Cases that do not meet Medical Necessity on concurrent nurse review will be sent to a 2nd level physician for review and determination.

If a member appeals the end-of-stay decision through Island Peer Review Organization (IPRO), the SNF is responsible for sending the medical records to IPRO by the end of the day on which they were requested. IPRO is open seven days a week to take appeal information.

Inpatient Rehabilitation Facility (IRF) Date Extensions	- Peer to Peer (P2P) must be requested within 1 business day or a denial letter will be issued. Or, additional clinical information that supports medical necessity must be received within 1 business day. If not, the determination is final and the case will be closed.
SNF Date Extensions (Concurrent review requests)	The Notice of Medicare Non-Coverage (NOMNC) will be issued no later than 2 calendar days prior to the discontinuation of coverage. The third calendar day will not be covered unless the decision is overturned or the NONMC is withdrawn. - P2P must be requested and occur within the 2 calendar day timeframe. - If P2P does not occur or if the decision is upheld, the member is responsible for paying for the continued stay if they choose not to discharge on the 3rd calendar day.
Member Appeals Process	- Medicaid and Commercial members requesting to appeal the decision to end skilled care in a PAC facility (SNF, IRF or LTAC) or HHC services should contact eviCore via phone at **800-835-7064** (Monday through Friday, 8 a.m. – 6 p.m. EST) or fax to **866-699-8128**. - Medicare members requesting to appeal the decision to end skilled care in a SNF facility or HHC services should follow the QIO process as outlined on the NOMNC. Providers should follow the process in the Dispute Resolution for Medicare chapter. - Medicare members may request an appeal of a denial based on the decision to end skilled care for concurrent IRF services by following the instructions provided in the denial letter. Providers should follow the process in the Dispute Resolution for Medicare chapter.

Reconsiderations Process (Commercial and Medicaid only)	- A Reconsideration is a post-denial, pre-appeal opportunity to provide additional clinical information. - Reconsideration must be requested within 14 days of the Initial Denial Date. - Peer to peer (P2P) requests can be made via verbal or written request. - P2P is conducted with the referring MD and one of eviCore's Medical Directors. - P2P results in either a Reversal or an Uphold of the original decision. - The DME Supplier and the Member are notified via mail and fax.
Appeals Process (Medicare, Medicaid and Commercial)	- 1st level Commercial and Medicaid appeals will be handled by eviCore. - Medicaid or Commercial members requesting to appeal a denial should follow the instructions provided on the denial letter. Appeal requests must be submitted to eviCore via phone at **800-835-7064** (Monday through Friday, 8 a.m. - 6 p.m. EST) or faxed to 866-699-8128. - Medicare appeals will be handled by EmblemHealth. - Medicare members may request an appeal of a denial by following the instructions provided in the denial letter. Providers should follow the process in the Dispute Resolution for Medicare chapter.

Turn-Around Time after an Appeal has been requested by the member:

- Expedited – up to 72 hours
- Standard – up to 30 days

EmblemHealth Members

The management of SNF/IRF/LTAC is not transitioning to eviCore. See Care Management chapter for applicable prior approval processes.