EmblemHealth

Provider Manual

Chapter 17: Utilization and Care Management

The Utilization Management program aligns our network practitioners, clinicians, hospitals, facilities, and ancillary services to meet our members' health care needs.

This chapter explains the philosophy, policies, and procedures used to coordinate optimal, cost effective, quality care for our members. We provide preauthorization, concurrent management, discharge planning, retrospective review, and case management services.

These processes are reviewed annually by our Quality Improvement/Care Management Committee. We invite comments and suggestions from our providers to assure these policies support the quality and value of the health care our members receive. Submit comments using our Message Center by signing in to **emblemhealth.com/providers**.

The procedures and practices discussed in this chapter apply to all our benefit plans. However, variations in referral requirements, authorization requirements, and coverage exist depending on the plan and benefit package. See the applicable subsections for further information.

EmblemHealth directly conducts utilization and care management, and delegates this function to certain utilization review agents. Utilization review agents fall into three categories:

- Those who have full responsibility for managing a population of members are called Managing Entities. EmblemHealth itself (also referred to as HIP and GHI) and its affiliated ConnectiCare companies are Managing Entities as well as the organizations we have authorized to manage our member's care. The current Managing Entities include:
  - ConnectiCare
  - EmblemHealth (also referred to as HIP or EmblemHealth Plan, Inc. formerly GHI))
  - Health Care Partners (HCP)
  - Montefiore CMO (CMO)
  - SOMOS

- The applicable Managing Entities information can be found:
  - On member ID cards: Logos for our Managing Entity partners are shown on the bottom left hand corner of the front of the Member ID cards. Their contact information may be found on the back of the card. See the Member Identification Card chapter of this manual for sample cards.
  - On the Eligibility Details page and by using the Preauthorization Lookup Tool in the secure provider portal.

- Delegated vendors for special Utilization Management programs. These vendors have partnered with us to oversee a certain set of services for all or a sub-set of our members. Please see the applicable guide or manual chapter for details on members and services covered and processes for requesting pre- and post-service reviews.
  - Beacon Health Options
    - Behavioral Health Services
  - ESI
    - Pharmacy Utilization
  - eviCore
    - Cardiology Imaging Program
    - Durable Medical Equipment
    - Home Care
    - Radiation Therapy Program
    - Radiology Program
    - Skilled Nursing Facility/Inpatient Rehabilitation/LTAC
  - New Century Health
    - Chemotherapy Drugs
  - Palladian
    - Chiropractic Program
    - Physical and Occupational Therapy Program
  - OrthoNet
    - Spine Surgery and Pain Management Therapies Program

- Blue Cross manages facility services for our EmblemHealth Plan, Inc. (formerly GHI) New York City Members.

In some cases, these vendors have also been delegated for claims adjudication. See the Claims Contacts in the Directory chapter for a summary on where to submit claims.

EmblemHealth's qualified clinical professionals use utilization management tools to help practitioners guide their patients' care through the continuum of services. This includes care provided for all conditions, both acute and chronic, physical and behavioral, in the offices of participating clinicians, hospitals, skilled nursing facilities, and other settings.

We help facilitate the primary care physician's (PCP's), or designated health care practitioner's, role through careful structuring of our network of specialty providers and facilities. Our referral and authorization processes focus on member eligibility, identification of participating providers, and review of member benefits. Some services might require preauthorization to ensure the right care is delivered in the right setting by the right provider and practitioner. Nurse case managers provide concurrent review and case management when members are hospitalized, receiving skilled nursing facility (SNF) care, rehabilitation, home care, or hospice services. Our nurse case managers assist the practitioner and member when the complexity of a member's needs requires services by multiple providers across different health care systems.

Note: Care for Medicaid and HARP members are coordinated through their Health Homes.

Utilization Management Decision Making

EmblemHealth uses nationally recognized criteria (including MCG) and evidence-based guidelines for clinical decisions. We rely on our medical policies, medical technology database, clinical practice guidelines (CPGs), and applicable state and federal (i.e. Centers for Medicare & Medicaid Services (CMS)) guidelines. Our utilization management criteria and medical policies are reviewed annually. CPGs are reviewed at least every two years unless regulatory requirements or national guidelines require otherwise. Updates are accessible from our newsletter *In the Know* which is emailed to providers monthly.

Guidelines and policies are available for review in Clinical Corner at emblemhealth.com/providers. EmblemHealth also provides the clinical review criteria used to make such determinations upon written request to:

EmblemHealth
Clinical Review Criteria
PO Box 2824
New York, NY 10116-2824

Medical Appropriateness Review

The purpose of medical appropriateness review is to ensure:

- All inpatient and outpatient care is medically necessary
- All care occurs in the appropriate setting

- Services and treatment are ordered and provided, whenever possible, by network providers

Utilization review determinations for medical appropriateness are made by evaluating information from the requesting physician, the member's medical record, consultations, and relevant laboratory and radiological information. All adverse determinations are made by a medical director. When applicable, the reviewing medical director consults with another physician who is in the same or similar specialty as the health care provider who would typically manage the medical condition, procedure, or treatment under review. Utilization management decisions are based only on appropriateness of care and service and existence of coverage.

The following are types of reviews we and our delegates conduct, along with the time frames in which our utilization determinations must be made (once the necessary information is received). Time frames may vary depending on the member's benefit plan. Determinations are made as expeditiously as the member's health and condition require.

Preauthorization

We must make a determination if a preauthorization is warranted and notify the member and the provider of the determination by phone and in writing. The determinations, for most non-urgent requests, must be made within three (3) business days of receipt of the necessary information, but depending on the line of business, and if additional information is required, the plan may have additional time to make a determination.

If the review does not meet medical necessity criteria, the preauthorization review nurse reviews the case with an EmblemHealth medical director who renders a decision. Whether the service is approved or denied as not medically necessary, the preauthorization review nurse notifies all applicable parties (i.e., the requesting provider and the member) by telephone and in writing (which may include sending the written notification by fax or secure email) one (1) working day of making the decision.

If a service is not medically necessary or appropriate based on a review of the clinical findings, the medical director may make the decision to deny coverage of a service for the episode of care. The nurse and/or medical director attempts to contact the requesting physician to allow them an opportunity to discuss the case with the medical director. The medical director does not make an adverse determination until all efforts have been made to resolve issues with the requesting physician.

The requesting physician is notified by telephone when we decide to deny coverage of a service or further service for an episode of care. The treating physician is given the telephone number of the EmblemHealth physician reviewer or utilization review agent and the opportunity to speak with the reviewer about the denial.

In addition to the phone calls and letters, providers can access the status of a preauthorization request, and the determination made, when they sign in to emblemhealth.com/providers. For EmblemHealth Plan, Inc. (formerly GHI) members, the determinations posted to our secure website are limited to those made with respect to elective inpatient stays.

Concurrent

We must make a determination if a concurrent approval is warranted and notify the member and provider by phone and in writing. The determination must be made within one (1) business day of receipt of the necessary information. In addition to the phone calls and letters, providers can access the status of a case where EmblemHealth is the Managing Entity when they sign in to emblemhealth.com/providers. Hospitals and skilled nursing facilities receive a Concurrent Review Status Report for HIP members twice daily, in the morning and afternoon, which is also posted to emblemhealth.com/providers.

If the review does not meet medical necessity criteria, the concurrent review nurse reviews the case with an EmblemHealth medical director who renders a decision. Whether the stay is approved or denied as not medically necessary, the concurrent review nurse notifies all applicable parties (i.e., the attending physician, the facility, and the member) by telephone and in writing (which may include fax/secure email) within one (1) business day of receipt of all necessary information of a determination. The nurse also gives members and practitioners written or electronic confirmation within 24 hours if the request is received and 24 hours prior to the end of the current approved period. If the request is received less than 24 hours before the end of the current approved period, the determination and notification are made within one (1) business day of receipt of all necessary information, but no more than 72 hours from receipt of request.

If a service, or continued use of a service, is not medically necessary or appropriate based on a review of the clinical findings, the medical director may make the decision to deny coverage of a service or further service for the episode of care. The nurse and/or medical director attempts to contact the attending physician to allow the physician an opportunity to discuss the case with the medical director. The medical director does not make an adverse determination until all efforts have been made to resolve issues with the attending physician.

When the plan intends to reduce, suspend, or terminate a previously authorized service within an authorization period, it must provide the member with a written notice at least ten (10) days prior to the intended action; this time period may be reduced in certain cases including fraud and/or death of the member. See Appendix F of the Medicaid Managed Care Model Contract.

We attempt to contact the treating physician by telephone when we decide to deny coverage of a service or further service for an episode of care. The treating physician is given the telephone number of the EmblemHealth physician reviewer or utilization review agent and the opportunity to speak with the reviewer about the denial.

We also notify the facility of a determination that results in a denial of coverage or of a further service for an episode of care. The facility is provided the telephone number of the EmblemHealth physician reviewer or utilization review agent and is also given the opportunity to speak with the reviewer about the denial.

Retrospective

We must decide if a retrospective approval is warranted and notify the member and the provider of the determination by phone and in writing. We must decide within 30 calendar days of receipt of a complete request.

If the review does not meet medical necessity criteria, the retrospective review nurse reviews the case with an EmblemHealth medical director who renders a decision. Whether the requested services are approved or denied as not medically necessary, the retrospective review nurse notifies all applicable parties (i.e., the attending physician, the facility, and the member) in writing (which may include fax/ secure email) within one (1) working day of making the

decision.

If a service or continued use of a service is not medically necessary or appropriate based on a review of the clinical findings, and following discussion with the attending physician, the medical director may make the decision to deny coverage of a service or further service for the episode of care. The nurse and/or medical director attempts to contact the attending physician to allow the physician an opportunity to discuss the case with the medical director. The medical director does not make an adverse determination until all efforts have been made to resolve issues with the attending physician.

We attempt to contact the treating physician by telephone when we decide to deny coverage of a service or further service for an episode of care. The treating physician is given the telephone number of the EmblemHealth physician reviewer or utilization review agent and the opportunity to speak with the reviewer about the denial.

Reconsideration/Peer-to-Peer Process

Whenever an adverse determination is rendered (a denial is issued), with or without the input of the clinician, the clinician can request a reconsideration (or peer-to-peer discussion). Such reconsideration shall occur within one (1) business day of receipt of the request (except retrospective) by discussion between the clinician and the medical director who rendered the decision, or a designated clinical peer reviewer.

When applicable, a reconsideration is available up until an appeal has been determined or the time frame for requesting an appeal has expired, whichever comes first. The member does not need to still be admitted to a facility or still be receiving the services for the conversation to occur. If the reconsideration is upheld (the original decision remains denied), the member/provider is still entitled to their appeal rights (unless the time frame has expired).

Note: This process applies to Medicare members ONLY when the requested service denied was in a participating inpatient acute facility and the denial was issued concurrently or retrospectively. All Medicare pre-service denials and all Medicare out-of-network denials, as well as any Medicare denials for other places of service, remain excluded from this process. The member/provider must continue to file an appeal or request a Medicare Reopen. An actual appeal must be submitted for Medicare members or a request for a Medicare Reopening. See the Medicare Reopening subsection of the Dispute Resolution for Medicare Plans chapter for more information.

If a facility provides additional information after a denial has been issued but the member has not yet been discharged:

- The Managing Entity performs concurrent review and upholds or rescinds the decision as indicated
- Reconsideration is for all days for which information is supplied

Referrals are only required for certain benefit plans. To see if a plan requires a referral, see our Referral Guide which has a short video, and links to the current year's Summary of Companies, Lines of Business, Networks and Benefits Plans and a list of plans that *do not require referrals*.

All services for members enrolled in benefit plans requiring referrals must be provided through network practitioners and ordered by the PCP, OB/GYN, primary caregiver (qualified advanced nurse practitioner), or participating specialist to whom the member was referred for testing and treatment by the PCP or OB/GYN. The following services do not require a referral:

1. Direct-access (self-referral) services.
2. Services for which members can self-refer to network providers, in accordance with their benefit plan.
3. Services for which Medicaid members can self-refer to network providers, County Department of Health clinics or providers who accept their Medicaid card.
4. Services for which members have and are using their out-of-network benefits.
5. Services for which the applicable Managing Entity's preauthorization is required for a member to use out-of-network providers. (For more information, go to the **Use of Out-of-Network Providers** section in this chapter.)
6. Services rendered by participating specialists for SOMOS-managed members for dates of service on or after **Dec. 1, 2020**.

Referral requirements may be different depending on the member's benefit package. Contact the Managing Entity listed on the member's ID card if clarification is needed.

How to Make a Referral

To make a referral for an EmblemHealth (HIP) managed member, sign in to emblemhealth.com/providers and complete a Referral transaction. Referrals may be entered up to 30 days after the specialist visit to avoid member access to care issues. For members assigned to other Managing Entities, their contracted PCPs and OB/GYNs will follow their protocols. Specialists should contact the PCP shown on the member's ID card or identified in the provider portal if a missing referral is needed.

OB/GYNs Referring to Specialists

Except for the types of specialists listed below, only the member's PCP may issue a referral for a specialist. OB/GYNs (e.g., gynecologists, obstetricians, obstetrician/gynecologists, and nurse midwives) may refer to the following specialists:

- Diagnostic mammography (Screening mammography does not require a referral or preauthorization. *)
- Diagnostic radiology and imaging (includes diagnostic imaging, diagnostic radiology, radiology, and magnetic resonance imaging**)
- Gynecologic oncology
- General surgery
- Infertility specialists
- Lamaze (No referral is necessary for Medicaid members.)
- Maternal and fetal medicine
- Neonatal/perinatal medicine
- Pediatric cardiology for fetal studies
- Radiation oncology (includes diagnostic radiological physics, radiation oncology and therapeutic radiology)
- Reproductive endocrinology

*Screening mammography appointments may be made with network radiologists without a referral or prescription. Members may call participating providers directly to make an appointment.

** Requires preauthorization. See the Who to Contact for Preauthorization section of the **Directory** chapter for additional information on how to obtain preauthorization.

Specialists Referring to Specialists

When a PCP creates a referral to a specialist which includes specialty services in addition to consultation, the specialist has the authorization to refer the member for additional in-network testing and services within the guidelines of their specialty including:

- Chemotherapy
- Dialysis
- Laboratory services
- Radiation therapy
- Radiology*
- Rehabilitation services (PT/OT/ST)

*See the Radiology Related Programs in Clinical Corner.

Referral Duration

A referral is only valid for the specific time frame designated for the referral type requested, or until the number of visits/units has been exhausted. See the Referral Duration table for details.

REFERRAL DURATION		
REFERRAL TYPE	**MAXIMUM # UNITS/VISITS**	**DURATION**
EmblemHealth Medicare HMO and HIP Plans		
Allergy Testing	12	90 days*
Chemotherapy	20	90 days*
Consultation	1	180 days

Consultation, Follow-up, Testing	6	180 days
Consultation, Follow-up, Testing, Treatment	6	180 days
Consultation, Follow-up, Treatment	6	180 days
Diagnostic Lab/X-Ray	1	45 days*
Radiation Therapy (see the Radiation Therapy Program chapter for more information)	Varies by treatment	Varies by treatment
Speech Therapy	10	10 visits within 30 days
HIP and Medicare HMO Plans in Palladian program		
Chiropractic Services	1	1 visit within 30 days
HIP Plan Excluded from Palladian Program		
Rehabilitation (Outpatient PT/OT)	8	8 visits within 90 days

*Or until the number of approved visits/units is exhausted.

Consultation Reports

All specialists should provide referring physicians with timely and informative consultation reports. This contributes to improving the quality of care provided to our members.

All consultation reports should be sent to the referring physician as determined by the member's physical status:

- **If emergent:** A consultation report is issued immediately following the visit by means of telephone or fax communication, with the written summary mailed to the referring physician within 24 hours of the visit.

- **If urgent:** A consultation report is issued within 24 hours of the visit.
- **If routine:** A consultation report is issued within five (5) to seven (7) business days after the visit.

All consultation reports contain at least the following information:

- Consultant's name, address, and phone number
- Specialty of consultant
- PCP's name, address and phone number
- Name, address, and phone number of referring physician
- Date of request and date of consultation
- Member's demographic data (including plan ID number)
- Urgency of the referral: emergent, urgent, or routine
- Documentation of the reason for the requested consultation
- Complete history and physical as it pertains to the consultation
- Documentation of all pertinent laboratory and radiographic results
- Assessment of identified problems specific to the consultant expertise, and any others included in the referring physician's report including differential diagnoses
- Documentation of recommended plan for the completion of the consultation, if applicable
- Documentation of recommended treatment/diagnostic plan
- Recommendations for follow-up by the consultant, if applicable

The consultation report is faxed back to the referring clinician at the completion of the service.

Second Opinions

EmblemHealth members are entitled to second opinions with network physicians as part of their covered benefit. The PCP or OB/GYN (when required by the member's plan) should provide a referral to another network physician when a second opinion is requested and deemed appropriate.

In the event of a positive/negative diagnosis of cancer, the treating provider should coordinate with the Managing Entity listed on the member's ID card. Coverage for cancer care second opinions to out-of-network specialists is:

- Limited to usual and customary charges only (for Medicare members, reimbursement is limited to the Medicare fee schedule for out-of-network specialists.)
- Requires the specialist's agreement to accept the reimbursement rate
- Necessitates a preauthorization from the Managing Entity to ensure appropriate claims payment

Second opinion referrals are for consultation only, and do not imply referral for ongoing treatment. In the event the second opinion differs from the first, the member may opt for a third opinion. Second and third opinions are arranged in the same manner as the original referral.

Preauthorization must be obtained by the physician or organization providing or requesting the service. We regularly review and update our preauthorization policies as part of an ongoing effort to decrease physicians' administrative burden and ensure prompt access to care for our members. See the Who to Contact for Preauthorization section of the **Directory** chapter for more information.

The following require preauthorization for **all** members, unless noted otherwise:

Standing Referrals

A PCP may refer members with chronic, disabling or degenerative conditions or diseases to a specialist for a set number of visits within a specified time. An EmblemHealth or Managing Entity medical director must approve standing referrals via the preauthorization process.

Specialists as PCPs

A Managing Entity's medical director may authorize a specialist to substitute as a PCP for a member with a life-threatening, or degenerative and disabling, condition or disease requiring specialized medical care over a prolonged period. Whenever possible, the specialist acting as a PCP should be dually board-certified. A treatment plan must be agreed upon between the PCP, the Managing Entity's medical director, and the specialist.

Specialty Care Centers

A member may request a referral to a specialty care center when they have a life-threatening, or degenerative and disabling, condition or disease requiring specialized medical care over a prolonged period. These referrals require preauthorization by the Managing Entity's medical director. The PCP, Managing Entity's medical director and treating provider must agree on the member's treatment plan.

Use of Out-of-Network Providers

All requests to see out-of-network providers are reviewed against the member's benefits, the provider network, and the medical necessity of treatment by an out-of-network provider. Members with out-of-network benefits (including appropriate out-of-pocket expenses) may choose to receive specialty care from an out-of-network specialist without a PCP referral. If the service requires preauthorization, the member is responsible for obtaining preauthorization from the Managing Entity.

Out-of-network services which receive preauthorization may be subject to a deductible and coinsurance, depending on the member's contract or benefit plan. If a preauthorization is not obtained, there may also be up to a 50 percent reduction of benefits depending on the member's contract or benefit plan.

Preauthorization is required for members who do not have out-of-network benefits. Preauthorization is also needed for referrals to an out-of-network provider when a network does not include an available provider with the appropriate training and experience to meet the needs of the members, or when medically necessary services are not available through network providers. If a specialist is not available in the network and preauthorization has been granted by the Managing Entity listed on the member's ID card, the member may receive care from an out-of-network specialist at no additional cost to the member.

For Medically Fragile Children and foster children, EmblemHealth authorizes services in accordance with established time frames in the:

- Medicaid Managed Care Model Contract
- OHIP Principles for Medically Fragile Children
- EPSDT, HCBS, and CFCO rules; and with consideration for extended discharge planning

EmblemHealth executes Single Case Agreements (SCAs) with non-participating providers to meet clinical needs of children when in-network services are not available. EmblemHealth pays at least the fee-for-service fee schedule for 24 months for all SCAs.

For more details regarding when out-of-network providers can be used, see the Provider Networks and Member Benefit Plans chapter. In addition, see the **Continuity of Care - Use of Out-of-Network Provider** section in this **chapter** to see accommodations made for new members.

Services Requiring Preauthorization

- Pre-service reviews (preauthorizations) are administered by the Managing Entity on the member ID card or by the vendor managing a utilization program on our behalf.
  - See the Clinical Corner at emblemhealth.com/providers for the Preauthorization Lists and a Preauthorization Check Tool.
  - For children placed in foster care, preauthorization requirements are currently being reviewed for several services including the services provided by the 29-I Health Facilities. It is anticipated that by 07/01/2021, the list will reflect that no preauthorization will be required for these services.
  - Specifically, for “Other Limited Health -Related Services” such as Neuropsychological testing as of 04/01/2021 and any mandated assessments will be auto-approved so no preauthorization will be required. Additionally, Core Limited Health Related Services will not require preauthorization.
- Preauthorization is not required for emergency admissions.
  - However, EmblemHealth and the Managing Entities must be notified within 24 hours of the admission using emblemhealth.com/providers.
  - Services are reviewed for medical necessity following notification and submission of clinical information.
  - See **Emergency Admission Procedures** under **Hospital and Facilities** section of this **chapter**.

Medicaid Members: Preauthorization for Procedures, Supplies, and Drugs for Erectile Dysfunction

Medicaid members may be prescribed erectile dysfunction (ED) drugs approved by the FDA for the treatment of non-ED-related conditions. In these cases, use of ED drugs may be approved, but only if:

1. The member is not on the Sex Offender Registry
2. The Preauthorization request outlined below is followed

The New York State Department of Health (NYSDOH) created a Preauthorization program for Medicaid members for the provision of ED procedures and supplies, so the member's eligibility can be confirmed. The physician must submit a Preauthorization request to EmblemHealth or to the entity listed on the back of the member's ID card for the excluded ED services. A Preauthorization clinical manager or a designated Preauthorization nurse sends an inquiry to the NYSDOH for confirmation of the member's eligibility to receive the requested procedures and supplies.

If the NYSDOH response acknowledges the member's eligibility, the request is reviewed for medical necessity. If appropriate, a physician's Preauthorization number is issued. Once the physician has obtained Preauthorization, the member can obtain the service requested. If the request is denied because it is deemed medically unnecessary, a medical necessity denial letter is sent to the physician/member.

If the NYSDOH response acknowledges the member is not eligible for coverage, the case is denied as "not a covered benefit", and the physician/member receive a benefit denial letter. The practitioner/member has the right to appeal and the right to request a fair hearing and an external appeal if the service request is denied for any reason. Go to the NYSDOH's website to obtain more information regarding procedures requiring preauthorization.

Preauthorization for Anticipated Care of Maternity Patients

The OB/GYN physician's office must notify EmblemHealth's Prior Authorization department, or the Managing Entity listed on the member's ID card, of the estimated date of confinement (EDC) for maternity patients after the first prenatal visit so a preauthorization can be recorded. This notification is the responsibility of the OB/GYN physician's office. Once the member has delivered, it is the facility's responsibility to notify EmblemHealth or the Managing Entity of the actual delivery.

Preauthorization for Infertility Services

EmblemHealth provides coverage for infertility services in accordance with New York State law and the member's benefits. For more information, including the **Infertility Treatment Pre-Authorization Request Form**, visit Medical Policies.

Preauthorization for Midwifery Services

The services of a midwife are covered for all our benefit plans. Preauthorization is required for all HIP members. For GHI members, preauthorization is only required if the midwife is not a network participant.

Note: If a provider and a midwife bill for the same services on the same date(s), only the first claim submitted is adjudicated, and the second claim treated as a duplicate submission. See Midwifery Services in the Credentialing chapter.

Additional Preauthorization Procedures for GHI Practitioners

Where possible, preauthorization requests should be made on the secure provider website at emblemhealth.com/providers. Otherwise, the written request must document needed identification information. Depending on the complexity of the request, clinical information sufficient to make a medical necessity determination should be documented. In most cases, a copy of a recent office note, or consultation summarizing the medical needs of your patient helps us to rapidly process the request. Information to facilitate preauthorization determinations include the following elements, as relevant to each individual case:

- Patient characteristics such as age, gender, height, weight, vital signs or other historical and physical findings pertinent to the condition proposed for treatment
- Precise information confirming the diagnosis or indication for the proposed medical service
- Details of treatment for the index condition, or any related condition, including names, doses and duration of treatment for pharmacotherapy, and/or detailed surgical notes for surgical therapy

- Appropriate laboratory or radiology results
- Office or consultation notes related to the proposed medical service
- Peer-reviewed medical literature, national guidelines or consensus statements of relevant expert panels
- Applicable CPT-4 and ICD diagnosis codes
- Complete facility and service information

Continuity/Transition of Care - New Members

During enrollment, the member selects a PCP from whom the member may request continuation of care. When appropriate, EmblemHealth permits new members to continue seeing their current out-of-network practitioner (transition of care) for up to 60 days.

On the effective date of enrollment, if a member has a life-threatening disease or condition, a degenerative and disabling disease or condition, or is undergoing active treatment for a chronic or acute medical condition, the member may continue to see their current out-of-network practitioner through the current period of active treatment, or for up to 90 days, whichever is less. An active course of treatment is when a member has regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol. Active treatment does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).

If the member has entered her second or third trimester of pregnancy, she may continue to see the nonparticipating practitioner through delivery, and postpartum care for up to 60 days, for care related to the delivery.

All transitions of care and continuity of services must be reviewed and approved by EmblemHealth or the member's assigned Managing Entity (see back of member ID card) prior to the services continuing. For the request to be considered, the member must have at least one of the following health conditions:

1. A condition during ongoing course of treatment with an out-of-network provider
2. Second and third trimester of pregnancy (up to 60 days postpartum)

EmblemHealth does not deny coverage of an ongoing course of care unless an appropriate provider of alternate level of care is approved for this care.

If transitions of care and/or continuity of care are approved, it is for a period of up to 60 days from the effective date of enrollment when the eligibility criteria are met. A single case agreement for continued services with an out-of-network health care provider must be agreed upon by EmblemHealth and the provider. The provider must do all the following:

1. Accept our reimbursement rates as payment in full
2. Adhere to our Quality Improvement Program
3. Provide medical information related to the enrollee's care
4. Otherwise adhere to our policies and procedures including those regarding referrals and obtaining

preauthorizations and a treatment plan approved by our applicable Preuthorization department (see the Who to Contact for Preauthorization section in the **Directory** chapter)

5. Continue treatment for an appropriate period (based on transition plan goals)
6. Share information about the treatment plan with the organization
7. Continue to follow the organization's UM policies and procedures
8. Charge only the required copayment

This transitional method does not require EmblemHealth to provide coverage for benefits not otherwise covered, or diminish or impair pre-existing condition limitations contained in the member agreement if the practitioner is unwilling to continue to treat the member or accept the organization's payment or other terms, or if the member is assigned to a practitioner group, rather than to an individual practitioner and has continued access to practitioners in the contracted group. It also does not apply if the organization discontinued a contract based on a professional review action as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 11101 et seq.).

Continuity of Care - Medicaid Children

For continuity of care purposes, EmblemHealth allows children to continue with their care providers, including medical, behavioral health, and Home and Community-Based Service (HCBS) providers, for a continuous episode of care. This requirement is in place for the first 24 months of the transition. It applies only to ongoing episodes of care during the transition period from fee-for-service to managed care.

To preserve continuity of care, children enrollees are not required to change Health Homes or their Health Home Care Management Agency at the time of the transition. EmblemHealth pays on a single case basis for children enrolled in a Health Home when the Health Home is not contracted with EmblemHealth.

For children transitioning from Medicaid fee-for-service, EmblemHealth continues to authorize covered Home and Community Based Service (HCBS) and Long-Term Services and Supports (LTSS) in accordance with the most recent Plan of Care (POC) for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity, and existing providers at the time of the transition remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with EmblemHealth) for no less than 180 days, during which time, a new POC is developed. During the initial 180 days of the transition, EmblemHealth authorizes without conducting utilization review any children's specialty services newly carved into managed care which are added to the POC under a person-centered process.

For 24 months from the date of transition of the children's specialty services carve-in, for fee-for-service children in receipt of HCBS at the time of enrollment, EmblemHealth continues to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity, and existing providers at the time of enrollment remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with EmblemHealth) for no less than 180 days, during which time a new POC is developed.

To facilitate a smooth transition of HCBS and LTSS authorizations, EmblemHealth accepts POCs for 1) our enrolled population or 2) a child for whom the Health Home Care Manager or Independent Entity obtains consent to share the POC with EmblemHealth and the family demonstrates the Plan selection process is complete. EmblemHealth continues to accept POCs for children in receipt of HCBS in advance of the effective date of enrollment when EmblemHealth receives notification of consent to share the POC with EmblemHealth from another Plan, a Health Home Care Manager, or the Independent Entity and the family demonstrates the Plan selection process is complete.

All ambulatory levels of care identified within the children's expanded benefits are included in preauthorization and concurrent review processes and include review and approval of the POC for the Medically Fragile Children population in accordance with the requirements set forth by the “Office of Health Insurance Programs Principles for Medically Fragile Children". Preauthorization is required for the HCBS POC to determine medical necessity, and whether it meets individual needs as a person-centered POC. EmblemHealth facilitates the transfer of the POC between the Health Home and/or Care Management Agency, EmblemHealth Utilization Management, and the appropriate delegate.

The Care Management Agency requests authorization from EmblemHealth Utilization Management, meets with the member directly, and completes the brief and full required assessment with the member. After the assessment, the Care Management Agency develops a POC with the member which recommends HCBS with goals for each service. The Care Management Agency sends the POC to their lead Health Home (depending on the guidelines prescribed by the lead Health Home) and an EmblemHealth Care Management liaison via a secure fax number.

The EmblemHealth Care Management liaison and/or Care Manager reviews the POC, determines medical and behavior health needs, and forwards the POC to the appropriate EmblemHealth Utilization Management staff and/or delegate. If there are any questions or issues with the POC, the EmblemHealth Care Management liaison and/or Care Manager acts as the liaison between the Care Management Agency, lead Health Home, EmblemHealth Utilization Management, and the appropriate delegate to coordinate care and services.

When EmblemHealth Utilization Management approves the POC, it sends a level-of-service determination letter with recommended HCBS providers to the Care Management Agency or lead Health Home. The HCBS provider completes their own assessment and submits a prior authorization request directly to EmblemHealth Utilization Management, or the delegate. Utilization Management contacts Care Management to review POC deviations and discuss any adjustments to either service delivery or the POC.

HCBS are required to manage EmblemHealth members in compliance with CMS HCBS Final Rule and any applicable State guidance. The POC is developed in a person-centered manner, compliant with federal regulations and state guidance, and meets individual needs. HCBS are required to ensure appropriate POCs are in place, maintained, or discontinued based on person-centered planning. In addition, HCBS must monitor ongoing services and utilize the authorization form every time they submit a request for services by following the CMS HCBS Final Rule and workflow when developing a POC and request authorization from EmblemHealth. EmblemHealth reviews the HCBS process to ensure it is managed in compliance with CMS HCBS Final Rule and any applicable State guidance, and the POC is developed in a person-centered manner, compliant with federal regulations and state guidance, and meets individual needs.

Depending on the POC review and findings, EmblemHealth reviews deviations and requires appropriate adjustments to either service delivery or the POC. EmblemHealth reviews and issues determinations within authorization request time-frames as described in the Medicaid Managed Care Model Contract and may request from the HCBS provider additional information related to the requested service authorization. HCBS process and POC must always adhere to CMS HCBS Final Rule. EmblemHealth reviews the POC and continued authorizations to identify service utilization patterns which deviate from any approved POC.

Continuity of Care Children in Foster Care

Continuity of care for foster children follows the same processes as for the Medicaid children described above, with additional guidance specific to foster children.

To facilitate a smooth transition of HCBS and LTSS authorizations, EmblemHealth accepts POCs for a child in the care of a LDSS/licensed Voluntary Foster Care Agencies where Plan election is confirmed by the LDSS/Voluntary Foster Care Agencies.

EmblemHealth continues to accept POCs for children in receipt of HCBS in advance of the effective date of enrollment when EmblemHealth receives notification of a child in the care of a LDSS/licensed Voluntary Foster Care Agencies, and Plan selection is confirmed by the LDSS/Voluntary Foster Care Agencies.

Children in foster care who are moved outside of the original county they have been living in may transition to a new primary care provider and other health care providers without disrupting their existing care plan. They may also access providers with expertise in treating children involved in foster care to ensure continuity of care and the provision of all medically necessary benefit package services.

Continuity/Transition of Care - Benefits Exhausted or Ended

We collaborate with members and their providers and practitioners to assure members receive the services needed, within the benefit limitations of their contracts. When benefits end for members, the Utilization Management department assists, if applicable, in the transition of their care.

Continuity of Care - When Providers Leave the Network

When a member's health care practitioner leaves EmblemHealth, the member is given the option of continuing an ongoing course of treatment with their current practitioner for a transitional period of up to 90 calendar days. If the member has entered the second trimester of pregnancy, the transitional period includes 60 days of postpartum care directly related to the delivery. Members who wish to continue seeing their current health care practitioner for a limited time must contact, or have their provider or practitioner contact, the appropriate Preauthorization department (see the Who to Contact for Preauthorization section in the **Directory** chapter).

EmblemHealth permits a member to continue with their current practitioner if the reason for leaving is not related to imminent harm to patients, to a determination of fraud, or to a final disciplinary action by a state licensing board which impairs the health professional's ability to practice. The practitioner must agree to all the following:

1. Continue to accept reimbursement at the rates applicable prior to the start of the transitional period as payment in full
2. Adhere to EmblemHealth's quality assurance requirements and provide us with necessary medical information related to such care
3. Otherwise adhere to our policies, which include but are not limited to, procedures regarding referrals, obtaining preauthorization for services, and obtaining an approved treatment plan
4. Continue treatment for an appropriate period (based on transition plan goals)
5. Share information about the treatment plan with the organization
6. Continue to follow the organization’s UM policies and procedures
7. Charge only the require copayment

This transitional method does not require EmblemHealth to provide coverage for benefits not otherwise covered, or diminish or impair pre-existing condition limitations contained in the member agreement if, the practitioner is

unwilling to continue to treat the member or accept the organization's payment or other terms, or if the member is assigned to a practitioner group, rather than to an individual practitioner and has continued access to practitioners in the contracted group. It also does not apply if the organization discontinued a contract based on a professional review action as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 11101 et seq.).

Transition from Pediatric to Adult Care and from Pediatric to OB/GYN Services

Physicians are encouraged to support the transition of members from pediatric to appropriate adult care, and pregnant adolescents from pediatrics to an adult primary care practitioner, OB/GYN, family practitioner, or internist.

We recognize the challenges for full-time students when health care needs arise while away at school. Special consideration is given to coverage of services outside of our service areas while a member is a full-time student. When the need arises, a nurse care manager is assigned to assist the student in coordinating their health care needs while away at school. The services must comply with the member's benefit plan.

The laboratories contracted with EmblemHealth are listed in our **Find a Doctor** tool and in the **Network Laboratory Services** section of the **Directory** chapter.

In-Office Testing List

Practitioners may perform the lab tests noted in the **In-Office Testing List** in their offices without preauthorization. Reimbursement is made according to contracted fee schedules. This policy which has been in place for HIP, HIPIC and Bridge members will cover all members effective July 1, 2020.

Members whose care is managed by SOMOS, Montefiore (CMO) and HealthCare Partners (HCP) may not have their lab tests administered in a practitioner's office, even if the members are in one of the above-listed benefit plans. (Check the member's ID or sign in to **emblemhealth.com/providers** to confirm eligibility.)

The utilization management process is intended to establish and support a strong patient care team approach, which results in higher quality of care and lower costs. This process includes, but is not limited to, preauthorization of facility admissions, concurrent management in the hospital, use of alternate care facilities and post-discharge follow-up.

In-Hospital Services

All in-hospital services and ancillary support should be provided by network physicians. See the **Use of Out-of-Network Providers** subsection in this chapter.

Elective Inpatient Procedures - Admitting Physicians

The admitting network physician is required to obtain preauthorization for elective inpatient procedures at least ten (10) business days in advance of the desired hospital admission date. This allows us enough time to obtain the necessary clinical information to process the request and to make appropriate arrangements for members (e.g., booking the facility space for the procedures and securing all lab work). Physicians can confirm the preauthorization status of an admission for a HIP-managed member by signing in to emblemhealth.com/providers or calling **866-447-9717.**

If the admitting physician is out-of-network, the member is responsible for contacting EmblemHealth or the Managing Entity for preauthorization. For more information, see the Who to Contact for Preauthorization section of the **Directory** chapter.

Elective Admission Procedures - Hospitals and Facilities (Including Acute, Inpatient Rehabilitation and Psychiatric Facilities)

The admitting facility (including hospitals) must confirm there is a preauthorization on file for all elective, non-emergent admissions and ambulatory procedures.

In the event the facility is aware the planned admission/procedure date has changed within a 90-day period, the facility should notify EmblemHealth or the Managing Entity of the new date(s) and ask to modify the date(s) of the preauthorization. An anticipated care report is faxed daily to the facility listing the approved days/services. If no services are approved for the facility, a report is not sent.

The facility must ask to see the member's ID card upon admission. The ID card provides line of business information as well as the Managing Entity's information for requesting preauthorization and submitting claims. The facility must verify member benefit and eligibility information by signing in to emblemhealth.com/providers.

Claims are denied if no preauthorization has been issued where one is required. For information on denial determinations, see the applicable **Dispute Resolution** chapters – Commercial/CHP, Medicaid or Medicare.

If a facility fails to obtain preauthorization for an elective inpatient hospital admission, claims will not be paid until medical necessity is established. Facilities will have 45 days to submit clinical information to EmblemHealth or the Managing Entity to support the elective inpatient services. A clinical determination will be made within 15 days of receipt of the clinical information, but no later than 60 days from the request. As usual, the facility may file a utilization review appeal for any denial.

Furthermore, New York State allows health plans to impose administrative denials if there is a systemic and repeated failure of any facility to obtain preauthorization for an elective inpatient admission.

Should the facility feel an overnight stay is warranted for an outpatient service, EmblemHealth or the Managing Entity must re-evaluate the admission for medical necessity. All necessary information must be submitted for re-approval.

Emergency Admission Procedures

If a member presents at a hospital emergency room and needs to be admitted, the hospital is required to notify the member's PCP immediately and the Managing Entity listed on the back of the ID card within 24 hours or as soon as possible thereafter. Here are ways to notify us of an emergency admission:

1. Contracted hospitals may notify EmblemHealth and the managing entities, SOMOS, HealthCare Partners and Montefiore CMO, electronically of all admissions through the emergency room by signing in to emblemhealth.com/providers for HIP and Medicare HMO members. Benefits of electronic notifications are:
   - 24/7 access.
   - Automatic date/time-stamped receipt immediately sent back as proof of the notification.
   - Immediate confirmation of member eligibility.
   - Automatic and immediate routing of cases managed by another entity on EmblemHealth's behalf; includes date/time stamp of notification to EmblemHealth.
   - PCP name and contact information provided.
   - Ability to follow status of inpatient case at emblemhealth.com/providers. As soon as a notification is submitted, an inpatient case is created and assigned the same trace number referenced on the ER Admission Notification Receipt. For HIP-managed members, hospitals may use the trace number to find the inpatient case using the preauthorization inquiry features. All cases appear in a pended status until all necessary information is received and concurrent review is performed.
2. Contracted hospitals may notify EmblemHealth of emergency admissions for HIP and Medicare HMO members by calling **866-447-9717** or faxing the notification to **866-215-2928**.
3. Contracted hospitals may notify EmblemHealth for GHI EPO/PPO and EmblemHealth EPO/PPO plans by calling **800-223-9870** or faxing the notification to **212-563-8391**.

Note: Our benefit plans do not require preauthorization for an admission through the emergency room; rather, we require notification, so the case may be reviewed on a concurrent basis. No authorization number is required, and the Managing Entity does not issue an authorization and/or case number until the case has been reviewed for medical necessity.

The responding Managing Entity obtains all relevant clinical information about the member. If the facility fails to notify the Managing Entity of an admission through the emergency room, the Managing Entity requests medical records upon receipt of the claim and conducts a retrospective utilization review for medical necessity. For more details, see the applicable Dispute Resolution chapters – Commercial/CHP, Medicaid or Medicare.

A member's PCP should respond to the hospital emergency room notification within 30 minutes. If the hospital attempts to contact the member's PCP and does not make contact within 30 minutes, the hospital is instructed to contact the Managing Entity listed on the member's ID card for assistance in locating the PCP.

Out-of-Network Facility Admissions

Admissions to out-of-network facilities in or out of the service area are monitored by telephonic review on a concurrent

basis by the Managing Entity listed on the member's ID card. If the member is stable and needs ongoing care, a transfer may be initiated to facilitate the return of the member to care within the primary delivery system.

Inpatient Transfers Between Hospitals/Acute Care Facilities

When a hospital or acute care facility does not have the services to ensure safe and/or quality care, it is the responsibility of the referring facility to contact the Managing Entity for all patient transfer requests by calling or faxing the applicable organization listed below:

Managing Entity/Members Phone	Phone	Fax
EmblemHealth for HIP members	**866-447-9717**	**866-215-2928**
EmblemHealth for Non-City of New York members and GHI retirees	**800-223-9870**	**212-563-8391**
GHI PPO City of New York members and non-Medicare eligible retirees with GHI PPO benefits, contact Empire BCBS	**800-521-9574**	**800-241-5308**
HealthCare Partners (HCP)-managed members	**800-877-7587**	**888-746-6433**
Montefiore (CMO)-managed members	**888-666-8326**	**n/a**
SOMOS	**844-990-0255**	**877-590-8003**

When contacting us, have the following information available:

- Member ID number
- Member name
- Name of hospital/acute care facility accepting patient
- Name of physician accepting patient (from accepting hospital)
- Name of physician transferring care (from transferring hospital
- Name of referring hospital/acute care facility
- Diagnosis
- Reason for transfer

For EmblemHealth-managed HIP and GHI members, a concurrent review nurse reviews and refers all requests to an EmblemHealth Medical Director for a determination based on the clinical urgency of the specific situation. A decision is made within one (1 business day or, in the case of a weekend, on the same day of receiving all requested information. If the transfer request is approved, the concurrent review nurse contacts the transferring facility and issues a case number for the transfer.

It is the accepting hospital/acute care facility's responsibility to confirm the transfer is authorized and to obtain the case number from the transferring facility. To receive payment, the accepting facility must include the case number on all associated claim submissions. If the request for the transfer is denied, refer to the applicable **Dispute Resolution** chapters – Commercial/CHP, Medicaid or Medicare.

Concurrent Review (Non-DRG Inpatient Stays)

Once a member is admitted to a facility, the applicable Managing Entity reaches out to the facility for clinical information to evaluate the ongoing medical necessity of the inpatient stay. Facilities are allowed 24 hours to provide the requested information. Decisions are made based on available information. EmblemHealth follows industry standard medical care guidelines (found at MCG.com) to determine the appropriate review frequency. Ongoing requests for clinical information are made consistent with the goal length of stay expected for the admission. Facilities should expect to receive requests for additional information approximately 24 hours before the expected goal length of stay has expired (excluding weekends and holidays). If the requested information is not provided, the day is denied. The member may not be billed for this day.

Concurrent Review (DRG Inpatient Stays)

For inpatient stays after July 20, 2020 that fall under a diagnosis-related group (DRG) payment system, facilities only need to provide clinical information to the Managing Entity for the initial length of stay and for discharge planning, unless:

- The facility plans to bill charges in addition to the DRG (commonly referred to as "outlier charges").
- The facility requests a review where:
  - a member's circumstances are unique (such as they have had a Transplant or were admitted to the NICU).
  - a prolonged hospital stay is expected, and outlier charges are likely to apply.
  - the circumstances around a member's stay or discharge are more complex than normally expected for the diagnosis.
  - the member needs case management.
  - the member does not feel comfortable leaving the facility even though it is medically appropriate.

Concurrent Review Status Report

The Concurrent Review Status Report is posted to our secure website at emblemhealth.com/providers, Monday through Friday (excluding holidays), twice a day at between 10 a.m. and 5 p.m. ET This report lists each admitted member and whether the current day is approved, denied, or pending further information. Pending information means we require additional information to make a determination. If the requested information is not provided, the day is denied. The member may not be billed for this day. For inpatient stays paid via a DRG methodology, please see the Concurrent Review (DRG Inpatient Stays) section above for cases where a member needs to stay beyond the approved length of stay.

Post-Service Review (In the event the participating hospital does not notify on admission)

Commercial/Child Health Plus

When a claim is submitted for an admission through the emergency department without having received timely notification, records are requested from the facility for an initial retrospective clinical review by the Post-Service Review department. The facility is given 30 days to submit the records. If records are received within 45 calendar days from receipt of request, they are reviewed for medical necessity. A decision is made and communicated to the provider and the member in writing within 15 calendar days of receipt of the requested clinical information. If the case is denied (in whole or in part), appropriate appeal rights are included in the communication.

Medicaid/Medicare

When a claim is submitted for an admission through the emergency department without having received timely notification, records are requested from the facility for an initial retrospective clinical review by the Post-Service Review department. The facility is given 30 days to submit the records. A clinical determination is made within 30 calendar days from receipt of request and communicated to the provider and the member in writing within the determination time frame. If the case is denied (in whole or in part), appropriate appeal rights are included in the communication.

Failure by EmblemHealth or the utilization review agent to make a determination within the required time frames is deemed adversely determined and subject to appeal.

Retrospective Utilization Review

Initial review, post-discharge, of a case where the claim was denied for no preauthorization, or for which no concurrent review was performed:

- Whoever is responsible for managing the case (i.e., the Managing Entity) performs the facility retrospective utilization review.
- The Managing Entity renders a decision within 30 days of receipt of the retrospective utilization review.

Note: While in the case of "no information denials," no true concurrent review is performed, such cases receive an initial clinical adverse determination (i.e., unable to establish medical necessity) and are therefore considered to have been reviewed. These denials, then, are subject to clinical appeals as indicated below, and not to retrospective utilization review.

Discharge Planning

The discharge planning process should begin as soon as possible to allow time to arrange appropriate resources for the member's care. Post-acute care-based services may include acute rehabilitation, skilled nursing facility stay, home care, durable medical equipment (DME), hospice care and transportation. The facility must request preauthorizations of medically necessary treatments from the Managing Entity, if the member's benefit plan includes these services.

Readmission Policy

On a concurrent basis, any readmission to the same facility/hospital /hospital system within **30 calendar days** of a member's discharge for the same or similar diagnosis is subject to a clinical review. The readmission is denied, and a benefit denial is issued if the readmission is determined to be a:

Relapse of conditions noted on the first admission

- Complications of treatment or diagnostic investigations
- Insufficient stabilization of patient's condition prior to discharge

The facility is advised of its grievance rights. In the event a readmission case requires additional clinical information and it is provided by the facility, the review determines if the circumstances of the second admission are related to the first admission.

Facilities may ask for the claim to be reconsidered (a peer-to-peer discussion) and reopened (Medicare only). If the facility sends additional clinical information, EmblemHealth reviews the claim and decides if the second admission is related to the first.

Medicare Outpatient Observation Notice MOON

The Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, requires all hospitals and critical access hospitals (CAHs) to provide written notification and an oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours. The standardized Medicare Outpatient Observation Notice (MOON), form CMS-10611 informs all Medicare beneficiaries when they are an outpatient receiving observation services and are not an inpatient of the hospital or CAH.

The notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated, or sooner if the individual is transferred, discharged, or admitted.

All hospitals and CAHs are required to provide this statutorily required notification. Instructions are available at:

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

For applicable HIP-managed members, see the SNF IRF LTAC chapter.

For all members not managed by HIP, follow these procedures.

Prior to Admission

The skilled nursing facility (SNF) staff is required to notify the Managing Entity of a member's admission. The call must be made **prior** to the member's admission. Notification of admission is **not** preauthorization for the admission.

For all admissions, the SNF should check member eligibility, benefits and preauthorization by signing in to emblemhealth.com/providers or by contacting the member's Managing Entity as listed on the back of the member's ID card.

At the Time of Admission

SNFs receiving patients who have not been given preauthorization should contact the Managing Entity on the member's ID card to obtain or verify the approval prior to admitting the member to the SNF. The SNF representative must have the following information available when contacting the Managing Entity:

- Member ID number
- Member name
- Admission date
- Clinical documentation supporting the appropriateness of the admission
- Copy of the hospital discharge summary and Patient Review Instrument (PRI)

The physician (PCP or consultant) attending to the patient while in the acute-care setting must attest by a certificate of medical necessity (CMN) to the patient's requirement for post-acute inpatient placement.

Failure to get preauthorization results in claim denial. See the applicable **Dispute Resolution** chapters – Commercial/CHP, Medicaid or Medicare.

Concurrent Review

Authorization for admission and continued stay is based on medical appropriateness and necessity of services. The Managing Entity evaluates the patient's ability to function prior to admission to the skilled care setting, the event which necessitated the skilled care admission, the patient's progress to date, and long- and short-term goals and objectives.

The Managing Entity does not issue a preauthorization and/or case number until the admission or procedure has been reviewed and either approved or denied. Notification of the determination is provided to the SNF at the time of the determination.

Once an initial authorization has been issued, it is the responsibility of the SNF to provide the Managing Entity with the necessary clinical updates, no less than every seven (7) days, to authorize additional days. The benefit for SNF care varies according to line of business. Member benefits may be verified after signing in to emblemhealth.com/providers.

Treatment Course Extension

The facility should request a treatment course extension at least 24 hours in advance. The Managing Entity should render a decision within 24 hours of receipt of the request.

Benefit Extensions

You may submit a benefit extension request by signing in to emblemhealth.com/providers for GHI EPO/PPO or EmblemHealth EPO/PPO members who have GHI or EmblemHealth listed as their primary insurer on our Member Eligibility look-up screens. Once signed in, click on Benefits/Eligibility.

You may also request a Benefit Extension Treatment Plan Form for an EPO/PPO member by calling:

- EmblemHealth: **877-482-3625**
- GHI: **800-223-9870**

Skilled nursing facilities which fail to provide clinical updates and/or progress notes to the Managing Entity (concurrent review nurse) are not 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 the 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.**

Specialist Referrals

We continue to provide routine services for members in a SNF, either for short-term care until the member returns home, or for long-term custodial care if the member chooses to permanently reside in the SNF (permanent residence is not covered under the member's benefit plan). Other services, such as dialysis, must be delivered at a network facility. If dialysis is provided to an inpatient member at the SNF, payment for dialysis is included in the rate for the inpatient stay, and the SNF is responsible for reimbursing the dialysis vendor.

The care manager responsible for authorizing continued stay can also coordinate specialty and transportation services needed by the member. The HMO member's PCP or the attending physician in the SNF is responsible for coordinating all medical care provided to the member at the SNF. If the PCP is coordinating the care, the SNF staff should keep the PCP informed of the patient's health status. To obtain the PCP's contact information, use the Member Eligibility Details after signing in to emblemhealth.com/providers or call the member's Managing Entity.

Hospital Transfers

If an emergency occurs, the facility should take all medically appropriate actions to safely transport the member to the nearest hospital, including the use of an ambulance, if necessary. The Managing Entity 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 should begin as soon as possible to allow time to arrange appropriate resources for the member's care. Post-acute care-based services may include acute rehabilitation, skilled nursing facility stay, home care, durable medical equipment (DME), hospice care, and transportation. The facility must request preauthorizations of medically necessary treatments from the Managing Entity, if the member's benefit plan includes these services.

For Medicare members, SNFs are responsible for notifying the member's Managing Entity of the planned discharge date so a Medicare notice of non-coverage (MNONC) can be issued in accordance with CMS guidelines at least two (2) days prior to discharge. The SNF is responsible for delivering the MNONC to the member on the day the notice is issued, having it signed by the member, and faxing the signed copy back to EmblemHealth on the same day. If the member is cognitively impaired, the SNF 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 MNONC, the SNF staff member who informed the proxy of the end date and appeal rights is to sign and date the notice and fax it back to EmblemHealth.

If a member appeals the end-of-stay decision through 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 (7) days a week to take appeal information.

Medicare Member Notices of Non-Coverage

If the member no longer meets medical necessity criteria, Medicare notice of non-coverage (MNONC) is issued to the Medicare member for continued SNF stays, home health care services, or comprehensive outpatient rehabilitation facility (CORF) services. If the MNONC is issued to a Medicare patient and the patient objects to the notice of non-coverage, the notice becomes effective two (2) days after the day of issuance, unless the Medicare patient requests a quality improvement organization (QIO) or IPRO for New York State review by noon of the first day following receipt of the notice. The QIO reviews the request and makes a determination within one (1) working day of receipt of the request with the hospital or home care records and notifies the member of its decision. If the QIO upholds the adverse determination of continued coverage, the member is liable for all costs commencing at noon of the day following receipt of the QIO determination.

Prior to Procedure

It is the responsibility of the physician or surgeon who performs the procedure in the ambulatory surgical facility to obtain preauthorization (if required). The practitioner must provide all required clinical information to the Managing Entity to obtain the preauthorization for the procedure or surgery.

The facility must confirm a preauthorization has been issued to HIP and Medicare HMO members by signing in to emblemhealth.com/providers. For all other members, call **Customer Service** as indicated in the Directory chapter. EmblemHealth does not issue a preauthorization and/or case number until the admission or procedure has been reviewed and either approved or denied.

At the Time of Procedure

Ambulatory surgery facilities must verify member eligibility and check the status of a preauthorization request by signing in to emblemhealth.com/providers or by calling **Customer Service** as indicated in the Directory chapter for EmblemHealth-managed members. For all other members, contact the Managing Entity as listed on the back of the member's card.

The ambulatory surgery representative must have the following information available when contacting Customer Service or the Managing Entity:

- Member ID number
- Member name
- Procedure date

- Diagnosis
- Clinical information supporting the medical necessity of the procedure
- CPT codes for the requested procedure

Ambulatory surgery claims are processed as outpatient care pursuant to the preauthorization. Failure to get preauthorization may result in claim denial. See the applicable **Dispute Resolution** chapters – Commercial/CHP, Medicaid or Medicare.

Hospital Transfers

If an emergency occurs and the member must be transported by ambulance to a hospital, the facility must notify the member's Managing Entity (for EmblemHealth-managed members, call **Customer Service** as indicated in the Directory chapter) immediately, or as soon as possible thereafter. In the event circumstances prevent immediate contact with the Managing Entity, the facility should take all medically appropriate actions to safely transport the member to the nearest hospital.

Hospice Benefits

Hospice services are covered for Commercial, Medicaid and Child Health Plus plan members. Medicare members requiring hospice services have the benefit covered by original (non-managed care) Medicare fee-for-service. For Medicare members receiving hospice services, EmblemHealth provides benefits for services not related to the terminal illness. Medicare members may revoke their hospice election at any time and return to EmblemHealth to receive care related to their terminal illness.

Electing Hospice

The hospice benefit is provided primarily at home, although it does not come under the home care benefit. Secondary places of service are skilled and inpatient hospital facilities for those hospice patients who have special needs requiring such an inpatient facility admission.

Although the treating physician is responsible for arranging hospice services for the patient, EmblemHealth continues to coordinate all non-hospice-related services (i.e., those not related to the terminal illness for the Commercial, Medicaid, Child Health Plus or Medicare member). To better service our members, we need to have a copy of the signed Hospice Election Form and/or Hospice Revocation Form submitted to EmblemHealth's Care Management department. The form(s) should include the member's name and the plan ID number.

A copy of the Hospice Election Form or Hospice Revocation Form can be mailed to:

EmblemHealth
Care Management Program
55 Water Street
New York, NY 10041-8190

Preauthorization for Admission to Hospice Agencies or Inpatient Facilities

Hospice agencies or inpatient facilities receiving Commercial and Child Health Plus patients who have not been given preauthorization should contact EmblemHealth's Prior Authorization department at **866-447-9717** to obtain or verify the approval prior to admitting the member to the service or facility.

The hospice representative must have the following information available when contacting EmblemHealth:

- Member ID number
- Member name
- Admission date
- The physician's signed attestation indicating the member has 6 months or less to live

The attending physician (PCP or consultant) must attest by a certificate of medical necessity (CMN) to the patient's requirement for hospice placement and the need for palliative care. If the hospice agency or facility does not have this documentation, the treating physician or hospital discharge planner must contact EmblemHealth. A letter is sent to the hospice specifying the level and number of units (days) approved. The hospice may call Customer Service for any member. The hospice may also check status of a HIP member's case by signing in to emblemhealth.com/providers.

Timeliness in obtaining approval ensures appropriate claims payment. Failure to get preauthorization results in the claim being denied. See the applicable **Dispute Resolution** chapters of this manual - Commercial/CHP, Medicaid or Medicare.

Care Provided During Hospice Election Period

For Commercial and Child Health Plus members, hospice agencies or facilities are responsible for all care related to the terminal illness during the period of hospice election. This includes emergency and non-emergency situations.

EmblemHealth must be notified of all care provided to the member. Medical necessity must be reviewed to modify the level of hospice care (e.g., from home care to inpatient). Hospice agencies or facilities which fail to provide clinical updates and/or progress notes to the Continuing Care Manager are not reimbursed for unauthorized days.

Hospital Transfers

Admission into a hospital does not automatically revoke the hospice election. Hospital admissions during the hospice election period are the financial responsibility of the hospice agency unless the member signs a Hospice Revocation Form.

If an emergency occurs and the member must be transported by ambulance to a hospital, the hospice agency or inpatient facility must notify EmblemHealth by calling Customer Service immediately, or as soon as possible thereafter. In the event circumstances prevent immediate contact with EmblemHealth, the agency or facility should take all medically appropriate actions to safely transport the member to the nearest hospital.

Note: For Medicare members receiving hospice services, any care not related to the terminal illness should be balance billed to EmblemHealth.

The Care Management model identifies the high-risk members who would benefit most from Care Management/Population Health Management interventions. A cascading decision tree rationale is used to select members for the appropriate interventions. There is a different criterion for each initiative depending on the line of business for Medicare, Medicaid and Commercial products. Relevant criteria for each intervention is reviewed and incorporated into the stratification process to identify the most severe and impactable members. EmblemHealth has a comprehensive strategy for population health management which at a minimum, addresses member needs in the following four areas:

- Keeping members healthy
- ·Managing members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

Practitioners are encouraged to manage care among settings and practitioners for medical and behavioral health thereby ensuring coordination and continuity of care for the member.

EmblemHealth's Case/Care Management program is a member centric approach to managing health care and service needs. The program is voluntary, permitting members to opt in or opt out and is provided at no cost to qualified members. A member must provide verbal and/or written consent to participate. Services may be provided by telephone or in person and are based on National Evidence Based and Clinical Practice Guidelines set forth by the Case Management Society of America's (CMSA) Standards of Practice, the voluntary practice guideline for the care management industry.

Complex Care Management

The Complex Care Management Program includes the following integrated services but may not be limited to Complex Care Management, Transplant Care Coordination, Long Term Services and Supports (LTSS), Special Needs Plan (SNP), HIV, high-risk pregnancy, infants requiring NICU services, and children with complex medical needs. To make a referral to these programs or for more information, call **800-447-0768** or the Managing Entity listed on the member's ID card.

- **Complex Care Management** is at least a 90-day program which focuses on intensive, personalized care management services and goal setting for members who have complex medical needs and require a wide variety of resources to manage health. Quality of care is promoted by using available resources and integration of services as well as a multidisciplinary team approach.
- **Transplant Care Coordination** services focus on building unique relationships with facilities and other service providers to ensure members obtain information, assistance, and the best possible care while maneuvering through the transplant medical process. Services include coordination with resources such as home health care services, durable medical equipment (DME), and inpatient hospitalizations, as well as care coordination and utilization management for 365 days post transplantation.
- **NICU Care Coordination** services focus on building unique relationships with members/caretakers as well as providers to ensure sharing of information, assistance, and delivery of the best possible care while admitted to a

NICU. Services include coordination with resources such as the inpatient hospital, post-acute providers, and community to provide care management for up to 365 days from the date of delivery.

- **HIV/AIDS Care Management** program provides members assistance with finding community resources and supports in navigating the medical system. The program helps members living with HIV/AIDS to self-manage their disease and health care needs.

  Assessment components include but are not limited to:
  - Health history, health status, and health-related needs
  - HIV disease progression, tuberculosis, hepatitis, sexually transmitted diseases, or other medical conditions
  - Viral load, CD4 count, last testing date for labs
  - If member is female of reproductive age – pregnancy status including name of OB/GYN, and Maternal Fetal Medicine (MFM) caring for member's HIV
  - Medications including assessment of adherence
  - Allergies to medication
  - Dental, vision, durable medical equipment, and home care services in place
  - Current health care providers; engagement in and barriers to care
  - Assessment of participation in clinical trials and complementary therapies
  - Partner risk - provide pre-exposure prophylaxis (PrEP) for persons engaged in high risk behaviors to keep them HIV negative or not virally suppressed
  - Assist with referrals to HIV Specialists and New York State Designated AIDS Treatment Centers

EmblemHealth also offers health and wellness activities including Diabetes Prevention Program, services provided through EmblemHealth Neighborhood Care, services provided by ACPNY, disease management programs, treatment of co-morbid depression, tobacco program, and more. See the Health Promotion and Care Management chapter of this manual.

Physicians also receive information about member activities via the care managers embedded in the ACPNY locations, physician notifications regarding case management activities, value-based arrangements and more.

EmblemHealth generally excludes coverage for treatments of an experimental or investigational nature which have not been proven safe and/or effective. To make a coverage determination on an individual patient case, the Utilization and Care Management department staff consults with the physicians involved in the member's care. Together, we make a coverage determination using the policy provisions and the various information sources set forth in the guidelines. Any coverage decisions reached are subject to review according to our grievance and appeal procedures. For more information on experimental/investigational treatments and clinical trials, see Medical Policies.

We also have a Technologies & Bioethics Committee composed of an interdisciplinary team of medical professionals and EmblemHealth department representatives. This committee meets a minimum of 10 times a year to decide when certain technologies previously considered experimental and investigational have come to satisfy the general medical standards in effect in our service area at the time of our evaluation. In doing so, the committee accesses all available resources and information on a particular developing technology and measures it against the criteria described in EmblemHealth's contract provisions. See the Medical Technologies Database for the list of medical technologies reviewed for coverage consideration.

EmblemHealth and our utilization review agents, in collaboration with our contracted physicians and hospitals, perform utilization management activities as required by State and Federal law, and consistent with professional standards developed by CMS, NCQA and URAC. The responsibilities and authority of the parties associated with our utilization management activities are outlined below.

Board of Directors

The Board of Directors is the entity accountable for utilization and care management activities. The Board endorses the written Utilization and Care Management program and receives and reviews utilization and care management statistical reports on a quarterly basis. The Board is responsible for considering and acting upon Utilization and Care Management program recommendations. The Board may accomplish its duties through an appropriately designated subcommittee.

Care Management Committee

The Care Management Committee reviews clinician over and under-utilization patterns and trends, physician performance profiling, and a variety of data which monitor the effectiveness and efficiency of the Utilization and Care Management processes. The committee is responsible for approval of EmblemHealth's Utilization and Care Management policies and procedures, both current and proposed.

Chief Medical Officer/ Medical Directors

EmblemHealth's chief medical officer has overall accountability for the Utilization and Care Management program and provides oversight and direction for all quality improvement and utilization and care management functions including establishing long and short-range Utilization and Care Management program goals relative to EmblemHealth's overall strategic plan. Medical directors serve as resources for physicians and Utilization and Care Management nurses on clinical issues.

Utilization and Care Management Department(s)

The function of the Utilization and Care Management department(s) is to support the utilization and care management activities of EmblemHealth, participating clinicians, hospitals, and other facilities. The Utilization and Care Management department(s) assists clinicians with the determination of appropriate care in an appropriate setting, including the use of participating clinicians to maximize member clinical outcomes and benefit coverage. Our Utilization and Care Management department(s) consists of licensed physicians, nursing professionals, and analysis personnel who work to improve the performance of internal and external processes and the care provided to members through data analysis and process management.

Clinical Personnel

Qualified health care professionals supervise utilization review decisions using procedures for preauthorization and concurrent review. Licensed nurses and other licensed health care professionals, in conjunction with the Medical Directors when appropriate, provide clinical and appropriateness review of referral for patient services based on accepted criteria. Data acquisition and utilization outcomes, trends, quality of care issues, and over and under-utilization statistics are reported to the Care Management Committee.

Documentation of Utilization and Care Management activities is performed primarily in our online computer systems, using specific software designed to facilitate clinical management and decision making. These online records reflect all review findings and actions taken during preauthorization and concurrent management processes. Patient information and review data are collected on all hospital admissions, alternate care admissions, emergency service requests, and all referral requests. Key data elements captured include patient identification, physician-specific data, review actions and outcomes, and other elements based on identified needs. Member confidentiality is ensured in compliance with all HIPAA regulations.

Utilization and care management reports are generated to identify areas of over and under-utilization. The Care Management Committee reviews the reports to determine the need for focused studies and/or intervention activities targeted at clinicians with utilization and/or quality concerns. When patterns of questionable or inappropriate utilization and/or quality concerns are identified, intervention strategies are planned and implemented. Consistent with the established utilization management reporting structure, relevant utilization and care management findings and recommendations are reported to the Care Management Committee, Quality Improvement Committee, and Board of Directors.

Risk identification and management is meant to identify and create an awareness of possible risks which may be potentially harmful to members, visitors, or employees, and reduce the probability of unplanned or unexpected financial loss. Through integration with the Quality Management process, the overall goals are to proactively prevent harm and identify trends.

All risk issues are referred to the Quality Management department for evaluation of potential quality of care issues. Those cases requiring immediate intervention are referred to a Medical Director, and substantial issues and trends are reported to the Clinical Quality Improvement Committee.

No practitioner or provider in Utilization and Care Management may review any case in which there is professional involvement. As a managed care organization, we provide quality care and services to each of our members. We do not specifically reward practitioners, providers or other individuals or agents performing utilization review for issuing denials of coverage or service. When reviewing cases, EmblemHealth and our utilization review agents base all utilization management decisions only on the appropriateness of care and service along with existence of coverage. In addition, staff who render utilization decisions are not provided with any form of financial compensation which would result in the under or over-utilization of services or the rendering of adverse determinations.