EmblemHealth®

PLAN NEWS & REGULATORY REMINDERS

A Message from Karen Ignagni
President and Chief Executive Officer, EmblemHealth

As one of the largest nonprofit health plans, EmblemHealth is leading the transformation to value-based care while working to make the promise of health coverage a reality for all New Yorkers. I'm proud to have joined EmblemHealth and believe that our partnership with you is building a better system for the people we serve.

As a health and wellness company, the well-being of our members is our primary concern. The collaborative relationship we have with you is helping our members – your patients – receive the right care, in the right setting, and at the right time.

Together, we are reducing emergency room visits for minor medical issues. When you're not available, our partnership will maintain the seamless care that we both want for your patients, such as accessing our new Virtual Office Visit commercial benefit, using our nurse advisory line or visiting an urgent care center. Our vision to transform care is focused on quality and value. To make this vision a reality we are:

- Aligning incentives with health outcomes.
- Continuing administrative efficiencies by offering electronic funds transfer/electronic remittance advice (EFT/ERA).
- Delivering a mobile app to help your patients better navigate their health care.

In the coming weeks, we will introduce the Primary Care Physician (PCP) Incentive Award Program, which will incentivize PCPs who care for Medicare, Medicaid/Child Health Plus or Qualified Health Plan members for meeting specific preventive care standards and adhering to standard guidelines related to care for acute and chronic conditions. The program is designed to ensure well visits, preventive screenings and appropriate follow-up care is received. EmblemHealth will provide data and performance analysis to PCPs for their paneled patients and provide support to prioritize care. Detailed information will be shared soon.

Last fall, EmblemHealth achieved Phase III CAQH Core® Certification – a voluntary certification program widely viewed as the industry "gold standard." In the New York City metro area, EmblemHealth is one of only two health plans – and the only nonprofit plan – to receive this certification. This achievement recognizes our efforts and dedication to streamline health care payments to partners like you. Together we are paving the way for positive change in the industry; helping people stay healthy, get well and live better. Thank you for your commitment and partnership in this transformation.

Sincerely,

Karen Ignagni
President and Chief Executive Officer

P.S. To help improve coordinated care and patient-well-being, we encourage you to join your Regional Health Information Organization (RHIO). Please help us advocate for waiving member consents for entities that are permitted to view protected health information (PHI).

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SECTION ONE

INFORMATION TO HELP YOU MANAGE YOUR EMBLEMHEALTH PATIENTS

EMBLEMHEALTH'S NETWORK AND BENEFIT PLANS

Over the past year, EmblemHealth has worked to consolidate our benefit plans and align our plans with their affiliated networks to make it easier for you to understand your network participation. You only need to know which networks you participate in to determine which members your practice can see. We've added the network name to our member ID cards for easy identification. We have also rebranded our Medicaid network the Enhanced Care Prime Network and added HARP and Essential Plan to our suite of Medicaid Managed Care (MMC) plans.

Our latest Provider Networks and Benefit Plans summary on page 4 lists all companies, provider networks and associated member benefit plans.

How can I tell which networks my practice participates in?

The easiest way to know whether or not your practice participates in a particular network is to review your Provider/Practice Profile on our secure provider portal. Take a few minutes to become familiar with the networks in which you participate. Also make sure your office staff, especially those responsible for booking appointments, is aware of your EmblemHealth network affiliations.

- Sign in to our secure website, **emblemhealth/providers** with your user name and password.
- On the left side of the screen, select Provider/Practice Profile.
- Scroll down to select the office location you wish to view.
- Scroll down to the lower section of the profile screen to see your network affiliations.

How do I know which network my patient has?

To identify the EmblemHealth network your patients are enrolled in look for the network name on the front of the member ID card.

Is Your Practice Information Correct? - Update Your Profile as Practice Changes Occur

You are required to notify EmblemHealth in a timely manner of any changes to your demographic information. It's important to routinely check your practice information in our online provider directory by using the Find a Doctor link from the Provider home page.

Keeping your contact information up to date helps ensure that:

- We send claim payments and other important information and contract amendments to the correct address
- Members can find your office and contact you
- You are in compliance with NYSDOH audits

If any of your information is inaccurate, please update the information* as follows:

1. Sign in to our secure website and select Provider/Practice Profile from the left navigation panel.
2. Select Update and make the changes to your profile.

If you don't have access to a computer, please fax your profile changes to our Provider Modifications team at **1-877-889-9061**.

It is also important to have a valid email address and fax number on file. It helps ensure you receive notices, updates to our administrative guidelines and other information. As we continue our efforts to become a greener organization we will convert more of our communications to electronic formats.

*Requested changes will not display automatically. Modifications that do not require verification may take up to 10 business days to appear. Some updates, such as to your license number, specialty or school, will be verified by our Credentialing department and may take longer to appear

We're updating our networks and providing you with more access to commercial members

If you are in the Prime Network or Premium Network, aka Vytra Premium Network, and not already linked to all the commercial benefit plans (except Child Health Plus), we will be updating our records to give you full access to all commercial members associated with these networks if, under our agreement, this change is permissible by notice without your express written consent.

Age range now assigned to internal medicine clinicians:

Internists in the Prime Network and Premium Networks who have not specified an age range for members will have their records updated to reflect members aged 18 and over. If you treat members in a different age range, e.g. 21 and over, you may request a change via the Provider/Practice Profile or, if you are part of a group that is delegated for credentialing, submit it via the monthly file process.

New policy for specialty designations

In order to improve our members' experience while seeking care, and to reduce inappropriate calls to your office, we will periodically update our directories to change the OB/GYN specialty designation to GYN (gynecology) for those who have not submitted a claim for obstetric services in the prior 24 months. Please let us know if you stopped practicing obstetrics less than two years ago and we will update our records accordingly.

EMBLEMHEALTH NETWORKS AND BENEFIT PLANS

Below is a list of EmblemHealth network and benefit plans as of January 1, 2016.

Company	Provider Network	Member Benefit Plan		
GHI	**Commercial:** CBP1, National & Tristate Networks	EmblemHealth EPO/PPO		
	Network Access Network	Network Access Plan		
	Medicare: Medicare Choice PPO Network	EmblemHealth Medicare ASO/PPO Medicare Dual Eligible (PPO) SNP		
HIP/ HIPIC	**Commercial:** NY Metro Network	EmblemHealth CompreHealth EPO/HMO		
	Select Care Network	All Select Care-Based Plans, including EmblemHealth Healthy NY Qualified Health Plans		
	Prime Network	Access® I/II Prime® HMO/POS	Prime® EPO/PPO Select® EPO/PPO	Child Health Plus GHI HMO Plans ConnectiCare†
	Premium Network (aka Vytra Premium Network)	Access® I/II Prime® HMO/POS	Prime® EPO/PPO Select® EPO/PPO	Vytra
	Medicaid/Commercial: Enhanced Care Prime Network	EmblemHealth Enhanced Care (MMC) EmblemHealth Enhanced Care Plus (HARP) Essential Plan (BHP)		
	Medicare: Medicare Essential Network	EmblemHealth Essential (HMO) EmblemHealth VIP High Option (HMO)		
	VIP Prime Network	EmblemHealth Medicare VIP (HMO) EmblemHealth Dual Eligible (HMO SNP) Medicare Supplemental (cost plan)		
	Associated Dual Assurance Network	GuildNet Gold Plus FIDA Plan		

[1]CBP Network ID cards may display the network name as CBP, EPO, EPO1, EPO2, PPO, PPO1 or PPO4.

†GHI HMO, CHP and ConnectiCare benefit plans are now associated with the Prime Network. ConnectiCare, Inc., an affiliate company, has access to the Prime Network as in-plan coverage. No referrals required. Please treat ConnectiCare, Inc. members as participating.

If a member calls and you do not participate in their network, please have your staff direct them to **emblemhealth.com/find-a-doctor/directory** to find a physician that participates in their plan. For a full current listing of EmblemHealth's provider networks to member benefit plans, see the Provider Networks and Member Benefit Plans chapter of the Provider Manual at **emblemhealth.com/ProviderManual**.

ACCESS AND AVAILABILITY STANDARDS - PROVIDING TIMELY CARE TO YOUR PATIENTS

The New York State Department Of Health (NYSDOH), Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) require that EmblemHealth conduct an appointment availability standards survey (to measure and improve patient access to routine, urgent, preventive and specialty care) and a 24-hour access standards survey (to gauge after-hours access to care). They are conducted twice a year, during the spring and fall, to determine our networks' overall compliance with the NYSDOH access and availability standards.

In addition to the EmblemHealth survey, the NYSDOH may call you once or more per year. Please answer these survey questions as you would for all members and demonstrate you can offer appointments within the required time frames and have the appropriate after-hours coverage in place.

Access to care surveys

A sample of participating primary care and OB/GYN practitioners from our print and online directories are randomly selected for the Access and Availability Standards survey. EmblemHealth does not call any practitioner more than once a year, unless they are found to be noncompliant. It is imperative that your contact information is correct in your Provider/ Practice Profile and our online directories so new and existing patients receive accurate information in order to contact you.

As a contracted practitioner, knowing and following the industry standard access and availability guidelines is a contractual requirement. The table on pages 6 to 8 provides our most current Access and Availability Standards. Please post this information for your appointment schedulers. You may also access and print a copy of this brochure at **emblemhealth.com/ provider-toolkit**, in the Access and Availability Standards section.

What happens if my office is noncompliant?

Practitioners who fail to meet access standards are notified of noncompliance and resurveyed approximately five months after the first survey. Practitioners who are not compliant after the second survey will be brought to the attention of our Credentialing/Recredentialing Committee and may be subject to termination from the network.

Increase member satisfaction – comply with office wait time standard

Members with appointments should be seen within 15 minutes, but no later than 30 minutes, of their scheduled appointment time or arrival time. The complaint we hear most from our members, which is also addressed in the yearly CAHPS® survey, is dissatisfaction with waiting room delays. If a delay is unavoidable, the member should be informed and offered alternatives. One option would be to allow members to check in by phone and come in closer to the time they will actually be seen by the physician.

Access and availability standards - Americans with Disabilities Act (ADA) requirements

All providers must meet ADA requirements and have a signed ADA Accessibility Attestation Form on file with EmblemHealth. Providers must notify EmblemHealth within 10 business days of any change in his/her ability to meet the ADA Accessibility standards as outlined in the signed ADA Accessibility Attestation Form, which can be found in the Credentialing chapter of the provider manual at **emblemhealth.com/ProviderManual**.

Lessons Learned: Top Reasons for Survey Failures - Avoid These Mistakes

Appointment Availability

- No answer/answering machine after three attempts to call on different days and different times
- On hold for more than 10 minutes in all three attempts and/or office staff is too busy to assist
- Appointment given was not within the availability standard for the type of appointment requested
- Practitioner or office staff states – he/she does not participate in the plan or does not practice at the location
- Is not scheduling appointments at the time of the call
- Office requires copies of medical records before making an appointment for a new patient
- His/her panel is closed, but the plan has it listed as open

24-Hour Access

- Answering machine recording does not include an option to reach the provider directly
- Answering machine recording simply instructs the member to go to the emergency room
- Answering machine does not have the ability to leave a message
- No answer after three attempts to call on different days and different times
- Respondent refused to speak to surveyor or verify provider

After hours access to care - where do your patients access care when your office is closed?

Hospital emergency rooms are for very serious or life-threatening problems, or any condition the member believes is life threatening. We urge you to let your patients know that hospital emergency rooms are not the place to go for common illnesses or minor injuries.

When your office is closed, urgent care clinics provide attention for non-life-threatening medical problems or problems that could become worse if the member waited to seek care. Urgent care clinics provide walk-in appointments and are often open seven days a week with extended hours.

Urgent care clinics are appropriate for:

- Common illnesses such as colds, the flu, ear aches, sore throats, migraines, fever, rashes
- Minor injuries such as sprains, back pain, minor cuts and burns, minor broken bones, or minor eye injuries

To find a list of network urgent care centers, use the Find a Doctor tool on our website at **emblemhealth.com/find-a-doctor.**

Appointment availability during office hours and after-office hours access standards

STANDARDS	DEFINITION	SCHEDULED APPOINTMENT TIME FRAME
Emergency Care (Emergent)[1]	Medical care given for a condition that, without immediate treatment, could result in placing the member's life or general health in severe jeopardy, or cause severe impairment in one or more bodily function(s), or cause severe dysfunction of one or more body organ(s) or part(s). Examples of emergency conditions include seizure, stab and gunshot wounds, diabetic coma, cardiac arrest, meningitis and obvious fracture (bone showing through skin).	Requires immediate face-to-face medical attention. If a practitioner or covering practitioner is not immediately available, the member or representative should call **911**.
Urgent Care	Medical care given for a condition that, without timely treatment, could be expected to deteriorate into an emergency or cause prolonged, temporary impairment in one or more bodily function(s), or development of a chronic illness or need for a more complex treatment. Examples of urgent conditions include abdominal pain of unknown cause, unremitting new symptoms of dizziness cause unknown and suspected fracture.	Requires timely face-to-face medical attention within **24 hours** of member notification of the existence of an urgent condition.
Non-Urgent Sick Visit	Medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non-urgent sick visit include cold symptoms, sore throat and nasal congestion.	Requires face-to-face medical attention within **48 to 72 hours** of member notification of a non-urgent condition, as clinically indicated.
Routine Primary Care	Include the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/reduce risk of development of chronic illness or the need for more complex treatment. Examples include psoriasis and chronic low back pain.	Requires a face-to-face visit within **4 weeks** of member request.
Preventive Care/Routine Physical Exam	Rendered to avert disease/illness and/or its consequences. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred.	Requires a face-to-face visit within **4 weeks** of member request.

1 Emergency Care (Emergent): "Emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

STANDARDS	DEFINITION	SCHEDULED APPOINTMENT TIME FRAME
Routine Specialty Care	Medical care given by a specialist. Examples include podiatry and neurology.	Requires a face-to-face visit within **4 weeks** of member request.
Assessment Regarding Ability to Perform/ Return to Work	An appointment for assessment of the member's mental health/ medical status needs as related to recommendation regarding member's capability to perform or return to work.	Requires appointment within **2 business days** of member request.
Initial Family Planning/ Reproductive Health Visits	Include screening and treatment services to prevent, diagnose, alleviate or ameliorate sexually transmitted diseases, anemia, cervical cancer, glycosuria, proteinuria, hypertension and breast disease. Also includes routine gynecological examinations, pregnancy testing and HIV counseling and testing.	Requires a face-to-face visit within **2 weeks/14 days** of member request.
Initial Prenatal Visit	Medical care given for a condition in which the patient has tested positive for pregnancy and is requesting an initial visit.	Requires appointment scheduled within **3 weeks** for first trimester, **2 weeks** for second trimester and **1 week** for third trimester. A follow-up appointment scheduled is given to the patient based on American College of Obstetricians and Gynecologists Guidelines and practitioner risk assessment.
Postpartum Visit	During the postpartum visit an assessment of the mother's blood pressure, weight, breasts, abdomen and a pelvic exam is conducted to determine the mother's physical health status and general wellbeing following childbirth.	Requires a face to face visit within **21** – **56** days following delivery
Routine GYN Visit	A situation in which a short delay in treatment would not result in deterioration to a more severe level or cause need for more complex treatment. Examples include routine Pap smear and refill of oral contraceptives.	Requires a face-to-face visit within **4 weeks** of member request.
Pediatrician Conference	A prenatal visit (during third trimester) is recommended for parents who are at high risk, for first-time parents and for those who request a conference.	Requires appointment scheduled within **10 days** of member request or as clinically indicated.
Follow-Up Visit for Breast- Fed Infants	Medical care given for a condition in which delay of treatment could result in failure to thrive, dehydration and/or malnutrition.	Requires face-to-face medical attention within 48 to 72 hours of discharge.
Initial Newborn PCP Visit	An appointment for assessment of a newborn's physical status to ascertain the general well-being of the child and to promote early detection of immediate medical needs and promote early educational opportunities.	Requires appointment within **2 weeks** of hospital discharge.
Routine Well-Child Visits	Provided to members under 21 years of age that are essential to: a) prevent, diagnose, prevent the worsening of, alleviate or ameliorate the effects of an illness, injury, disability, disorder or condition; b) assess the overall physical, cognitive and mental growth and developmental needs of the child; and c) assist the child to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.	Requires well-child services within **4 weeks** of member request.
Any Other Condition		Up to medical judgment of the practitioner.

STANDARDS	DEFINITION AND BENCHMARK
Geographic (GEO) Access Standards for All Physicians	Members must be offered a choice of at least three PCPs, three OB/GYNs and three high-volume specialists within program distance/travel time standard. • Normal condition/primary road – 30 miles/30 minutes. • Rural areas – 60 miles/60 minutes.
Office Waiting Time Standard	Members with appointments should be seen within 15 minutes, but no later than 30 minutes, of their scheduled appointment time or arrival time, whichever is later. If a delay is unavoidable, the member should be informed and offered alternatives.
24-Hour Accessibility	All network practitioners must be available, either directly or through coverage arrangements, 24 hours a day, 7 days a week, 365 days a year. Availability must be by live voice direct to the practitioner or covering practitioner, or via an answering service that can reach the practitioner or covering practitioner. If an answering machine is used, it must provide an option for the member to directly contact the practitioner or covering practitioner in case of emergencies. An answering machine cannot simply refer the member to an emergency room unless it is a life-threatening issue.

USING THE EMBLEMHEALTH WEBSITE

New to our website?

Take a Tour and learn more about the tools and resources available to you at **emblemhealth.com**. The Take a Tour link is located inside the login screen box on the provider home page.

Register for access to our secure website.

The most efficient, safe and streamlined way to do business with EmblemHealth is through our secure website. It is also the quickest, most cost-effective and environmentally friendly way to receive and send information. If you haven't already done so, please sign up for secure access today on our provider home page at **emblemhealth.com/Providers**. In the yellow Sign In to My Account box, click Register for Access and complete the required fields.

Note: HIP providers have a provider number for each of their locations and must register each provider number separately. GHI providers have only one provider number, but must register for each of their TINs separately.

How do I use Find a Doctor to find my provider number(s)?

- Go to our Find a Doctor search at **emblemhealth.com/find-a-doctor.**
- Do a Visitor Search by entering your ZIP code.
- If you are a HIP provider, select an HMO plan in which you participate (e.g., HIP Prime® HMO). If you are a GHI provider, select an EPO/PPO plan in which you participate (e.g., EmblemHealth PPO).
- Search by your name.
- On the results page, click on your name to access your provider number, listed as Directory Number on the screen. If you are a HIP provider and have multiple locations, click See Other Locations and then See Details for each location to gather all of your provider numbers.

How many times do I need to register?

- If you are a HIP provider, you need to register each office location separately, using your location-specific provider numbers. So if you have three locations, you will need to complete the registration process three times.
- If you are a GHI provider, you need to register each TIN used to submit claims separately. So if you have two TINs, you will need to complete the registration process two times. Use the same provider number for each registration.
- If you are both a HIP and GHI provider, please follow the instructions in the first two bullets.

Once registered, use the security application to set up staff, link to yourself at other locations and link to other clinicians in your practice.

THE EMBLEMHEALTH PROVIDER MANUAL – AN EXTENSION OF YOUR PROVIDER CONTRACT

Your go-to document

The EmblemHealth Provider Manual is your go-to document for our latest administrative guidelines. The information contained in the provider manual is an extension of your contract with EmblemHealth, and as a network provider you are required to follow the policies and procedures contained in the manual. The EmblemHealth provider manual is available from the provider page at **emblemhealth.com/ProviderManual** and includes topics such as:

- Networks/benefit plans descriptions and tables
- Member rights and responsibilities
- Access and availability standards
- Medical record guidelines
- Credentialing standards
- Pharmaceutical management procedures
- Dispute resolution protocols
- Care and case management programs
- Disease management programs
- Utilization management programs
- Referrals and prior approval requirements
- Clinical review criteria
- Regulatory policies and requirements (outlines the government reporting requirements to which you must adhere)

Subscribe to Receive Provider Manual Updates Today!

Sign up to receive an email when changes are made to the EmblemHealth Provider Manual. Revisions are made as policies are reviewed, new programs introduced and contractual and regulatory obligations change. To ensure you always have the most up-to-date information, please visit **emblemhealth.com/ProviderManual** and select the entire manual, a chapter or section and click the Subscribe button at the top right of the page.

NETWORK LABORATORY SERVICES

Keeping members in network

Quest Diagnostics (Quest) is our preferred free-standing, independent commercial lab. Quest helps members receive maximum plan benefits with lower out-of-pocket expenses and ensures complete clinical outcome data reporting to EmblemHealth.

Quest will provide a collection box and courier service to and from your office for specimen collection. If specimens need to be drawn outside of your office, members should be directed to the nearest contracted laboratory Patient Service Center and be given the requisition form to hand carry.

For specialty lab tests not available from Quest, you may use one of the other contracted free-standing, independent commercial labs listed in the Directory chapter of the provider manual.

Members may also receive services at hospital-affiliated labs, where covered under the hospital agreement with us.

Quest even offers a special free online tool, Care360®, which allows our members to give you permission to see all of their lab test results in one location. This not only reduces unnecessary duplication of tests, but supports care coordination among all providers.

Participating practitioners are required to utilize our network laboratories. Failure to comply may result in removal from our network.

ENROLL IN EMBLEMHEALTH'S NO COST EFT-ERA PROGRAM TODAY

Have you enrolled in PNC Remittance Advantage? If not, now is the time! On **October 22, 2015, EmblemHealth discontinued mailing paper remittances** to providers who are currently receiving both 835 electronic and paper remittances. PNC Remittance Advantage offers paperless claim payments and electronic remittances **free of charge**. We urge you to take advantage of this program. Electronic transactions are fast, convenient and lower the risk of lost or stolen payments. PNC Remittance Advantage combines direct Electronic Funds Transfer (EFT) payments with 835 Electronic Remittance Advices (ERA).

How to enroll

Gather your provider ID number and bank account information. Go to PNC Remittance Advantage at **https://rad.pnc.com**. Select the Register for Portal and Online Payment Services link and follow the instructions for enrollment. If you need additional help with the registration process, please call the PNC Remittance Advantage help line at **1-877-597-5489,** Monday through Friday, 8:30 am to 8:30 pm.

Informational webinars

PNC offers webinars online. If your practice or organization is interested in a webinar, you may email PNC at **Remit.Advantage@pnc.com**. If you have questions or need assistance, please contact PNC at **1-877-597-5489**.

Encourage NYC Patients to Download the Small Steps app

Living a healthy life can be a challenge and communicating to your patients how to remain healthy can be an even harder endeavor. EmblemHealth wants to support you in keeping your patients on the path toward a healthier lifestyle. Tracking healthy habits like staying active and keeping hydrated is easy with the Small Steps to a Healthier You app. Your patients can download this simple app from iTunes and the Google Play Store for FREE or by visiting **smallsteps.emblemhealth.com**.

SECTION TWO
QUALITY IMPROVEMENT INITIATIVES

OVERVIEW: QUALITY IMPROVEMENT PROGRAM

EmblemHealth's Quality Improvement Program (QIP), in alignment with state, federal and accreditation requirements, establishes protocols to facilitate continuous improvement in medical (including pharmaceutical and dental) and behavioral health (BH) care and service provided to EmblemHealth's complex, cultural- and language-diverse membership. The program takes an active position in helping our members stay healthy, get better quickly and live effectively with illness. Through outreach in easy-to-understand language via mail, telephone, web and fax, QI staff periodically contact members

and physicians to encourage them to complete recommended preventive and follow-up services for chronic health conditions. EmblemHealth practitioners participate in quality improvement initiatives, including CMS and HHS specific initiatives, implemented by the QIP through the Quality Committee structure. The EmblemHealth website offers tools and resources to help providers address their patient's needs and safety. For more information on the QIP, visit the provider page of **emblemhealth.com**, select Provider Resources and go to the Provider Toolkit. The Toolkit contains a link to the Quality Improvement Program Overview. We welcome your input and suggestions and seek to foster open communication between health care constituencies to ensure the best quality care for our members. Please contact the QI team at **1-888-447-5451** with your feedback.

STRIVING FOR EXCELLENCE - HELP US REACH FIVE STARS!

Coming Soon….our Quality Incentive Program for HMO PCPs with members in Medicare, Medicaid/ CHP and Qualified Health Plans (including HARP and Essential Plan). Plus, a member incentive program will also be available to encourage members to get the care they need, when they need it.

GAPS IN PREVENTIVE HEALTH AND CHRONIC CARE MAINTENANCE

EmblemHealth is in the unique position of having access to information about all health care services provided to each member. This enables us to identify any gaps in their preventive and/or chronic care maintenance. When gaps are identified, EmblemHealth notifies members of the gap, educates them about the importance of the needed service, and encourages them to discuss this topic at an upcoming office visit. To ensure the member's provider is aware of these gaps, EmblemHealth often sends providers a panel report identifying their EmblemHealth patients with gaps in care.

MEDICAL RECORD GUIDELINES – ACCURACY COUNTS

We require our network practitioners to maintain accurate medical records and we provide the resources to help you meet the expectations regarding medical records. Clinical practice guidelines, member preventive health guidelines and medical record review tools are available under the Provider Manual and Additional Resources section of the provider page of **emblemhealth.com**. For more information on medical record review requirements, please refer to the EmblemHealth provider manual, also available on that page.

Include advance directives in member's medical record

Our physicians and practitioners should discuss advance care planning with all patients aged 66 years and older, or as appropriate. Documentation regarding advance care planning being discussed and the date of the discussion should be noted in the patient's medical record. When a patient provides a copy of an advance directive (e.g., living will, power of attorney, health care proxy), actionable medical orders (e.g., do not resuscitate [DNR], Physician Orders for Life Sustaining Treatment [POLST]), living will, or designation of a surrogate decision maker, the provider should include the document(s) in the patient's medical record. It is a best practice to include a prominent notation that the medical record contains an advance directive.

CMS medical record documentation requirements

CMS requires that patient medical records are accurate and complete, legible and must include the patient's name and date of service, as well as documentation supporting the diagnosis, treatment plan and outcomes. An acceptable practitioner signature and credentials must appear on each patient encounter record in their medical file.

REPORTING CLINICAL PERFORMANCE

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is a set of performance measures used to assess, compare and report the quality of care provided by managed care organizations. The specifications are developed by NCQA, a private, non-profit organization dedicated to improving health care quality. HEDIS® performance of regional and national managed care plans is publicly reported annually in Quality Compass. Summary data and additional information can be found at NCQA's website, **ncqa.org**.

Quality Assurance Reporting Requirements (QARR)

QARR is a tool used by New York State to measure performance. It contains both HEDIS® and NYS-specific measures. The Medicare Health Outcomes Survey (HOS) is used to gather data related to the physical and mental health status of a random sample of Medicare members.

Because HEDIS® performance measures are supported by clinical recommendations from the U.S. Preventive Services Task Force (USPSTF) and other national organizations, EmblemHealth requires practitioners to strictly adhere to HEDIS® guidelines and specifications for all members during each measurement year. EmblemHealth will communicate the HEDIS® results to both practitioners and members to encourage the use of preventive services and thus, improve health outcomes.

Here's how you can help:

When billing, use applicable codes that correspond to ALL services rendered during the visit. Include the codes with the most specific definition of the diagnosis, procedure, and/or associated result. This practice will likely lead to an automatic HEDIS®/QARR 'hit', which may potentially reduce chart collection.

Remember to:

- Bill with appropriate CPT, HCPCS and ICD codes
- Provide the health plan with access to the member's EMR or encounter data
- Closely follow Clinical Practice Guidelines
- Use codes associated with HEDIS®/QARR value sets

ANNUAL CONSUMER ASSESSMENT OF HEALTH CARE PROVIDERS AND SYSTEMS (CAHPS®) SATISFACTION SURVEY

How Your Patients, Our Members, Rate You and EmblemHealth

The importance of members' experiences with their physicians

In March, the CAHPS® survey will be issued to a sample of members and to rate member satisfaction with their doctors and with us. The quality of your interactions with your patients, our members, is reflected in the CAHPS® survey results. The following survey categories address members' experiences with their physicians when obtaining care. It is in these categories that you can best help improve your patients' experiences, and their satisfaction.

- **Getting care quickly:** Rates the member's experience with getting doctor appointments as quickly as needed. Consider having your patients arrange their next appointment at the conclusion of their office visits. If calling the office, encourage them to contact the office during times that are less busy so they can easily get through.
- **Getting needed care:** Rates ease of getting appointments with specialists, getting necessary care, tests or treatments. Consider making that appointment while the patient is in the office. This helps to ensure the patient is adhering to the mutually agreed upon treatment plan.
- **How well doctors communicate:** Rates how well the members' doctors explained things in a way the patient understood, listened carefully to the patient, showed respect for what was said, and whether enough time was spent with them. Understanding and addressing their cultural and language needs impacts how a patient perceives the relationship with the doctor. See cultural competency modules available on learn a link

- **Shared decision making:** Rates if the doctor talked with the patient about reasons he/she may or may not want to take the medication. Also asked what he/she thought was best when discussing starting or stopping a prescription medicine. Reasons could include cost, fear of side effects and more.
- **Coordination of care:** Rates the member's experience with how often his/her personal doctor seemed informed and up-to-date about the care the member got from other doctors, specialist, or health practitioners. Coordination of care also includes addressing if you talked about medications, gave test results and if the member received help managing care. Assisting the member to secure appointments, following-up with appointments and getting the medications, can help the member adhere to the treatment plan.
- **Health promotion and education:** Rates whether the member and his/her doctor talked about specific things the member could do to prevent illness.

The 2015 CAHPS® results indicate that members could be more satisfied with getting needed care and getting care quickly. Facilitating access to care when needed is important to patient health and satisfaction.

You Can Help

You can help us improve member satisfaction by offering patient appointments for dates sooner than expected, seeing patients within 15 minutes of their appointment times, having your office staff inform patients if you will be late for an appointment, spending unhurried time with patients and explaining medical matters in easy to understand terms.

MEMBER HEALTH MANAGEMENT – PATH PROGRAMS

We offer health management programs (also known as PATH programs) to help your patients manage their chronic medical conditions. Teaming with you to enhance their quality of life is our goal. The program supports practitioner care plans by using evidence-based clinical practice guidelines to emphasize how members can prevent complications and flare-ups of chronic conditions.

The following PATH programs are voluntary and available to all members who meet eligibility requirements:

PATH Program	Phone Number/ Contact	Medical Condition
Better Breathing PATH for Asthma	**1-888-881-3112**	Asthma (limited to Medicaid members only)
Better Breathing PATH for COPD	**1-888-881-3112**	COPD (chronic obstructive pulmonary disease)
Diabetes Care PATH	**1-888-881-3112**	Diabetes
Healthy Beginnings PATH	**1-888-447-0337**	Prenatal program (We partner with Alere to identify and enroll pregnant members into Healthy Beginnings PATH.)
Heart Care PATH for Coronary Artery Disease	**1-888-881-3112**	Coronary artery disease
Heart Care PATH for Heart Failure	**1-888-881-3112**	Heart failure
Kidney Care PATH	**1-866-561-7518**	End-stage renal disease or chronic renal failure (We partner with OptumHealth Resource Services to identify and enroll members into Kidney Care PATH.)
Steps-4-Safety PATH	**1-888-447-5451**	Fall prevention and reduction of environmental risk factors that can lead to falls
New York State Smoker's Quitline	**1-866-697-8487**	Tobacco cessation

If you think any of your EmblemHealth patients could benefit from these programs, call us or have your patients call us. Our PATH programs are designed to complement your care. We offer outbound calls and ongoing education. Members in need of PATH programs are identified via health-risk surveys, claims data, self-referral and referrals through you, their doctors and practitioners. For additional information about our PATH programs, refer to the Health Promotion and Disease Management > PATH Programs section of the provider manual.

Help Your Patients Stay Fit

EmblemHealth has health and wellness programs, tools and resources to help members stay fit and enhance their quality of life. EmblemHealth members have access to **Healthy Discounts** programs at no additional cost. Participating vendors offer discounts for health club memberships, acupuncture, massage therapy, nutrition counseling, weight loss services, hearing and vision care, vitamins and supplements, and other comprehensive health care products and services. More information about these services is available at **emblemhealth.com**.

BEHAVIORAL HEALTH SCREENING

EmblemHealth supports the early detection, assessment and treatment for BH issues in the primary care setting. Early detection and intervention can have a significant impact on the health outcomes and quality of life of individuals we serve. Effective screening may also help you determine when a patient might need to be referred for treatment in a BH treatment setting. EmblemHealth strongly encourages you to screen your patients for depression, anxiety and substance abuse using the free and easy-to-use tools that can be found at **emblemhealth.com**.

SECTION THREE

WHAT'S NEW FOR 2016

2016 CHANGES to EMBLEMHEALTH SELECT CARE BENEFIT PLANS

The New York health insurance marketplace, also known as the NY State of Health Marketplace, is an online medium where individuals and small businesses can compare and shop for health plans. EmblemHealth offers individual and small group Select Care plans both on the Marketplace (on-exchange) and off the Marketplace (off-exchange).

The table below lists all of the EmblemHealth Select Care Network plans for 2016

2016 Select Care Network Benefit Plans			
On Marketplace		**Off Marketplace**	
Individual			
Marketplace Plans: Select Care Bronze Select Care Silver EmblemHealth Essential Plan*	Select Care Gold Select Care Platinum Select Care Basic	**Individual Direct Purchase Plans:** Select Care Bronze D Select Care Silver D	Select Care Gold D Select Care Platinum D Select Care Basic D
Small Business			
Marketplace Plans: Select Care Bronze S Select Care Silver S Select Care Gold S	Select Care Platinum S EmblemHealth HMO HD6300 S EmblemHealth HMO 35/55 S EmblemHealth HMO 40/60 S	**Direct Purchase Plans:** EmblemHealth HMO 15/35 EmblemHealth HMO HD6300	EmblemHealth HMO 35/55 EmblemHealth HMO 40/60 EmblemHealth Healthy NY HMO

Note: Most of these plans have a deductible that applies to in-network services.
*Utilizes the Enhanced Care Prime Network; providers are reimbursed at the EmblemHealth Medicaid rate.

When referring your Select Care patients to a specialist or other ancillary service or facility, please refer members to other Select Care providers. The Select Care Network includes a full complement of physicians, participating hospitals, community health centers, urgent and immediate care centers, plus a wide range of additional services. To locate participating providers, please use the Find a Doctor online directory at **emblemhealth.com/find-a-doctor** and create all your referrals using our secure provider portal.

NEW FOR 2016 – ESSENTIAL PLAN

- Offered on the EmblemHealth Enhanced Care Prime Network
- Unlike other on-exchange products, service area is limited to an eight-county region

Both individual and small group Select Care plans and the Essential Plan cover the 10 categories of essential health benefits. Individuals pay no cost-sharing (no deductible, copay or coinsurance) on preventive care services, such as checkups, screenings and vaccinations. For 2016 health coverage, the open enrollment period ended on January 31 for individual plans both on and off the Marketplace. Small groups have a rolling open enrollment and can apply during any month of the year.

For more information, see our quick reference guide at **emblemhealth.com/~/media/Files/PDF/Providers/SelectCare_Welcome.pdf.**

EmblemHealth offers its individual and small group Select Care and Essential Plan members a number of noteworthy value-added benefits, such as our health and wellness programs and discounts:

- **Virtual Office Visits:** Offers Select Care members a faster and more convenient way to consult a doctor via phone, computer or tablet (excluding the Essential Plan).
- **Gym Reimbursement:** Members can get reimbursed for the cost of membership.
- **Local Fruit & Veggies Program:** Aims to increase member access to local fruits and vegetables and offers a discount on those purchases, while giving them an incentive to visit their PCP.

SUMMARY OF MEDICARE BENEFIT & PLAN DESIGN CHANGES FOR 2016

- Added comprehensive dental to VIP HMO and VIP High Option plans
- Reduced premium for Essential HMO members in Westchester County
- Introduction of premium for Essential HMO in New York, Queens and Richmond counties
- Over-the-counter (OTC) medications decreased to $20 per month for HMO SNP
- OTC medications decreased to $15 per month for PPO SNP
- Rx Tier 5 - specialty cost-sharing decrease for non-SNP plans from 33 percent to 25 percent
- Lower Initial Coverage Limit (ICL): $2,950 for non-SNP plans
- Premium & cost-sharing increases for all plans, except for those described above
- Nonrenewal of MLTC Plus (HMO SNP) plan

Remind members they can access a full list of services and any benefit limitations by referencing their Evidence of Coverage (EOC).

Please be sure to refer your Medicare patients to other Medicare providers. To locate participating providers, please use the Find a Doctor directory at **emblemhealth.com/find-a-doctor** and create all your referrals using our secure provider website at **emblemhealth.com/Providers**.

To identify Medicare members, look for the Medicare network names - Medicare Essential, VIP Prime, or Medicare Choice PPO - on the front of the member ID card, or sign in to our secure provider website to view the member's eligibility.

ENROLLMENT IN MEDICARE REQUIRED TO PRESCRIBE DRUGS FOR MEDICARE MEMBERS

CMS has issued a new rule that requires physicians and, when applicable, other eligible professionals who write prescriptions for Part D drugs to be enrolled in Medicare in an approved status (or validly opt out, if appropriate) **no later than January 1, 2016**, for their prescriptions to be covered under Part D beginning June 1, 2016. To enroll in Medicare, please visit the CMS Part D Prescriber Enrollment website at **go.cms.gov/PrescriberEnrollment**.

MERGER: VALUE OPTIONS AND BEACON HEALTH STRATEGIES

Value Options and Beacon Health Strategies recently merged and are now known as Beacon Health Options. Both organizations shared a vision to improve the health and well-being of individuals coping with mental health and substance use conditions. There are no changes to your patients' benefits as a result of this merger.

CHANGES TO PRECERTIFICATION PROCESS FOR GHI PPO CITY OF NEW YORK EMPLOYEES/NON-MEDICARE ELIGIBLE RETIREES WITH GHI PPO BENEFITS

Effective January 1, 2016, utilization management for the City of NY employees or non-Medicare eligible retirees with GHI PPO benefits will be managed by Empire BCBS for inpatient and outpatient services. EmblemHealth will process pre-certification requests for the following:

- Home Health Care
- Home Infusion Therapy (billed by a home infusion specialist)
- MRI/MRA/PET/CAT/Nuclear Cardiology
- Nutritional Supplements and Enteral Formulas

To request precertification from Empire BCBS, please call **1-800-521-9574.**

To request precertification from EmblemHealth you may utilize our secure provider website **emblemhealth.com/Providers**, fax your request to **1-212-563-8391**, or call the Coordinated Care Intake department at **1-800-223-9870**.

SECTION FOUR:

MEDICAID AND LOW COST PLAN PROGRAM UPDATES

MEDICAID PRIME NETWORK REBRANDED TO ENHANCED CARE PRIME NETWORK

To help our doctors and practitioners recognize our Medicaid members, we worked with the NYSDOH to identify new names for the network and benefit plan we could include on our member ID cards. If you participate in the Enhanced Care Prime Network (formerly Medicaid Prime Network), then you may see patients with these three associated benefit plans:

- Medicaid Managed Care plan, rebranded as Enhanced Care;
- HARP plan, offered as of October 1, 2015, is now Enhanced Care Plus; and
- Basic Health plan, offered as of January 1, 2016, called Essential Plan.

The Essential Plan is not a Medicaid product. It is a hybrid between a Qualified Health Plan (QHP) and Medicaid. It offers comprehensive coverage to all individuals between the ages of 19 and 64 (U.S. citizens) or 21 and 64 (legal residing immigrants) earning between 133 percent and 200 percent of the federal poverty level. The Essential Plan is available as a commercial product in the five boroughs of NYC, Nassau, Suffolk and Westchester counties through the New York State of Health Marketplace.

If a member calls and you do not participate in their network, please have your staff direct them to **emblemhealth.com/find-a-doctor/directory** to find a physician that participates in their plan.

REMINDER: MEDICAID PROVIDER NONINTERFERENCE

Medicaid providers and their employees or contractors cannot interfere with the rights of Medicaid recipients in making decisions about their health care coverage. Medicaid providers and their employees or contractors are free to inform recipients about their contractual relationships with MMC programs, including Fully Integrated Duals Advantage (FIDA). However, they are prohibited from directing, assisting or persuading recipients on which plan to choose or keep.

If a Medicaid recipient expresses interest in a MMC program, providers and their employees or contractors must not dissuade or limit the recipient from obtaining information about these programs. Instead, they should direct the recipient to **New York Medicaid Choice**, the NYS enrollment broker responsible for providing Medicaid recipients with eligibility and enrollment information for all managed long-term care plans. The phone number is **1-888-401-6582**.

HEALTH AND RECOVERY PLAN (HARP): WHAT PROVIDERS NEED TO KNOW

EmblemHealth Enhanced Care Prime Network providers may now also see patients in a new benefit plan called EmblemHealth Enhanced Care Plus (a Health and Recovery Plan or HARP). HARP is a managed care product for adult Medicaid beneficiaries aged 21 and over, who are eligible for mainstream MMC, and meet the criteria for Serious Mental Illness (SMI) and Substance Use Disorders (SUD).

EmblemHealth Enhanced Care Plus enrollment began October 1, 2015, and will be phased in, beginning with current EmblemHealth Enhanced Care plan adult enrollees in NYC who are system-identified as HARP eligible. Eligible MMC enrollees will either be passively enrolled or given an option to enroll in a HARP, depending upon current plan enrollment. EmblemHealth Enhanced Care Plus (HARP) will begin to be offered in Nassau Suffolk and Westchester counties in July 2016.

HIV Special Needs Plans (SNP) will cover the expanded BH benefit and all HARP services for eligible enrollees, in addition to the SNP covered benefit package.

It is important for EmblemHealth Enhanced Care Prime Network providers to be familiar with their network affiliations. Providers should also become familiar with the BH transition process to better assist consumers in understanding enrollment notices, HARP selection and to maintain current patient relationships. Providers are encouraged to refer to the July 2015 Special Edition Medicaid Update located at **health.ny.gov/health_care/medicaid/program/update/2015/jul15_mu_speced.pdf** to learn more about expansion of BH services in MMC and the services available through HARP.

EMBLEMHEALTH ENHANCED CARE PLUS MEMBERS THAT NEED CARE DURING NONTRADITIONAL OFFICE HOURS

EmblemHealth maintains an extensive network of after hour and urgent care centers throughout the service area. Members should be educated about and urged to utilize these facilities instead of the hospital emergency room for nonurgent care.

Enhanced Care Plus members have access to a behavioral health (mental health or substance use) **crisis hotline** at any time through Emblem Behavioral Health Services at **1-888-447-2526**. Members whose PCP is in the Montefiore network should call **1-800-401-4822**.

2015 MEDICAID REDESIGN TEAM UPDATES

The following summarizes the 2015 Medicaid changes. For more detailed information see the Claims Corner section on **emblemhealth.com/Providers**.

Issue Date 1/16/2015: **Benefit Change – Permanent Nursing Home Stays**

Phase I: New York City Residents
Effective **February 1, 2015**, the MMC nursing home benefit will be expanded to include coverage of permanent stays in residential health care facilities for Medicaid recipients aged 21 and over who reside in the five boroughs of New York City.

Medicaid recipients in permanent nursing home status prior to February 1, 2015, will continue to be covered by fee-for-service Medicaid.

MMC plans will be responsible for members who enter permanent resident status on and after February 1, 2015, and these members will no longer be disenrolled from their managed care plan.

Phase II: Nassau, Suffolk and Westchester County Residents
Effective **April 1, 2015**, the MMC nursing home benefit will be expanded to include Medicaid recipients aged 21 and over who reside in Nassau, Suffolk and Westchester counties.

Voluntary Enrollment
Effective **October 1, 2015**, eligible New York City, Westchester, Nassau and Suffolk county Medicaid recipients who were in permanent residence in a nursing home will be able to enroll in managed care on a voluntary basis.

Issue Date 1/30/2015: **Obstetrical Providers Reimbursed for Immediate Postpartum Contraception**

On July 17, 2014 – the NYSOH issued a Medicaid policy change which allows health care providers to be reimbursed when intrauterine devices (IUDs) and contraceptive implants are offered and chosen immediately after childbirth.

Issue Date 6/1/2015: **MRT Compliance C-Section/Early Delivery Billing Update**

Effective **July 1, 2015**, New York State Medicaid will further reduce payment for early elective deliveries performed without an acceptable medical indication. Claims for elective deliveries prior to 39 weeks without a documented medical indication will be reduced by 25 percent. The increased penalty reflects the Medicaid Program's commitment to providing high quality prenatal care by ensuring appropriate delivery for both mothers and babies. This action affects the payment policy for MMC obstetric delivery claims.

COMPLIANCE: HOME CARE WORKER WAGE PARITY LAW

Organizations, hospitals or hospital systems who contract with entities to provide home care services for EmblemHealth Medicaid members in NYC as well as Nassau, Suffolk or Westchester counties are required to provide the NYSDOH and EmblemHealth with quarterly written certification of your organization's or hospital's compliance with the minimum wage requirements of the Home Care Worker Wage Parity — Public Health Law of §3614-c.

Submitting your quarterly certifications to EmblemHealth

We will contact you each February, May, August and November via fax and ask that your wage parity certifications be faxed back to EmblemHealth. Annual certifications are due by March 1 of every year. Quarterly certifications are due to EmblemHealth on March 1, June 1, September 1 and December 1 of each year. We ask that you comply with this regulation and provide your information when requested.

MEDICAID PROVIDER DISCLOSURE OF OWNERSHIP AND CONTROL

The NYSOH requires written disclosure regarding ownership, control and criminal convictions related to certain controlling persons' involvement in Medicare, Medicaid or Title XX programs. Specifically:

- Section 42 CRF455.104 – Requires Managed Care Organizations, like EmblemHealth, to collect the disclosure of complete ownership, control and relationship information from certain entities identified in the statute. These include: all participating hospitals, skilled nursing facilities, home health agencies, independent clinical laboratories, renal disease facilities and any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges for health-related services for which it provides claims payment under any plan or program established under Title V or Title XX of the Act.
- Section 42 CRF455.106 – Requires Managed Care Organizations, like EmblemHealth, to collect and report health care-related criminal conviction disclosure information (initially and upon renewal of their contracts), of any managing employee who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or a Title XX program.

Disclosure forms must be completed and submitted as part of the credentialing and recredentialing processes. Disclosure forms must also be submitted when a reportable event occurs and upon request of the NYSDOH and EmblemHealth.

MEDICAID EXPANDS COVERAGE FOR HIV TESTING

Effective December 1, 2015, NYS MMC began reimbursement for an HIV-1/2 immunoassay capable of detecting HIV-1 antigen(s) and HIV-1 and HIV-2 antibodies (CPT 87806) in an office setting. Additional information regarding rapid HIV testing can be found on the NYSDOH website.

TRANSPORTATION CARVE-OUT FOR MEDICAID MANAGED CARE ENROLLEES IN NASSAU AND SUFFOLK COUNTIES

Effective December 1, 2015, emergency and non-emergency transportation (NEMT) services were carved out of the MMC benefit package for all MMC enrollees in Nassau and Suffolk counties. LogistiCare Solutions, LLC was selected as the NEMT management contractor for Nassau and Suffolk counties. Medical providers are advised to contact LogistiCare Solutions, LLC at 1-844-678-1106 to arrange for NEMT of managed care enrollees in Nassau and Suffolk counties beginning December 1, 2015.

SCHOOL-BASED HEALTH CARE BENEFIT

Effective July 1, 2016, the provision of School-Based Health Center (SBHC) and SBHC- Dental (SBHC-D) Services will be incorporated into the MMC benefit package. As a result, MMC Plans will be responsible for reimbursing our SBHC sponsor agencies for services to Medicaid enrollees.

SECTION FIVE

2015 RECAP

POLICY ALERTS:

The following additional Policy Alerts were published in 2015. Refer to **emblemhealth.com/Providers/Provider-Resources.aspx.**

Submitting A Request for an Expedited Appeal or Reconsideration

An expedited appeal can be requested for situations where the patient's health could be placed in serious jeopardy or their ability to regain maximum function could be impacted if the standard timeframe was applied.

Expedited appeals apply only to services that have not yet occurred or are ongoing, not in cases where services have already been provided.

The quickest way to file an expedited appeal is to call **1-888-447-6855** or fax us at **1-866-350-2168**.

For fax submissions, please include a copy of the initial adverse determination notice and all additional clinical information you want us to consider in the appeal.

Spine Surgery and Pain Management Therapies Program

During the fourth quarter of 2015, EmblemHealth implemented a new utilization management program for spine surgery and pain management therapy. This program requires providers to contact OrthoNet directly to obtain prior approval for select spine surgery and interventional pain management therapy procedures. This applies to services provided by practitioners in their offices (POS 11), in an outpatient hospital (POS 22), ambulatory surgery center (POS 24) or inpatient hospital (POS 21) setting. Our partnership with OrthoNet gives you access to experts in the field of Orthopedics and Pain Management who can assist you in planning the best and most effective course of treatment for your patients.

For more information on this program, including affected networks, prior approval process and complete code list refer to the Provider Manual, EmblemHealth Spine Surgery and Pain Management Program chapter.

CLAIMS CORNER

The following additional Claims Corner articles were published in 2015. Refer to **emblemhealth.com/Providers** for more information.

ClaimsXten® — Claims Audit Software

In February 2015 EmblemHealth upgraded its ClaimsXten® software to the newer ICD-9- and ICD-10-compliant version and expanded its use to include GHI claims in April 2015. ClaimsXten® is now used to apply consistent and accurate claim editing and processing guidelines for all commercial and government medical claims. Prior to this update, only HIP claims were edited by the ICD-9-compliant version of this product. EmblemHealth follows the policies of CMS, the American Medical Association and its own medical policy regarding the correct coding of claims.

Reimbursement Policy Concerning an Unplanned Return to the Operating Room; Modifier 78 Will Receive a 20% Fee Reduction

EmblemHealth follows CMS reimbursement Policy for **Modifier 78** for all Lines of Business. **Modifier 78 is used to report the unplanned return to the operating/procedure room by the same physician following an initial procedure for a related procedure during the postoperative period.**

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first surgical procedure, and requires the use of the operating/procedure room, it may be reported by adding the Modifier 78 to the related procedure.

New Reimbursement Rules for Modifier 53 – Discontinued Procedure

Effective September 1, 2015, reimbursement under all plans is at 50 percent of the base fee schedule. This does not include multiple surgical reductions, bilateral pricing, etc., that may also be applied.

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. It may be necessary to indicate that a surgical or diagnostic procedure was started, but discontinued due to extenuating circumstances or conditions that threaten the well-being of the patient. This circumstance must be reported by adding CPT modifier 53 to the code reported by the physician for the discontinued procedure.

Correct Use of Modifier 25

AMA CPT describes and defines the use of Modifier 25 as follows:

Description: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.

Definition: It may be necessary to indicate that on the day a procedure or service was performed, as identified by a CPT code, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided, or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

To avoid any payment adjustments, we recommend you apply the definition for use of Modifier 25 when coding your claims, in addition to carefully documenting each service provided. Accurate coding translates clinical documentation into uniform diagnostic and procedural data sets and provides the evidence that the services billed were rendered to the patient.

Disputing a Claim Determination

If you do not agree with a payment determination, you have the right to file a grievance. You must first submit the portion of the medical record that supports additional reimbursement. We will review the submitted medical record(s) to assess the guidelines used and medical documentation to support the use of Modifier 25. EmblemHealth will adjust those claims where documentation substantiates the use of this modifier.

Drug Testing and Screening Code Updates

- **2015 American Medical Association (AMA) Current Procedural Terminology (CPT) Drug Testing Codes (80300 – 80377)**
  Consistent with CMS coverage guidelines, EmblemHealth will not recognize the new 2015 AMA published drug testing CPT codes 80300 through 80377. These CPT codes are not eligible for health insurance plan reimbursement under the Physician Fee Schedule or under the clinical laboratory fee schedule.
- **2015 CMS Drug Testing Codes (G6030 – G6058)**
  For free-standing and hospital-based clinical laboratories only, EmblemHealth will recognize Healthcare Common Procedure Coding System (HCPCS) codes G6030 through G6058 for drug testing services, consistent with CMS coverage guidelines. However, HCPCS codes G6030 through G6058 are not eligible for reimbursement under the Physician Fee Schedule and EmblemHealth will not reimburse physicians for these services.
- **Physician Point-of-Care Drug Screening:**
  Qualitative drug screen testing performed in the physician office setting is eligible for reimbursement when reported with Healthcare Common Procedure Coding System Level II codes G0431 and/or G0434. Both codes G0431 and G0434 will be eligible for one (1) unit of reimbursement per date of service.

Coding – Oral Antiemetic Drug Akynzeo®

Akynzeo® (Q0181 or Q9978) must be billed on the same claim with dexamethasone (J8540) to qualify for consideration of coverage. There must be no unbundling of the netupitant and palonosetron combination in Akynzeo®. Claim lines billed without a KX, GA or GZ modifier will be rejected as missing information.

New Medicare Preventive Services

CMS added three new covered services for members effective as of January 1, 2015:

- Group therapy for obesity
- Digital Breast Tomosynthesis that allows for three-dimensional imaging of tissue using X-ray technology
- Chest CAT (CT) scans are covered for Medicare members when a history of smoking or other environmental factors have been shown

Annual Fee Schedule Updates From CMS/Medicaid, Etc.

Each year EmblemHealth updates its systems based upon fee schedules approved by CMS. These updated fee schedules are used to calculate applicable payments to our practitioners. It is EmblemHealth's policy that once the newest schedule is received from CMS, it is loaded, tested and available to pay claims within 60 days. Once loaded, claims received after the load date are paid using the updated fee schedule, if applicable, and no retroactive adjustments based on this new fee schedule will be made on claims submitted prior to the initial 60-day time frame.

Submitting Claims for Noncredentialed Practitioners in a Group Arrangement or for a Nonpar Substitute Physician

All providers that are part of an EmblemHealth-contracted medical group are considered contracted providers for purposes of processing claims. In the rare circumstance that a medical group individual practitioner is not credentialed in the EmblemHealth network, he or she is considered to be covered by the group arrangement.

For all other practitioners whose practice includes a noncredentialed individual practitioner that shares the same TIN or NPI, specialty/taxonomy code and location with them (Substitute Practitioner), claims for the Substitute Practitioner's services should be submitted/billed by the medical group or by the regular participating practitioner and will be reimbursed at the regular participating practitioner's contracted fee schedule. Substitute Practitioners are not required to enroll with the health plan and should not bill the health plan directly.

Costs Connected With Cosmetic Surgery Are Not Covered

EmblemHealth adopted cosmetic procedures to include any services related to a noncovered cosmetic procedure. across all of our networks and plans. Ancillary services related to cosmetic procedures are not considered medically necessary and are also not covered. EmblemHealth does not cover cosmetic procedures under the following circumstances:

1. When the procedure is performed solely for psychological reasons.
2. In the absence of documentation that substantiates the procedure is being performed to restore or improve bodily function or is medically necessary.

All cosmetic surgery requires prior approval.

Coverage Policy for Helicobacter Pylori

As of July 20, 2015, EmblemHealth no longer covers Helicobacter pylori (H. pylori) antibody testing (CPT 86677) as this serological antibody test does not accurately identify active H. pylori infection, nor does it provide accurate therapeutic guidance.

Help Your Members Manage Healthcare Costs with the Treatment Cost Calculator (TCC)

Talk to your patients about utilizing the TCC which is accessible from the member portal. With this tool you can help your patients determine their financial responsibility before they decide to undergo a treatment or procedure. The online tool provides accurate, real-time estimates of out-of-pocket costs that are personalized to the member using their specific benefits, deductible, provider and location. The TCC provides timely, accurate and trusted information to help make critical healthcare decisions.

EMBLEMHEALTH NEIGHBORHOOD CARE – RESOURCES FOR YOU AND YOUR PATIENTS

Our EmblemHealth Neighborhood Care (EHNC) locations serve the whole community, including you and your patients, regardless of what, if any, insurance they have. The warm and welcoming staff at our EHNC locations is there to answer questions, solve problems and provide solutions, helping to remove obstacles in the way of health and well-being.

EHNC does not provide medical care. It does, however, provide assistance to keep patients compliant with the care plans you give them, including medication adherence. EHNC also offers care plan assistance, classes, events, health screenings, information and help understanding insurance. To help you refer your members to us, we have created and posted EHNC Referral Forms to the Provider Tool Kit. In addition, each site has a neighborhood room – a space that is available to you to hold staff meetings or other events.

Periodically, we offer you and your staff educational workshops at these sites. Please come for an orientation or a refresher on how to make EmblemHealth work with your practice. See our Forums and Webinars at **emblemhealth.com/Providers**.

Please feel free to stop by any of the EHNC locations any time, call to schedule a tour or go online and get more information at **ehnc.com**.

All EHNC sites are open Monday to Friday, 10 am to 6:30 pm and Saturday, 10 am to 3:30 pm.

Harlem
215 W 125th Street New York, NY 10027
1-866-469-0999

Chinatown
87 Bowery New York, NY 10002
1- 855-283-2151

Cambria Heights, Queens
206-20 Linden Blvd, Cambria Heights, NY 11411
1- 866-539-0999

Opening April 2016 - Crown Heights, Brooklyn
546 Eastern Parkway, Brooklyn, NY 11225

LEARN ONLINE – REQUIRED TRAINING AND OPPORTUNITIES – WEBINARS AND FORUMS

Training and continuing education – required online learning

Required training is accessible via the Learn Online page on **emblemhealth.com**, (accessible from the Provider Resources page), including:

- Each year, all providers are required to review the Fraud, Waste and Abuse training module.
- Each year, all providers in the Medicare Choice PPO Network and the VIP Prime Network are required to complete the Special Needs Plan (SNP) Model of Care (MOC) Training for each of the Dual Eligible SNPs in which they participate, as mandated by the Centers for Medicare & Medicaid Services (CMS). In March 2016 you will receive an ID/PIN number to take this online training. Providers without computers may request a printed version and attestation of completion to return to us for tracking and reporting to CMS.

- We offer monthly online live webinars on the second Wednesday of each month at 10am and 2pm. We hope you and your staff will join us for one of our live webinars to learn:
  - About EmblemHealth's newest suite of networks and products
  - Ways we can support you in caring for your patients
  - Key ways you can simplify how you administer our plans

RELIGIO-CULTURAL COMPETENCY

Jump-start your cultural competency education and take advantage of the Medical Manual for Religio-Cultural Competency. It is the most comprehensive guide to religion and health care, providing practical information to help you understand how a patient's medical decisions can be influenced by their religious observances. As a leader in providing information on innovative and evidence-based approaches to health care, EmblemHealth is pleased to offer this first-of-its-kind publication at no cost to our network practitioners. To order a copy from EmblemHealth, go to the Learn Online page under Provider Resources at **emblemhealth.com/providers** and scroll down to see the offer for a free book.

SECTION SIX

REGULATORY NOTICES

CONFIDENTIALITY PROTOCOLS FOR DOMESTIC VIOLENCE VICTIMS AND ENDANGERED VICTIMS

Please let your affected patients know they are entitled to these privacy protections:

- Group policy members may request that we enforce an order of protection against the policyholder or other person, and we will not disclose their address or telephone number (or of any person or entity providing covered services to the member) for the duration of the order.
- We will accommodate any reasonable request for a covered individual to receive communications of claim-related information by an alternative means or at an alternative location, if they give us a valid order of protection or they let us know that they are a victim of domestic violence and will be in danger by the disclosure of certain information.

MANDATORY REPORTING

Government reporting procedures - Tracking public health

To ensure public safety and track conditions that affect public health, New York State agencies, the NYSDOH and the NYCDOHMH have enacted laws practitioners must follow. Our network practitioners are required to participate in these government reporting procedures and, as part of this mandate, may need to report to one or more of the following agencies and adhere to all rules, regualtions and codes:

- Centers for Disease Control and Prevention (CDC)
- Food and Drug Administration (FDA)
- NYC Department of Health and Mental Hygiene (NYCDOHMH)
- NYS Cancer Registry (NYSCR)
- NYS Central Register of Child Abuse and Maltreatment
- NYS Department of Health (NYSDOH)
- NYS Immunization Information System (NYSIIS)
- NYS Penal Code
- NYS Pesticide Poisoning Registry
- NYS Rules and Regulations on Controlled Substances-Public Health Law

- NYCDOHMH Citywide Immunization Registry (CIR)
- NYCDOHMH Lead Poisoning Prevention Program (LPPP)
- NYSDOH Alzheimer's Disease and Other Dementias Registry
- NYSDOH Bureau of Communicable Disease Control
- NYSDOH Bureau of Occupational Health - Occupational Lung Disease Registry
- NYSDOH Center for Environmental Health
- NYSDOH Congenital Malformations Registry
- NYSDOH Division of Quality and Surveillance for Nursing Homes and ICFs/MR (DQS)
- NYSDOH Hospital Complaints
- NYSDOH Office of Professional Medical Conduct

Communicable disease reporting

Practitioners must report suspected or confirmed cases of communicable diseases, such as tuberculosis (TB), to the patient's local health department, as required by the NYS and City health laws.

- The NYSDOH has communicable disease reporting guidelines as well. For mandatory physician reporting of patient information, visit the NYSDOH website at health.ny.gov and search for Infection Control Reporting Requirements, which lists communicable diseases and instructions All diseases that require submission must be reported within 24 hours of a diagnosis.

EmblemHealth conducts a monthly Communicable Disease Audit to ensure that practitioners comply with these regulations. We choose practitioners at random based on a review of reportable diagnoses identified by the NYSDOH.

Citywide immunization registry reporting

For Medicaid and Child Health Plus (CHP) members, you are also required to provide data exchange services to support the Citywide Immunization Registry (CIR) and Lead Poisoning Prevention Program (LPPP).

New York City's Health Code Article 11 requires that certain diseases and conditions be reported to NYCDOHMH immediately and others within 24 hours. Visit the NYCDOHMH website at **nyc.gov** and refer to Health Care Providers > Notifiable Diseases & Conditions. For immediate consultation on public health issues, call the Provider Access Line at **1-866-692-3641.**

NONDISCRIMINATION

The network provider represents and warrants to EmblemHealth that he or she will not discriminate against members with respect to the availability or provision of health services based on a member's race, ethnicity, creed, sex, age, national origin, religion, place of residence, HIV status, source of payment, plan membership, color, sexual orientation, marital status, veteran status, or any factor related to a member's health status, including, but not limited to, a member's mental or physical disability or medical condition or handicap or other disability, claims experience, receipt of health care, medical history, genetic information or type of illness or condition, evidence of insurability (including conditions arising out of acts of domestic violence), disability or on any other basis otherwise prohibited by state or federal law.

Further, the provider shall comply with Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 C.F.R. part 84; the Americans with Disabilities Act; the Age Discrimination Act of 1975, as implemented by regulations at 45 C.F.R. part 91; other laws applicable to recipients of federal funds; and all other applicable laws and rules, as required by applicable laws or regulations. The provider shall not discriminate against a member based on whether or not the member has executed an advance directive. The provider acknowledges that EmblemHealth is receiving federal funds and that payments to the provider for covered services are in whole or in part from federal funds.

YOUR PROVIDER AGREEMENT – REQUIRED LANGUAGE

Your Provider Agreement includes mandatory contract language required by the State of New York and CMS, including the Managed Care Law of 2009, the NYS DOH Standard Clauses, the Special Provisions Related to Medicaid Members and the Medicare Advantage Addendum. Below is a list of the required contract language documents, copies of which can be found in the Required Provisions to Network Provider Agreements chapter of the Provider Manual.

- **Managed Care Law of 2009**
- **Medicare Advantage/Medicare-Medicaid Required Provisions**
- **New York State Standard Clauses – May 2015**
- **Provision Related to Medicaid, Managed Long Term Care and Family Health Plus Members**
- **Special Provisions Related to Medicaid and Family Health Plus Members**
- **Standard Clauses for Managed Care Provider/IPA Contracts for the Fully-Integrated Duals Advantage Program**

Note: This document provides website names as a convenience, as well as an educational and informational service to our providers. They are not intended to provide medical or professional advice. All medical information, whether from these websites or from any other source, must be reviewed carefully by the practitioner. The opinions and information expressed herein are not necessarily those of EmblemHealth. EmblemHealth does not guarantee or warrant that the websites referenced in this document, or any information contained therein, are complete, accurate or up to date since the date of this document's publication in February 2016.

NOTES

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