CARE MANAGEMENT

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This chapter outlines our philosophy, policies and procedures for the coordinated care of our members, including referral and prior approval requirements, case management programs and utilization review guidelines.

OVERVIEW

The purpose of the Care Management program is to create an alliance among our network practitioners, clinicians, hospitals, facilities and ancillary services in order 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 prior approval, concurrent management, discharge planning and case management services. These processes are reviewed by our Quality Improvement/Utilization Management Committee on an annual basis.

EmblemHealth will provide the clinical review criteria used to make such determinations upon written request to the plan's Care Management program. Please forward all requests to:

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

We invite comments and suggestions from our providers to assure these policies support the quality and value of the health care that our members receive. Please submit comments using our Message Center by signing in to **www.emblemhealth.com**.

Help for Providing Care Through a Continuum of Services

Qualified clinical professionals in the Care Management program 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 and in hospitals, skilled nursing facilities and other settings.

We strive to 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 prior approval to help the member select the right care, in the right setting with the right provider. 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. Where the complexity of a particular member's needs requires services by multiple providers across different health care systems, our nurse case managers will assist the practitioner and member to support the care needs. Care for FIDA members will be coordinated in their IDTs and Medicaid and HARP members through their Health Homes.

The procedures and practices discussed in this chapter apply to all of our plans; however, certain variations in **referral requirements**, **authorization requirements** and coverage exist depending on the plan and benefit package. Please see the applicable subsections for further information.

Note: EmblemHealth conducts care management and also delegates this function to certain utilization review agents. Whether the care management for a particular member is delegated depends on the PCP that member has selected. Follow the instructions on the back of each plan member's ID card to contact the managing entity responsible for that member's care management, or contact the member's plan if you have any questions. For HIP members, managing entity may also be identified on the Eligibility Details page after signing into the secure provider website: **www.emblemhealth.com/Providers**.

UTILIZATION MANAGEMENT PROCESS AND POLICY

Utilization Management Decision Making

For clinical decision making, we utilize nationally recognized criteria (including InterQual) and evidence-based guidelines, such as our medical policies (provided in Clinical Corner at **www.emblemhealth.com/providers/provider-resources/clinical-corner**) and CMS guidelines. The Quality Improvement/Utilization Management Committee (QIUMC) reviews our utilization management criteria and medical policies annually. Guidelines and policies are available for review upon request.

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 will consult 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 that is under review.

Medical Appropriateness Review

The purpose of medical appropriateness review is to ensure that:

- 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

Serious Medical Conditions

As stated in the participating provider agreements, the provider acknowledges that we have procedures to identify, assess and establish treatment plans for individuals with complex or serious medical conditions. In signing their contracts, providers agree to comply with all applicable EmblemHealth administrative guidelines, including the policies and procedures.

TYPES OF UTILIZATION REVIEWS

The following are types of reviews that we and our delegates conduct, along with the time

frames in which our utilization determinations must be made (once the necessary information is received).

Prior Approval

We must make a determination if a prior approval is warranted and notify the member and the provider of the determination by phone and in writing. The determination must be made within three business days of receipt of the necessary information.

In addition to the phone calls made and letters sent, providers will be able to access the status of a prior approval request, and the determination when made, at **www.emblemhealth.com** after signing in. At this time, for 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 business day of receipt of the necessary information. Hospitals and skilled nursing facilities receive a Concurrent Review Status Report for HIP and CompreHealth EPO (Retired August 1, 2018) members twice daily in the morning and afternoon, which is posted to **www.emblemhealth.com** behind sign-in.

In addition to the phone calls made and letters sent, providers will be able to access the status of a case when they sign in to **www.emblemhealth.com**. Hospitals and skilled nursing facilities receive a Concurrent Review Status Report for HIP and CompreHealth EPO (Retired August 1, 2018) members twice daily in the morning and afternoon, which is posted to **www.emblemhealth.com** behind sign-in.

Retrospective

We must make a determination if a retrospective approval is warranted and notify the member and the provider of the determination by phone and in writing. We must make a decision within 30 days of receipt of the necessary information.

Expedited

The expedited review must be conducted when we determine, or when the provider indicates a delay would seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum functions. Members have the right to request an expedited review, but we may provide an adverse determination and notice will be given under standard time frames.

Reconsiderations are available to providers for adverse determinations whenever possible. Physicians who were not involved in the initial determination will review appeals. Written notice of the determination will be provided to the patient, to the attending provider, and to the facility, if applicable. Notification of adverse determinations will include the clinical rationale for the determination and all applicable grievance and appeal rights. Provider appeal rights are further described in the Dispute Resolution chapters of this manual.

Expedited Review of Inpatient Cases

If the review does not meet medical necessity criteria, the concurrent review nurse reviews the case with an EmblemHealth medical director who will render 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/or fax within one working day of making the decision, and gives members and practitioners written or electronic confirmation within 24 hours if the request is received 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 will be made within one business day of receipt of all necessary information but no more than 72 hours from receipt of request.

PRIOR APPROVAL PROCEDURES - PRACTITIONERS AND FACILITIES

The physician or organization providing or requesting the service is responsible for obtaining prior approvals. As part of an ongoing effort to decrease physicians' administrative burden and ensure prompt access to care for our members, we regularly review and update our prior approval policies. Please subscribe to this chapter and its sections to receive email notification of updates.

The following require prior approval 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 period. An EmblemHealth or managing entity medical director must approve standing referrals via the prior approval process.

Specialists as PCPs
A specialist may substitute as a PCP for a member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, when authorized by the managing entity's medical director. Whenever possible, the specialist who will be acting as a PCP should be dually board-certified. A treatment plan must be agreed upon among the PCP, the managing entity's medical director and the specialist.

Specialty Care Centers
A member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a referral to a specialty care center. Such referral will require prior approval by the managing entity's medical director. A treatment plan must be agreed upon among the PCP, the managing entity's medical director and the provider.

Use of Out-of-Network Providers
All requests to see out-of-network providers are reviewed against the member's benefits, the plan's provider network, and the medical necessity of treatment by an out-of-network provider.

Members with a Point of Service, PPO, or Access II contract may elect to receive specialty care from an out-of-network specialist without a PCP referral if they elect to use their out-of-network benefits (including appropriate out-of-pocket expenses). If the service requires prior approval, the member is responsible for obtaining prior approval from the managing entity.

For more details regarding when out-of-network providers can be used, please see the **Commercial Networks**, **Medicaid Network,** and **Medicare Networks** sections of 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 that will be made for new members.

Prior approval is required for members who do not have out-of-network benefits. Prior approval 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. See the **How to Obtain a Prior Approval** section of this chapter for more information on how to request prior approval. If a specialist is not available in the network and prior approval 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 will authorize services in accordance with established time frames in the:

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

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

Submitting an ICD-10 Compliant Prior Approval or Referral Request

When submitting a prior approval or referral request, use the date that you are **entering** the prior approval or referral request (NOT the date of service) to determine whether to use ICD-9 or ICD-10 codes. Unless there are any new CMS guidelines, the following requirements apply with no exceptions.

- For prior approval or referral requests entered **before** October 1, 2015, use ICD-9 codes only. Those submitted with ICD-10 codes will not be accepted and must be modified to use ICD-9 codes.
- For prior approval or referral requests entered **on or after** October 1, 2015, use ICD-10 codes only. Those submitted with ICD-9 codes will not be accepted and must be modified to use ICD-10 codes.
- Prior approval or referral requests submitted with a combination of ICD-9 and ICD-10 codes will not be accepted and must be modified to use either ICD-9 or ICD-10 codes (based on date of entry of prior approval request).

For more information on submitting ICD-10 compliant claims, please see the **Claims** chapter.

Continuity/Transition of Care - New Members

Upon enrollment, the member shall select a PCP from whom the member may request continuation of care. When appropriate, EmblemHealth will permit new members to continue seeing their current out-of-network practitioner for up to 60 days or as otherwise required to accommodate the needs of **medically fragile children** and **foster children** covered by Medicaid.

If on the effective date of enrollment a member has a life-threatening disease or condition or a degenerative and disabling disease or condition, the member may continue to see their current out-of-network practitioner for up to 60 days. In the case of pregnancy, if the member has entered into her second trimester, she may continue to see the nonparticipating practitioner through delivery and postpartum care for up to 60 days for care related to the delivery for Medicaid members. 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 in the midst of ongoing course of treatment with an out-of-network provider
2. Second and third trimester of pregnancy (up to 60 days postpartum directly related to the delivery for Medicaid members)

If transitions of care and/or continuity of care is approved, it will be 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 of the following:

- Accept our reimbursement rates as payment in full
- Adhere to our **Quality Improvement program**
- Provide medical information related to the enrollee's care
- Otherwise adhere to our policies and procedures including those regarding referrals and obtaining prior approvals and a treatment plan approved by our applicable Prior Authorization department. (See the **How to Obtain Prior Approval** section in this chapter.)

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.

Continuity/Transition of Care - Benefits Exhausted or Ended

We collaborate with the members and their providers and practitioners to assure that members receive the services needed, within the benefit limitations of their contracts. When benefits end for members, the Utilization Management department will assist, 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 will be given the option of continuing an ongoing course of treatment with his or her current practitioner for a transitional period of up to 90 days. If the member has entered the second trimester of

pregnancy, the transitional period includes the provision of postpartum care through 60 days postpartum 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 contact the appropriate Anticipated Care department (see the **How to Obtain Prior Approval** section in this chapter).

EmblemHealth will permit a member to continue with their current practitioner as long as 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 that impairs the health professional's ability to practice. The practitioner must agree to all of 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 prior approval for services and obtaining an approved treatment plan

Services That Require Approval for HIP Network Plans

Pre-authorization List

What requires prior approval?
Services that require prior approval are now consistent for the networks listed above, unless the service is not covered by the member's benefit plan. When submitting a prior approval request, there may be minor exceptions in timing, for example, the number of referral visits allowed before a prior approval request must be made. A **Prior Approval Look-up Tool** to simplify determination of what procedures need pre-service review and approval became operational on January 22, 2014. Sign in to our secure website to access the Look-up Tool.

Who conducts the pre-service review?
Pre-service reviews are administered by the managing entity on the member ID card or by the vendor managing a utilization program on our behalf. The following services require prior approval in accordance with the member's benefit plan:

- All inpatient confinements:
  - Emergency admissions*
  - Elective hospital admissions
  - Skilled nursing facility admissions
  - Rehabilitation facility admissions
  - Inpatient hospice admission
- Services and procedures provided in an ambulatory or outpatient surgery center. For exceptions, effective **June 15, 2014**, see **Services That Do Not Require Prior Approval**.
- All procedures (outpatient, ambulatory surgery and inpatient) that require an assistant surgeon or co-surgeon
- Reconstructive surgery or other procedures that may be considered cosmetic, including but not limited to:

  - Blepharoplasty/canthopexy/canthoplasty
  - Breast reconstruction/breast enlargement
  - Breast reduction/mammoplasty
  - Cervicoplasty
  - Chemical peels
  - Cosmetic procedures (see EmblemHealth's **cosmetic surgery procedures medical policy** located in **Clinical Corner** under **Provider Resources**)
  - Excision of excessive skin due to weight loss
  - Gastroplasty/gastric bypass
  - Gender reassignment surgery
  - Hair transplant
  - Injection of filling material
  - Lipectomy or excess fat removal
  - Otoplasty
  - Pectus excavatum repair
  - Rhinoplasty/rhytidectomy
  - Surgical treatment of gynecomastia
  - Sclerotherapy or surgery for varicose veins
- Outpatient cardiac and pulmonary rehabilitation
- Nonemergent services when rendered by nonparticipating providers in accordance with the member's benefit plan
- All procedures considered experimental and investigational (see the **EmblemHealth Medical Technologies Database** located in **Clinical Corner** under **Provider Resources**)
- All home health care services, including home uterine monitoring, home hospice and home sleep study services
- Home infusion therapy
- Some types of durable medical equipment (DME; see **Durable Medical Equipment** chapter.)
- Dental implants and oral appliances
- Elective (nonemergent) transportation by ambulance, ambulette or medical van, and all transfers via air ambulance (see the **Medical Transportation Procedures** chapter)
- Genetic testing, including:
  - BRCA 1 and BRCA 2 Genetic/BRAC Analysis Rearrangement Testing (BART)
  - Genetic testing for colorectal cancer
  - Genetic testing for long QT syndrome
  - Genetic testing - BRAC Analysis Rearrangement Testing (BART)
  - Genetic testing - comparative genomic hybridization (CGH) microarray for chromosomal imbalance (various manufacturers)
  - Genetic testing - cystic fibrosis
  - Genetic testing - familial hypertrophic cardiomyopathy
  - Genetic testing - KRAS sequence variant analysis for predicting response to colorectal cancer drug therapy
- Assisted reproductive infertility treatments, including pre-implantation genetic testing
- All major organ transplant evaluations and transplants, including but not limited to kidney, liver, heart, lung and pancreas and bone marrow replacement, and stem cell transfer after

high-dose chemotherapy

- Services covered by vendor-administered utilization programs, which may require prior approval. See **Prior Approval Requests for Vendor-Administered Utilization Management Programs** for services and entities responsible for authorizing services.
  - All inpatient behavioral health services for psychiatric care, including alcohol and substance abuse detoxification and rehabilitation (see the **Behavioral Health Services** chapter)
  - Chiropractic services (see the **Chiropractic Program** chapter)
  - Outpatient PT/OT (see the **Physical Therapy and Occupational Therapy** chapter)
  - Outpatient diagnostic radiology services (see the **Radiology Program** and **Cardiology Imaging Program** chapters)
  - Radiation therapy (see the **Radiation Therapy Program** chapter)
  - Specialty drugs (see the **Injectables and Specialty Pharmacy Program** chapter)
  - Spine surgery and pain management therapies (see the **EmblemHealth Spine Surgery and Pain Management Therapies Program** chapter)

* Prior approval is not required for emergency admissions. However, EmblemHealth must be notified within 24 hours. The services will be reviewed for medical necessity following notification and submission of clinical information.

Services That Require Prior Approval for EmblemHealth EPO/PPO

- All non-emergency inpatient hospital admissions (acute, rehabilitation, behavioral health and skilled nursing facility care)
- Assistant surgeon (does not apply to Medicare members). Prior approval should be requested at the time the surgery is authorized to determine the necessity of the request.
- Services and procedures provided in an ambulatory or outpatient surgery center. For exceptions, effective **July 1, 2016**, see **Services That Do Not Require Prior Approval**.
- Air ambulance
- Land ambulance (non-emergent)
- Ambulette
- Diagnostic heart catheterization (contact eviCore at **1-800-835-7064**)
- Durable medical equipment (customized[1] or rental[2]) (See the **Durable Medical Equipment** chapter for more information.) **Note:** Prior approval required only for DME in excess of $2,000 ($500 for Medicare Advantage)
- Home health care (nursing, PT, OT, ST, home infusion therapy)
- Hospice (covered under Medicaid Managed Care and traditional Medicare). Prior approval requirement does not apply to Medicare Advantage.
- Hyperbaric oxygen therapy
- Lymphedema therapy
- Midwifery services
- Neuropsychological and psychological testing
- Outpatient cardiac and pulmonary rehabilitation
- Podiatry procedures (hammer toe repair, hallux valgas correction, excision of Morton's neuroma, resection of calcaneal spur/plantar fasciotomy, resection of Haglunds deformity)
- Radiation therapy (see the **Radiation Therapy Program** chapter for more information)
- Skilled nursing facility admissions

- Sleep studies
- Sub-acute behavioral health services (partial hospitalization, ambulatory detoxification, outpatient electroconvulsive therapy)
- Transplant evaluation and services
- Services covered by vendor-administered utilization programs, which may require prior approval. See **Prior Approval Requests for Vendor-Administered Utilization Management Programs** for services and entities responsible for authorizing services.
  - All inpatient behavioral health services for psychiatric care, including alcohol and substance abuse detoxification and rehabilitation (see the **Behavioral Health Services** chapter)
  - Chiropractic services (see the **Chiropractic Program** chapter)
  - Outpatient PT/OT (see the **Physical Therapy and Occupational Therapy** chapter)
  - Outpatient diagnostic radiology services (see the **Radiology Program** and **Cardiology Imaging Program** chapters)
  - Radiation therapy (see the **Radiation Therapy Program** chapter)

[1]Any prosthetic, orthotic or equipment that must be designed and built to meet the specific needs of a patient (e.g., power wheelchairs, braces, prosthetic limbs). Please note that mastectomy supplies (HCPCS codes L8000, L8001, L8010 and L8030) do not require prior approval.

[2]Any equipment intended for short-term home use (e.g., oxygen and its delivery devices, hospital beds, wheelchairs and scooters). In general, Medicare coverage rules apply.

Prior Approval Requests for Vendor-Administered Utilization Management Programs

EmblemHealth has engaged a number of vendors to conduct utilization management for certain segments of our member populations. Full descriptions may be found in the following chapters:

- **Cardiology Imaging Program**
- **Chiropractic Program**
- **Injectables and Specialty Pharmacy Program**
- **Physical and Occupational Therapy Program**
- **Radiation Therapy Program**
- **Radiology Program**

If a member is not covered by the vendor program, prior approval must be obtained from the managing entity indicated on the member's ID card or on our website.

Prior Approval for Procedures, Supplies and Drugs for Erectile Dysfunction Treatment

In May 2005, the NYSDOH suspended all coverage for erectile dysfunction (ED) prescription drugs for the Medicaid and Healthy New York programs, as well as for direct pay members.

Effective February 1, 2006, health plans were required to employ procedures attendant to legislation to exclude from coverage procedures and supplies for the treatment of ED for sex offenders enrolled in Medicaid. No guidance has been received from the New York State Department of Financial Services (NYSDFS) on how the ED ban will be implemented for the Healthy New York program or direct pay members.

Medicaid members may be prescribed 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 Prior Approval Request outlined below is followed

The NYSDOH created a prior approval program for Medicaid members for the provision of ED procedures and supplies, so that the member's eligibility can be confirmed. The physician must submit a prior approval request to EmblemHealth or to the entity listed on the back of the member's ID card for the excluded ED services. A prior approval clinical manager or a designated prior approval nurse will send 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 will be reviewed for medical necessity. If appropriate, a physician's prior approval (PPA) number is issued. Once the physician has obtained prior approval, the member can obtain the service requested. If the request is denied because it is deemed medically unnecessary, a medical necessity denial letter will be sent to the physician/member.

If the NYSDOH response acknowledges that the member is not eligible for coverage, the case will be denied as "not a covered benefit" and the physician/member will 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 the **procedures that require prior approval**.

Prior Approval 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) of maternity patients after the first prenatal visit so a prior approval 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 the plan or the managing entity of the actual delivery.

It is the responsibility of the admitting facility to notify the plan of all emergency admissions.

Prior Approval for Midwifery Services

The services of a midwife are covered for all our benefit plans. Prior approval is required for all HIP, CompreHealth EPO (Retired August 1, 2018), Medicare HMO and GHI HMO lines of business. For GHI PPO, EmblemHealth EPO/PPO, ConsumerDirect and InBalance plans, Vytra ASO plans and the Vytra plan for the City of New York, prior approval is only required if the midwife is not a plan participant.

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

Additional Prior Approval Procedures for GHI Practitioners

Where possible, prior approval requests should be made on the secure provider website at **www.emblemhealth.com**; 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 will help us rapidly process the request. Information that can facilitate prior approval determinations includes 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

Note: ICD-10 diagnosis codes were implemented in our systems effective October 1, 2015.

Services That Do Not Require Prior Approval - Effective November 1, 2017

CPT CODES THAT DO NOT REQUIRE PRIOR APPROVAL - EFFECTIVE NOVEMBER 1, 2017		
CPT Code	**CPT Description**	**Place of Service (POS)***
01992	anesth n block/inj prone	11, 22, 24
10021	fna w/o image	22, 24
11980	implant hormone pellet(s)	11
14040	tis trnfr f/c/c/m/n/a/g/h/f	22, 24
14041	tis trnfr f/c/c/m/n/a/g/h/f	21, 22, 24
17311	mohs 1 stage h/n/hf/g	22, 24
19120	removal of breast lesion	22, 24
19301	partial mastectomy	21, 22, 24
19302	p-mastectomy w/ln removal	21, 22, 24
19303	mast simple complete	21, 22, 24
21556	exc neck tum deep < 5 cm	22, 24
25111	remove wrist tendon lesion	22, 24
26055	incise finger tendon sheath	22, 24
29540	strapping of ankle and/or ft	11, 22, 24
29806	shoulder arthroscopy/surgery	22, 24
29807	shoulder arthroscopy/surgery	22, 24
29823	shoulder arthroscopy/surgery	22, 24
29824	shoulder arthroscopy/surgery	22, 24
29866	autgrft implnt knee w/scope	22, 24
29877	knee arthroscopy/surgery	22, 24
29880	knee arthroscopy/surgery	22, 24

CPT CODES THAT DO NOT REQUIRE PRIOR APPROVAL - EFFECTIVE NOVEMBER 1, 2017		
CPT Code	**CPT Description**	**Place of Service (POS)***
29888	knee arthroscopy/surgery	22, 24
30140	resect inferior turbinate	22, 24
30802	ablate inf turbinate submuc	22, 24
31255	removal of ethmoid sinus	22, 24
31541	larynscop w/tumr exc + scope	11, 22, 24
31575	diagnostic laryngoscopy	11, 22, 24
31620	endobronchial us add-on	21, 22, 24
31622	dx bronchoscope/wash	22, 24
31625	bronchoscopy w/biopsy(s)	11, 22, 24
31628	bronchoscopy/lung bx each	22, 24
32405	percut bx lung/mediastinum	21, 22, 24
36216	place catheter in artery	22, 24
36245	ins cath abd/l-ext art 1st	22, 24
36415	routine venipuncture	11, 22, 24
36569	insert picc cath	22, 24
36589	removal tunneled cv cath	22, 24
36590	removal tunneled cv cath	22, 24
37210	embolization uterine fibroid	22, 24
37225	fem/popl revas w/ather	22, 24
38220	bone marrow aspiration	11, 22, 24
38221	bone marrow biopsy	11, 22, 24
38510	biopsy/removal lymph nodes	22, 24
38792	ra tracer id of sentinl node	22, 24
38900	io map of sent lymph node	22, 24
42826	removal of tonsils	22, 24
42830	removal of adenoids	22, 24
43774	lap rmvl gastr adj all parts	22, 24
45990	surg dx exam anorectal	11, 22, 24
46260	remove in/ex hem groups 2+	22, 24
47000	needle biopsy of liver	22, 24
47563	laparo cholecystectomy/graph	22, 24
49320	diag laparo separate proc	22, 24
49505	prp i/hern init reduc >5 yr	22, 24
49560	rpr ventral hern init reduc	22, 24
49568	hernia repair w/mesh	22, 24
49650	lap ing hernia repair init	22, 24
49652	lap vent/abd hernia repair	22, 24
50200	renal biopsy perq	22, 24
51600	injection for bladder x-ray	22, 24
51701	insert bladder catheter	22, 24
51728	cystometrogram w/vp	22, 24
51729	cystometrogram w/vp&up	22, 24
51741	electro-uroflowmetry first	22, 24
51798	us urine capacity measure	11, 22, 24
52005	cystoscopy & ureter catheter	22, 24
52204	cystoscopy w/biopsy(s)	22, 24
52240	cystoscopy and treatment	22, 24
52310	cystoscopy and treatment	22, 24

CPT CODES THAT DO NOT REQUIRE PRIOR APPROVAL - EFFECTIVE NOVEMBER 1, 2017		
CPT Code	**CPT Description**	**Place of Service (POS)***
52332	cystoscopy and treatment	22, 24
52351	cystouretero & or pyeloscope	22, 24
52353	cystouretero w/lithotripsy	22, 24
54161	circum 28 days or older	22, 24
54512	excise lesion testis	22, 24
54640	suspension of testis	22, 24
55040	removal of hydrocele	22, 24
55250	removal of sperm duct(s)	22, 24
55530	revise spermatic cord veins	22, 24
56820	exam of vulva w/scope	11, 22, 24
57288	repair bladder defect	22, 24
57454	bx/curett of cervix w/scope	11, 22, 24
57505	endocervical curettage	11, 22, 24
57522	conization of cervix	11, 22, 24
58100	biopsy of uterus lining	11, 22, 24
58120	dilation and curettage	22, 24
58340	catheter for hysterography	22, 24
58350	reopen fallopian tube	22, 24
58353	endometr ablate thermal	22, 24
58558	hysteroscopy biopsy	22, 24
58561	hysteroscopy remove myoma	22, 24
58563	hysteroscopy ablation	22, 24
58565	hysteroscopy sterilization	22, 24
58661	laparoscopy remove adnexa	22, 24
58662	laparoscopy excise lesions	22, 24
58670	laparoscopy tubal cautery	22, 24
58671	laparoscopy tubal block	22, 24
58925	removal of ovarian cyst(s)	22, 24
59015	chorion biopsy	22, 24
59400	obstetrical care	11
59840	abortion	22, 24
59841	abortion	22, 24
60100	biopsy of thyroid	22, 24
60240	removal of thyroid	22, 24
61782	scan proc cranial extra	22, 24
62270	spinal fluid tap diagnostic	22, 24
63030	low back disk surgery	22, 24
64613	destroy nerve neck muscle	22, 24
64708	revise arm/leg nerve	22, 24
64721	carpal tunnel surgery	22, 24
64727	internal nerve revision	22, 24
65756	corneal trnspl endothelial	22, 24
65757	prep corneal endo allograft	22, 24
65875	incise inner eye adhesions	22, 24
66180	implant eye shunt	22, 24
66821	after cataract laser surgery	22, 24
66830	removal of lens lesion	22, 24
66982	cataract surgery complex	22, 24

CPT CODES THAT DO NOT REQUIRE PRIOR APPROVAL - EFFECTIVE NOVEMBER 1, 2017		
CPT Code	**CPT Description**	**Place of Service (POS)***
67312	revise two eye muscles	22, 24
67314	revise eye muscle	22, 24
67318	revise eye muscle(s)	22, 24
67320	revise eye muscle(s) add-on	22, 24
68700	repair tear ducts	22, 24
68815	probe nasolacrimal duct	11, 22, 24
69436	create eardrum opening	11, 22, 24
69990	microsurgery add-on	21, 22, 24
92018	new eye exam & treatment	11, 22
92133	cmptr ophth img optic nerve	11, 22
92134	cptr ophth dx img post segmt	11, 22
92526	oral function therapy	11, 22
92550	tympanometry & reflex thresh	11, 22
92570	acoustic immitance testing	11, 22
92626	eval aud rehab status	11, 22
92960	cardioversion electric ext	22, 24
92980	insert intracoronary stent	22, 24
93000	electrocardiogram complete	11, 22, 24
93015	cardiovascular stress test	11, 22, 24
93227	ecg monit/reprt up to 48 hrs	11, 22, 24
93451	right heart cath	22, 24
93452	left hrt cath w/ventrclgrphy	22, 24
93651	ablate heart dysrhythm focus	22, 24
93652	ablate heart dysrhythm focus	22, 24
93660	tilt table evaluation	22, 24
93662	intracardiac ecg (ice)	22, 24
93926	lower extremity study	11, 22, 24
93976	vascular study	11, 22, 24
93978	vascular study	11, 22, 24
93980	penile vascular study	11, 22, 24
94375	respiratory flow volume loop	11, 22, 24
94690	exhaled air analysis	11, 12
94727	pulm function test by gas	11, 22, 24
97010	hot or cold packs therapy	11, 22, 24
G0108	Diab manage trn per indiv	11
G0268	Removal of impacted wax md	11, 22, 24
G0289	Arthro, loose body + chondro	22, 24

*POS 11 = Office; POS 12 = Home; POS 21 = Inpatient hospital; POS 22 = Outpatient hospital; POS 24 = Ambulatory surgical center

CPT CODES THAT DO NOT REQUIRE PRIOR APPROVAL - **THIS LIST IS RETIRED AS OF NOV 1, 2017**		
CPT Code	**CPT Description**	**Place of Service (POS)***
01992	anesth n block/inj prone	11, 22, 24
10021	fna w/o image	22, 24
11980	implant hormone pellet(s)	11
14040	tis trnfr f/c/c/m/n/a/g/h/f	22, 24

CPT CODES THAT DO NOT REQUIRE PRIOR APPROVAL - THIS LIST IS RETIRED AS OF NOV 1, 2017		
CPT Code	**CPT Description**	**Place of Service (POS)***
14041	tis trnfr f/c/c/m/n/a/g/h/f	21, 22, 24
17311	mohs 1 stage h/n/hf/g	22, 24
19120	removal of breast lesion	22, 24
19301	partial mastectomy	21, 22, 24
19302	p-mastectomy w/ln removal	21, 22, 24
19303	mast simple complete	21, 22, 24
21556	exc neck tum deep < 5 cm	22, 24
25111	remove wrist tendon lesion	22, 24
26055	incise finger tendon sheath	22, 24
29540	strapping of ankle and/or ft	11, 22, 24
29806	shoulder arthroscopy/surgery	22, 24
29807	shoulder arthroscopy/surgery	22, 24
29823	shoulder arthroscopy/surgery	22, 24
29824	shoulder arthroscopy/surgery	22, 24
29826	shoulder arthroscopy/surgery	22, 24
29827	arthroscop rotator cuff repr	22, 24
29866	autgrft implnt knee w/scope	22, 24
29877	knee arthroscopy/surgery	22, 24
29880	knee arthroscopy/surgery	22, 24
29888	knee arthroscopy/surgery	22, 24
30140	resect inferior turbinate	22, 24
30802	ablate inf turbinate submuc	22, 24
31255	removal of ethmoid sinus	22, 24
31541	larynscop w/tumr exc + scope	11, 22, 24
31575	diagnostic laryngoscopy	11, 22, 24
31620	endobronchial us add-on	21, 22, 24
31622	dx bronchoscope/wash	22, 24
31625	bronchoscopy w/biopsy(s)	11, 22, 24
31628	bronchoscopy/lung bx each	22, 24
32405	percut bx lung/mediastinum	21, 22, 24
36216	place catheter in artery	22, 24
36245	ins cath abd/l-ext art 1st	22, 24
36247	ins cath abd/l-ext art 3rd	22, 24
36415	routine venipuncture	11, 22, 24
36569	insert picc cath	22, 24
36589	removal tunneled cv cath	22, 24
36590	removal tunneled cv cath	22, 24
37210	embolization uterine fibroid	22, 24
37221	iliac revasc w/stent	22, 24
37224	fem/popl revas w/tla	22, 24
37225	fem/popl revas w/ather	22, 24
37226	fem/popl revasc w/stent	22, 24
37227	fem/popl revasc stnt & ather	22, 24
38220	bone marrow aspiration	11, 22, 24
38221	bone marrow biopsy	11, 22, 24
38510	biopsy/removal lymph nodes	22, 24
38525	biopsy/removal lymph nodes	22, 24

CPT CODES THAT DO NOT REQUIRE PRIOR APPROVAL - THIS LIST IS RETIRED AS OF NOV 1, 2017		
CPT Code	**CPT Description**	**Place of Service (POS)***
38792	ra tracer id of sentinl node	22, 24
38900	io map of sent lymph node	22, 24
42826	removal of tonsils	22, 24
42830	removal of adenoids	22, 24
43774	lap rmvl gastr adj all parts	22, 24
45990	surg dx exam anorectal	11, 22, 24
46260	remove in/ex hem groups 2+	22, 24
47000	needle biopsy of liver	22, 24
47562	laparoscopic cholecystectomy	22, 24
47563	laparo cholecystectomy/graph	22, 24
49320	diag laparo separate proc	22, 24
49505	prp i/hern init reduc >5 yr	22, 24
49560	rpr ventral hern init reduc	22, 24
49568	hernia repair w/mesh	22, 24
49585	rpr umbil hern reduc > 5 yr	22, 24
49650	lap ing hernia repair init	22, 24
49652	lap vent/abd hernia repair	22, 24
50200	renal biopsy perq	22, 24
50590	fragmenting of kidney stone	22, 24
51600	injection for bladder x-ray	22, 24
51701	insert bladder catheter	22, 24
51728	cystometrogram w/vp	22, 24
51729	cystometrogram w/vp&up	22, 24
51741	electro-uroflowmetry first	22, 24
51798	us urine capacity measure	11, 22, 24
52000	cystoscopy	22, 24
52005	cystoscopy & ureter catheter	22, 24
52204	cystoscopy w/biopsy(s)	22, 24
52240	cystoscopy and treatment	22, 24
52310	cystoscopy and treatment	22, 24
52332	cystoscopy and treatment	22, 24
52351	cystouretero & or pyeloscope	22, 24
52353	cystouretero w/lithotripsy	22, 24
54161	circum 28 days or older	22, 24
54512	excise lesion testis	22, 24
54640	suspension of testis	22, 24
55040	removal of hydrocele	22, 24
55250	removal of sperm duct(s)	22, 24
55530	revise spermatic cord veins	22, 24
55700	biopsy of prostate	22, 24
56820	exam of vulva w/scope	11, 22, 24
57288	repair bladder defect	22, 24
57454	bx/curett of cervix w/scope	11, 22, 24
57505	endocervical curettage	11, 22, 24
57522	conization of cervix	11, 22, 24
58100	biopsy of uterus lining	11, 22, 24
58120	dilation and curettage	22, 24

CPT CODES THAT DO NOT REQUIRE PRIOR APPROVAL - THIS LIST IS RETIRED AS OF NOV 1, 2017		
CPT Code	**CPT Description**	**Place of Service (POS)***
58340	catheter for hysterography	22, 24
58350	reopen fallopian tube	22, 24
58353	endometr ablate thermal	22, 24
58558	hysteroscopy biopsy	22, 24
58561	hysteroscopy remove myoma	22, 24
58563	hysteroscopy ablation	22, 24
58565	hysteroscopy sterilization	22, 24
58661	laparoscopy remove adnexa	22, 24
58662	laparoscopy excise lesions	22, 24
58670	laparoscopy tubal cautery	22, 24
58671	laparoscopy tubal block	22, 24
58925	removal of ovarian cyst(s)	22, 24
59015	chorion biopsy	22, 24
59400	obstetrical care	11
59840	abortion	22, 24
59841	abortion	22, 24
60100	biopsy of thyroid	22, 24
60240	removal of thyroid	22, 24
61782	scan proc cranial extra	22, 24
62270	spinal fluid tap diagnostic	22, 24
63030	low back disk surgery	22, 24
64613	destroy nerve neck muscle	22, 24
64708	revise arm/leg nerve	22, 24
64721	carpal tunnel surgery	22, 24
64727	internal nerve revision	22, 24
65756	corneal trnspl endothelial	22, 24
65757	prep corneal endo allograft	22, 24
65875	incise inner eye adhesions	22, 24
66180	implant eye shunt	22, 24
66821	after cataract laser surgery	22, 24
66830	removal of lens lesion	22, 24
66982	cataract surgery complex	22, 24
67255	reinforce/graft eye wall	22, 24
67312	revise two eye muscles	22, 24
67314	revise eye muscle	22, 24
67318	revise eye muscle(s)	22, 24
67320	revise eye muscle(s) add-on	22, 24
68700	repair tear ducts	22, 24
68815	probe nasolacrimal duct	11, 22, 24
69436	create eardrum opening	11, 22, 24
69990	microsurgery add-on	21, 22, 24
92018	new eye exam & treatment	11, 22
92133	cmptr ophth img optic nerve	11, 22
92134	cptr ophth dx img post segmt	11, 22
92526	oral function therapy	11, 22
92550	tympanometry & reflex thresh	11, 22
92570	acoustic immitance testing	11, 22

CPT CODES THAT DO NOT REQUIRE PRIOR APPROVAL - THIS LIST IS RETIRED AS OF NOV 1, 2017		
CPT Code	**CPT Description**	**Place of Service (POS)***
92626	eval aud rehab status	11, 22
92960	cardioversion electric ext	22, 24
92980	insert intracoronary stent	22, 24
93000	electrocardiogram complete	11, 22, 24
93015	cardiovascular stress test	11, 22, 24
93227	ecg monit/reprt up to 48 hrs	11, 22, 24
93451	right heart cath	22, 24
93452	left hrt cath w/ventrclgrphy	22, 24
93459	l hrt art/grft angio	22, 24
93460	r&l hrt art/ventricle angio	22, 24
93650	ablate heart dysrhythm focus	22, 24
93651	ablate heart dysrhythm focus	22, 24
93652	ablate heart dysrhythm focus	22, 24
93660	tilt table evaluation	22, 24
93662	intracardiac ecg (ice)	22, 24
93886	intracranial complete study	11 ,22, 24
93926	lower extremity study	11, 22, 24
93976	vascular study	11, 22, 24
93978	vascular study	11, 22, 24
93980	penile vascular study	11, 22, 24
94375	respiratory flow volume loop	11, 22, 24
94690	exhaled air analysis	11, 12
94727	pulm function test by gas	11, 22, 24
96365	ther/proph/diag iv inf init	11, 22, 24
96415	chemo iv infusion addl hr	11, 22, 24
97010	hot or cold packs therapy	11, 22, 24
G0108	Diab manage trn per indiv	11
G0268	Removal of impacted wax md	11, 22, 24
G0289	Arthro, loose body + chondro	22, 24

*POS 11 = Office; POS 12 = Home; POS 21 = Inpatient hospital; POS 22 = Outpatient hospital; POS 24 = Ambulatory surgical center

Other Services That Do Not Require Prior Approval

- Mastectomy supplies

The following services performed in a provider office or outpatient facility. (Place of Service: Office [11], outpatient [22] and ambulatory surgery center [24]). Referral rules for initial specialty care office visits still apply for those members whose plan requires a referral:

- Endoscopy (CPT codes 43200-43232; 43234-43272; 44360-45392).
  Note: Capsule endoscopy (CPT code 91110) **does** require prior approval.
- Colonoscopy (CPT codes 44391-44393; 45378-45380; 45382-45385).
  Note: Virtual colonoscopy HCPCS codes 0066T and 0067T do require prior approval.
- Dilated eye exam for EmblemHealth Medicaid members.
  Note: Effective January 1, 2009, Medicaid members diagnosed with diabetes may self-refer (i.e., no prior approval or referral is required) to any network provider of vision services (an

optometrist or ophthalmologist) for a dilated eye (retinal) exam once in any 12-month period.

- Emergency hospital admissions.
- Emergency services.
- Services provided when EmblemHealth is the secondary insurer.
- Pulmonary perfusion imaging.
- Services that do not require prior approval but may require a referral from the member's PCP (e.g., basic X-rays, mammograms and bone density tests).
- Office/outpatient physical and occupational therapy initial visit(s). For GHI HMO members, an initial physical therapy referral for the first six visits from the PCP is required. For HIP fee-for-service members, a referral is needed for the initial evaluation visit. All additional visit requests for these services should be faxed to Palladian at **1-716-712-2817**.

How To Obtain a Prior Approval

All providers must verify member eligibility and benefits prior to rendering non-emergency services.

HOW TO OBTAIN PRIOR APPROVAL	
Plan/Managing Entity	**Instructions**
HIP	Requests may be submitted via the secure provider website: **www.emblemhealth.com/Providers**, or faxed **(866) 215-2928**. Call **(866) 447-9717** for more information or to use the IVR system. Hospitals and skilled nursing facilities can verify prior approval status by reviewing their concurrent review status reports.
EmblemHealth EPO/PPO (GHI)	Requests may be submitted via the secure provider website: **www.emblemhealth.com/Providers**, faxed to **(212) 563-8391,** or by calling the Coordinated Care Intake department at **(800) 223-9870**. See **Additional Prior Approval Procedures for GHI Practitioners** for more information.
Medicare PPO (GHI)	Requests may be submitted via the secure provider website: **www.emblemhealth.com/Providers** or faxed to **(877) 508-2643**. Call **(866) 557-7300** for more information or to use the IVR system. For questions regarding the prior approval process or the status of a specific request, call Customer Service at **(877) 244-4466**. See **Additional Prior Approval Procedures for GHI Practitioners** for more information.

HOW TO OBTAIN PRIOR APPROVAL	
Plan/Managing Entity	**Instructions**
HealthCare Partners	Call (**800) 877-7587** or fax your request to (**888) 746-6433**.
Montefiore CMO	Call **(888) 666-8326**. For behavioral health services, call **(800) 401-4822**.
Empire BCBS	Effective January 1, 2016, utilization management for GHI PPO City of New York employees and non-Medicare eligible retirees with GHI PPO benefits will be managed by Empire BCBS for inpatient and outpatient services. Call **(800) 521-9574** Fax **(800) 241-5308** For Infertility services, including artificial insemination and IVF: Call WIN Fertility **(833) 439-1515** To see what needs authorization, use their look-up tool: **https://www.empireblue.com /wps/portal/ehpprovider**. See a **list of all services requiring pre-certification from Empire BCBS**.
Behavioral Health Services	
Emblem Behavioral Health Services Program	Requests may be submitted via the Beacon Health Options website: **https://www.beaconhealthoptions.com/providers/** or by calling Beacon Health Options at **(888) 447-2526**. (For members in plans underwritten by HIP or HIPIC)
EmblemHealth Behavioral Management Program	Requests may be submitted via the Beacon Health Options website: **https://www.beaconhealthoptions.com/providers/** or by calling Beacon Health Options at **(800) 692-2489**. (For members in plans underwritten by GHI)
Montefiore	Requests may be submitted by calling **(800) 401-4822**. (For members who have the Montefiore logo on the lower left corner of their ID card)
Cardiology and Radiology Services; ; Durable Medical Equipment (DME); Skilled Nursing Facility; Inpatient Rehabilitation Facility; Long-Term Care Facility; Home Health Care	

HOW TO OBTAIN PRIOR APPROVAL	
Plan/Managing Entity	**Instructions**
eviCore	Requests may be submitted via the eviCore website: **www.evicore.com** (submit post-acute care requests via **Allscripts**), or by calling (866) 417-2345 (for HIP members) or (800) 835-7064 (for EmblemHealth EPO/PPO members)
Chiropractic Services	
HIP	Requests may be submitted via the Palladian website: **www.palladianhealth.com**, by calling (877) 774-7693 or faxed to (716) 809-8324.
Outpatient Physical and Occupational Therapy	
HIP	Requests may be submitted via the Palladian website: **www.palladianhealth.com**, by calling (877) 774-7693, or faxed to **(716) 809-8324**.
Spine Surgery and Pain Management Therapy Program	
HIP	For forms via **orthonet-online.com** by calling **(844) 730-8503**. Requests and supporting clinical information must be faxed to **(844) 296-4440**.
Pharmacy Services	
EmblemHealth Pharmacy Benefit Services	Call (877) 444-3657, Monday through Friday, 8 a.m. to 6 p.m.
EmblemHealth Injectable Drug Utilization Management Program	Requests may be submitted by calling **(888) 447-0295,** Monday through Friday, 8 a.m. to 6 p.m., or faxed to (877) 243-4812.
Specialty Pharmacy Program	Requests may be submitted via **accredo.com** by calling **(855) 216-2166**, Monday through Friday, 8:30 a.m. to 5 p.m. or faxed to **(888) 302-1028**.
Home Infusion Therapy	Requests may be submitted via **Homeinfusion@emblemhealth.com** by calling (800) 367-8103 (Voice Mail) or faxed to (212) 510-5978.

Referrals and Elective Hospital Prior Approvals By Plan

The following table indicates which types of benefit plans require referrals and hospital prior approvals, except in emergency situations:

REFERRALS AND ELECTIVE HOSPITAL PRIOR APPROVALS BY PLAN			
Type of Plan	**Benefits Available**	**Referral Required?**	**Elective Hospital Prior Approval Required?**
Access I	Network only	No	Yes
Access II	Network and out-of-network	No, No	Yes, Yes
Prime POS	Network and out-of-network	Yes, No	Yes, Yes

REFERRALS AND ELECTIVE HOSPITAL PRIOR APPROVALS BY PLAN			
Type of Plan	**Benefits Available**	**Referral Required?**	**Elective Hospital Prior Approval Required?**
EPO (i.e., Prime EPO/ Select EPO, CompreHealth EPO (retired August 1, 2018))	Network only	No	Yes
Prime HMO/ GHI HMO/ Select Care (HMO Plans)	Network only	Yes	Yes
Medicaid (Including Child Health Plus)	Network only	Yes	**Yes**
Medicare HMO	Network only	Yes	Yes
Medicare PPO	Network and out-of-network	No, No	Yes, Yes
GHI PPO	Network and out-of-network	No, No	Yes, Yes
Prime PPO/ Select PPO	Network and out-of-network	No, No	Yes, Yes
Vytra ASO clients	Network and out-of-network	Check with ASO administrator	Check with ASO administrator

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

Services Requiring Pre-Certification for GHI PPO City of New York Employee and Non-Medicare Eligible Retirees with GHI PPO Benefits

Precertification requirements were introduced January 1, 2016 for many services provided on an inpatient and outpatient basis. Starting January 1, 2019, a site of service review was introduced for four procedures when services are requested in an outpatient hospital setting.

To make a precertification or site of service review request call the **NYC Healthline at 1-800-521-9574**.

SERVICES REQUIRING PRE-CERTIFICATION	
Services	**Precertification Required Yes / No**
Inpatient Facility	Yes Contact Beacon Health at 1-800-692-2489
Inpatient Psychiatric & Substance Abuse	Yes

SERVICES REQUIRING PRE-CERTIFICATION	
Services	**Precertification Required Yes / No**
Facility	
Maternity-Pregnancy & Delivery • Stays under 48 hours normal delivery, 96 hours C-Section requires notification only • Over 48/96 hours requires pre-certification	Yes
NICU Admission	Yes
Acute Inpatient Rehabilitation **NOTE:** This benefit is part of the Skilled Nursing Facility (SNF) benefit. 1 day in an acute inpatient rehabilitation bed = 2 days in a SNF. 30 days in an acute inpatient rehab is equal to 60 SNF days. Therefore, the SNF benefit remaining would only be 30.	Yes
Skilled Nursing Facility (SNF) **NOTE:** NYC Healthline can choose to substitute outpatient benefits for SNF days. The formula used is 2 ½ outpatient visits = 1 inpatient SNF day. Only NYC Healthline can authorize	Yes

SERVICES REQUIRING PRE-CERTIFICATION	
Services	**Precertification Required Yes / No**
substitution of benefits. No outpatient benefits are available under this benefit if no pre-certification is received.	
Outpatient hospital or free-standing ambulatory surgery facility (not in a doctor's office) • Includes possible/cosmetic procedures, reconstruction, outpatient transplants, optical/vision related procedures, breast reconstruction, cochlear implants, functional endoscopy/nasal surgery, joint replacements, experimental/investigational procedures, hyperbaric O2 chamber, infertility with underlying condition, pain management, spinal stimulatory implants, wound vac, bariatric surgery and spinal surgery • See list of all codes requiring precertification for Ambulatory **Surgery**	Yes
Infertility services, including artificial insemination and IVF • Precertification required when in the MD office, outpatient facility or free standing facility	Contact WIN Fertility at 833-439-1515

SERVICES REQUIRING PRE-CERTIFICATION	
Services	**Precertification Required Yes / No**
Physical Therapy Outpatient **NOTE:** after 16 visits, needs authorization	Yes
Outpatient speech therapy **NOTE:** after 16 visits, needs authorization	Yes
Occupational Therapy Outpatient	Not covered, except as part of the home care services benefit
DME (Par and Non-Par) Examples-Not limited to the following: • Electric Beds • Wheelchairs	Yes When the charge for DME equals or exceeds $2,000
Prosthetics (Par and Non-Par)	Yes
Specialty Drugs (non-self injectables) in office or outpatient facility • See list of all codes requiring precertification for Non-Self-**Injectables**	Yes
Dialysis	Pre-cert for **network status and place of service only** as dialysis is a NYS Mandate
Attention Providers As of January 1, 2019, if you are planning to perform any of these procedures in a hospital setting, you	Notification is required

SERVICES REQUIRING PRE-CERTIFICATION	
Services	**Precertification Required Yes / No**
are required to call the NYC Healthline **800-521-9574**, at least 3 weeks in advance of the scheduled date, to discuss with Medical Management: • Cataract Surgery • Knee Arthroscopy • Colonoscopy • Endoscopy	
Radiation Therapy	Yes
Cardiac Rehabilitation Outpatient	Yes
Air Ambulance (scheduled only)	Yes
Genetic Testing	Yes
The following services continue to require precertification by **EmblemHealth**. Providers should call **1-800-223-9870** for precertification.	
Home Health Care	Yes
Home Infusion Therapy (billed by a home infusion specialist)	Yes
MRI/MRA/PET/CAT/ NUCLEAR CARDIOLOGY/	Yes
Nutritional Supplements and Enteral Formulas	Yes

REFERRAL PROCEDURES - PRACTITIONERS

All services for members enrolled in benefit plans that require 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, with the exception of the following services. (These 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. See **Provider Networks and Member Benefit Plans** chapter for more details regarding what plans require referrals.
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 prior approval is required for a member to use out-of-network providers. (For more information, please go to the **Use of Out-of-Network Providers** section in this chapter.)

Referral requirements may be different depending on the member's benefit package, so please contact the managing entity listed on the member's ID card if clarification is needed.

How To Make a Referral

Referrals must be made to a network specialist who participates in the member's benefit plan and must include the number of recommended visits to the specialist. Specialist participation can be validated using the Provider Directory or the provider search feature, Find A Doctor, at **www.emblemhealth.com**, as applicable.

HOW TO MAKE A REFERRAL FOR SPECIALTY SERVICES	
Plan/Managing Entity	**Instructions**
CompreHealth (Retired August 1, 2018), EPO, GHI HMO, HIP and Medicare HMO	Enter referral request by signing in to **www.emblemhealth.com**.
EmblemHealth EPO/PPO and GHI EPO/PPO	No referral required.
Vytra HMO	Enter your referral request by signing in to **www.emblemhealth.com** or call **1-888-288-9872**.

Referring to Physical and Occupational Therapy Practitioners

Refer to the **Physical and Occupational Therapy Program** chapter.

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 prior approval.*)
- 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 participants directly to make an appointment. Go to **www.emblemhealth.com/~/media/Files/PDF/Providers/Mammography_Sites.pdf** to view the list of network mammography sites available to HIP and CompreHealth EPO (Retired August 1, 2018) members.

** Requires prior approval. Please see the **How to Obtain a Prior Approval** section of the Radiology Program chapter for additional information on how to obtain prior approval.

Specialists Referring to Specialists

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

- Chemotherapy
- Dialysis
- Laboratory services
- Radiation therapy
- Radiology*
- Rehabilitation services (PT**/OT**/ST)
- In the case of an emergency, as determined by the immediate treating physician.
- If the member is an EPO or PPO plan member who can self-refer for any services within their plan's network.
- If the member is a VIP HMO, Access I or Access II member.

*Please see the **Prior Approval Procedures** section of the **Radiology Program** chapter for a list of services and CPT codes that require prior approval and for additional information on applicable members and managing entities.

** For GHI HMO members after the first six visits, and for certain HIP members after the first initial consultation visit, the servicing provider will be required to obtain a prior approval from **www.palladianhealth.com**. For more information, see the **Physical and Occupational Therapy Program** chapter.

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 period. An EmblemHealth or

managing entity medical director must approve standing referrals via the prior approval process.

Specialists as PCPs

A specialist may substitute as a PCP for a member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, when authorized by the managing entity's medical director. Whenever possible, the specialist who will be acting as a PCP should be dually board-certified. A treatment plan must be agreed upon among the PCP, the managing entity's medical director and the specialist.

Specialty Care Centers

A member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a referral to a specialty care center. Such referral will require prior approval by the managing entity's medical director. A treatment plan must be agreed upon among the PCP, the managing entity's medical director and the provider.

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 following table for details.

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*
Dialysis	13	30 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
GHI HMO Plans		
Most Services		1 year

REFERRAL TYPE	MAXIMUM # UNITS/VISITS	DURATION
Rehabilitation (Outpatient PT/OT)	6 visits	1 year
HIP and Medicare HMO Plans in Palladian program		
Rehabilitation (Outpatient PT/OT) and Chiropractic Services	1	1 visit within 30 days
HIP Plan Excluded from Palladian Program		
Rehabilitation (Outpatient PT/OT)	8	8 visit within 90 days
Vytra Plans		
Most Services	1-14 visits depending on the specialty care provider	1 year
Rehabilitation (PT/OT/ST)	Determined on a case-by-case basis	Determined on a case-by-case basis

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

Consultation Reports

All specialists are reminded to provide referring physicians with timely and informative consultation reports. This will contribute 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 will be 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 will be issued within 24 hours of the visit.
- **If routine**: A consultation report will be issued within five to seven business days after the visit.

All consultation reports will 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 will be 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 prior approval 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 that 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.

CONTINUITY OF CARE WITH OUT-OF-NETWORK PROVIDERS

Continuity/Transition of Care - New Members

Upon enrollment, the member shall select a PCP from whom the member may request continuation of care. When appropriate, EmblemHealth will permit new members to continue seeing their current out-of-network practitioner for up to 60 days or as otherwise required to accommodate the needs of medically fragile children and foster children covered by Medicaid.

If on the effective date of enrollment a member has a life-threatening disease or condition or a degenerative and disabling disease or condition, the member may continue to see their current out-of-network practitioner for up to 60 days. In the case of pregnancy, if the member has entered into her second trimester, she may continue to see the nonparticipating practitioner through delivery and postpartum care for up to 60 days for care related to the delivery for Medicaid members. 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 in the midst of ongoing course of treatment with an out-of-network provider
2. Second and third trimester of pregnancy (up to 60 days postpartum directly related to the delivery for Medicaid members)

If transitions of care and/or continuity of care is approved, it will be 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 of the following:

- Accept our reimbursement rates as payment in full
- Adhere to our **Quality Improvement program**
- Provide medical information related to the enrollee's care
- Otherwise adhere to our policies and procedures including those regarding referrals and obtaining prior approvals and a treatment plan approved by our applicable Prior Authorization department. (See the **How to Obtain Prior Approval** section in this chapter.)

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

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.

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 will be in place for the first 24 months of the transition. It applies only to episodes of care that were ongoing during the transition period from fee for service to managed care.

To preserve continuity of care, children enrollees will not be required to change Health Homes or their Health Home Care Management Agency at the time of the transition. EmblemHealth will pay 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 will continue 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 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 will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new Plan of Care is to be developed.

During the initial 180 days of the transition, EmblemHealth will authorize any children's specialty services newly carved into managed care that are added to the Plan of Care under a person-centered process without conducting utilization review. 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 will continue to authorize covered HCBS

and LTSS in accordance with the most recent Plan of Care for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity, and existing providers at the time of enrollment will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time a new Plan of Care is to be developed.

To facilitate a smooth transition of HCBS and LTSS authorizations, for children in receipt of HCBS, EmblemHealth will begin accepting Plans of Care on May 1, 2018, for 1) our enrolled population or 2) a child for whom the Health Home Care Manager or Independent Entity has obtained consent to share the Plan of Care with EmblemHealth and the family has demonstrated the Plan selection process has been completed. EmblemHealth will continue to accept Plans of Care for children in receipt of HCBS in advance of the effective date of enrollment when EmblemHealth is notified by another Plan, a Health Home Care Manager or the Independent Entity that there is consent to share the Plans of Care with EmblemHealth and the family has demonstrated the Plan selection process has been completed.

All ambulatory levels of care identified within the children's expanded benefits will be included in prior approval and concurrent review processes and include review and approval of the Plan of Care for the Medically Fragile population in accordance with the requirements set forth by the “Office of Health Insurance Programs Principles for Medically Fragile Children". And prior authorization will be required for the HCBS Plan of Care to determine medical necessity and to ensure it is a person-centered Plan of Care that meets individual needs. EmblemHealth will facilitate the transfer of the Plan of Care 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 Plan of Care with the member that recommends HCBS and has a goal around each HCBS recommended. This Plan of Care is sent from the Care Management Agency to their lead Health Home (depending on the guidelines prescribed by the lead Health Home) and an EmblemHealth Care Management liaison via the secure fax number.

The EmblemHealth Care Management liaison and/or Care Manager reviews the Plan of Care, determines medical and behavior health needs, and forwards the Plan of Care to the appropriate EmblemHealth Utilization Management staff and/or delegate.If there are any questions or issues with the Plan of Care, 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. EmblemHealth Utilization Management works to approve the Plan of Care, and sends a level of service determination letter to the Care Management Agency or lead Health Home with recommended HCBS providers.The HCBS provider completes their own assessment and submits a prior authorization request directly to EmblemHealth Utilization Management and or delegate directly. Utilization Management will collaborate by outreaching to Care Management to review Plan of Care deviations and discuss any required appropriate adjustments to either service delivery or the Plan of Care.

HCBS are required to manage EmblemHealth members in compliance with CMS HCBS Final Rule and any applicable State guidance, and that the Plan Of Care (POC) is developed in a person-centered manner, compliant with federal regulations and state guidance, and meets individual needs. HCBS is required,to ensure appropriate POCs are in place, maintained, or discontinued based on person-centered planning. In addition, HCBS are to 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 will review the HCBS process to ensure that it is managed in compliance with CMS HCBS Final Rule and any applicable State guidance, and that 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 will conduct outreach to review such deviations, and require appropriate adjustments to either service delivery or the POC. EmblemHealth will review and issue determinations within authorization request time frames as described in the Medicaid Managed Care Model Contract, and may request additional information related to the requested service authorization from the HCBS provider. HCBS process and POC are to be in accordance with CMS HCBS Final Rule at all times. EmblemHealth will monitor to determine if any service utilization patterns that deviate from any approved POC are identified by reviewing POC and continued authorization.

Continuity of Care Children in Foster Care

Continuty of care for foster children will follow the same processes as for the **Medicaid children** described above with the addition of the following, which are specific to foster children:

To facilitate a smooth transition of HCBS and LTSS authorizations, for children in receipt of HCBS, EmblemHealth will begin accepting Plans of Care on November 1, 2018, for a child in the care of a LDSS/licensed Voluntary Foster Care Agencies, where Plan election has been confirmed by the LDSS/Voluntary Foster Care Agencies.

EmblemHealth will continue to accept Plans of Care for children in receipt of HCBS in advance of the effective date of enrollment when EmblemHealth is notified that a child in the care of a LDSS/licensed Voluntary Foster Care Agencies, Plan selection has been 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 the care plan that is in place. They may also access providers with expertise in treating children involved in foster care as necessary 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 the members and their providers and practitioners to assure that members receive the services needed, within the benefit limitations of their contracts. When benefits end for members, the Utilization Management department will assist, 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 will be given the option of continuing an ongoing course of treatment with his or her current practitioner for a transitional period of up to 90 days. If the member has entered the second trimester of pregnancy, the transitional period includes the provision of postpartum care through 60 days postpartum 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 contact the appropriate Anticipated Care department (see the **How to Obtain Prior Approval** section in this chapter).

EmblemHealth will permit a member to continue with their current practitioner as long as 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 that impairs the health professional's ability to practice. The practitioner must agree to all of 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 prior approval for services and obtaining an approved treatment plan

OUT-OF-AREA STUDENTS

We recognize the challenges for full-time students when health care needs arise during an active course of study. Special consideration will be given to coverage of services outside of our service areas while a member is a full-time student actively involved in a course of study. 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.

LABORATORY SERVICES

The laboratories contracted with EmblemHealth to provide covered laboratory services are listed in our **Find a Doctor** tool at **www.emblemhealth.com/find-a-doctor**.

Quest Diagnostics Incorporated

Quest Diagnostics Incorporated (Quest) is contracted with all EmblemHealth plans to provide general laboratory services (all 8000 CPT codes).

- Quest Diagnostics Patient Services Locator: **1-800-377-7220**
- Quest Diagnostics Customer Service department: **1-866-MY-QUEST (1-866-697-8378)**
- Quest Diagnostics website: **www.questdiagnostics.com**

Quest laboratories will provide a collection box and courier service to and from the practitioner's office for specimen collection. If specimens need to be drawn outside of the

practitioner's office, members should be directed to the nearest contracted laboratory Patient Service Center and given the requisition form to hand carry.

Selected tests are available on a STAT (emergency) basis. Specimens requiring STAT services should not be given to your routine Route Service Representative. Instead, practitioners should call their local Quest Diagnostics laboratory to request a STAT service or pick-up. STAT results are reported by telephone as soon as available. Written and/or electronic reports will follow per your routine medical report delivery system.

Note: Quest is able to provide most laboratory services. For specialty lab tests not available from Quest, we have contracts with other labs. For network hospitals with their own lab contracted with EmblemHealth, physicians may use this lab rather than Quest if applicable.

In-Office Testing List (For CompreHealth EPO*, Medicare HMO, HIP and Vytra Plans)
For members in the CompreHealth EPO*, Medicare HMO, HIP and Vytra plans listed below, practitioners may perform the lab tests noted in the In-Office Testing List below in their offices without a prior approval. Reimbursement will be made according to contracted fee schedules.

- HMO
- POS
- Medicare HMO
- Medicare Dual Eligible HMO SNP
- Medicaid
- Child Health Plus

Members whose care is managed by 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 benefits plans. (Check the member's ID or sign in to **www.emblemhealth.com** to confirm eligibility.)

IN-OFFICE TESTING LIST - HIP EFFECTIVE APRIL 13, 2016		
Code	**Description**	**Specialty***
G0475	HIV antigen/antibody, combination assay, screening	
G0476	HPV screening* *Effective July 9, 2016	
G0477	Drug screen; multiple	Pain Medicine, Addiction Medicine
G0478	Drug screen; single	Pain Medicine, Addiction Medicine
81000	Urinalysis; non-automated, with microscopy	
81002	Urinalysis; non-automated, without microscopy	

IN-OFFICE TESTING LIST - HIP EFFECTIVE APRIL 13, 2016		
Code	**Description**	**Specialty***
81003	Urinalysis; automated, without microscopy	
81025	Urine pregnancy test	
82247	Bilirubin; total	Pediatrics
82248	Bilirubin; direct	Pediatrics
82270	Blood, occult, by peroxidase activity, qualitative, feces, 1 determination	
82272	Blood, occult, by peroxidase activity; qualitative, feces, 1 to 3 simultaneous determinations	
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1 to 3 simultaneous determinations	
82670	Estradiol	OB/GYN / Maternal Fetal Medicine / Reproductive Endocrinology
82803	Gases, blood, any combination of pH, pCO2, pO2 , CO2, HCO3	
82947	Glucose; quantitative, blood (except reagent strip)	
82948	Glucose; blood, reagent strip	
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use	
83516	InflammaDry	Opthalmology
83655	Lead	
83861	Microfluid analysis tears	Ophthalmology
84132	Potassium; serum, plasma or whole blood	
85007	Blood count; blood smear, microscopic examination with manual differential WBC count (includes RBC morphology and platelet estimation)	Hematology / Oncology
85014	Blood count; hematocrit (Hct)	Hematology / Oncology
85018	Blood count; hemoglobin (Hgb)	Hematology / Oncology /Pediatrics**
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Hematology / Oncology / Pediatrics***
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WEB and platelet count)	Hematology / Oncology

IN-OFFICE TESTING LIST - HIP EFFECTIVE APRIL 13, 2016		
Code	**Description**	**Specialty***
85060	Blood smear, peripheral, interpretation by physician with written report	Hematology / Oncology
85610	Prothrombin time	
85651	RBC sedimentation rate; non-automated	Ophthalmology
85652	RBC sedimentation rate; automated	Ophthalmology
86403	Particle agglutination; screen, each antibody	
86485	Skin test; candida	Infectious Disease, Allergy / Immunology
86486	Skin test, unlisted antigen, each	
86510	Skin test; histoplasmosis	
86580	Skin test; tuberculosis, intradermal	
86701-QW	OraQuick ADVANCE® rapid HIV-1 antibody test	
86702-QW	OraQuick ADVANCE® rapid HIV-2 antibody test	
86703-QW	HIV-1 and HIV-2 single assay	
86735	Antibody; mumps	Infectious Disease, Allergy / Immunology
87210	Smear; wet mount, eg. saline, India ink, KOH preps (for suspected vaginitis when doing pelvic exam)	
87220	Smear; tissue exam by KOH preps	
87430	Streptococcus, group A (detection by enzyme immunoassay technique)	
87651****	Group A Streptococcus testing	Midwives, Nurse Practitioners and all Physicians
87804	Influenza rapid test	
87806	HIV 1 Antigen with HIV1 and HIV 2 antibodies	
87880	Streptococcus, group A (detection by immunoassay with direct optical observation)	
89060	Joint fluid crystals - crystal identification by light microscopy with or without polarizing lens analysis	Orthopedics / Rheumatology
89300	Semen analysis; Huhner test	Urology / Reproductive Endocrinology
89310	Semen analysis; motility and count	Urology / Reproductive Endocrinology

IN-OFFICE TESTING LIST - HIP EFFECTIVE APRIL 13, 2016		
Code	**Description**	**Specialty***
89320	Semen analysis; complete	Urology / Reproductive Endocrinology
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test	Urology / Reproductive Endocrinology

*Most of the codes on the In-Office Testing List may be performed by all practitioners. However, some codes may only be performed by practitioners in the specialty type(s) listed within the "Specialty" column of the table.

**Pediatrics added November 15, 2012.

***Pediatrics added December 26, 2013.

****Limited to Members participating in EmblemHealth Enhanced Care (Medicaid) Network.

IN-OFFICE TESTING LIST - COMPREHEALTH EPO (RETIRED AUGUST 1, 2018)/HIP/VYTRA EXPIRED OCTOBER 31, 2010 (TO BE USED FOR BACK BILLING ONLY.)		
Code	**Description**	**Specialty**
81000	Urinalysis	
81002	Urinalysis; non-automated, without microscopy	
81003	Urinalysis; automated, without microscopy	
81025	Urine pregnancy test	
82247	Bilirubin; total	Pediatrics
82248	Bilirubin; direct	Pediatrics
82270	Blood, occult, by peroxidase activity, qualitative, feces, 1 determination	
82272	Blood, occult, by peroxidase activity; qualitative, feces, 1 to 3 simultaneous determinations	
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1 to 3 simultaneous determinations	
82670	Estradiol	OB/GYN / Maternal Fetal Medicine / Reproductive Endocrinology
82803	Gases, blood, any combination of pH, pCO2, pO2 , CO2, HCO3	
82947	Glucose; quantitative, blood (except reagent strip)	
82948	Glucose; blood, reagent strip	

IN-OFFICE TESTING LIST - COMPREHEALTH EPO (RETIRED AUGUST 1, 2018)/HIP/VYTRA EXPIRED OCTOBER 31, 2010 (TO BE USED FOR BACK BILLING ONLY.)		
Code	**Description**	**Specialty**
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use	
83655	Lead	
84132	Potassium; serum, plasma or whole blood	
85007	Blood count; blood smear, microscopic examination with manual differential WBC count (includes RBC morphology and platelet estimation)	Hematology / Oncology
85014	Blood count; hematocrit (Hct)	Hematology / Oncology
85018	Blood count; hemoglobin (Hgb)	Hematology / Oncology
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Hematology / Oncology
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WEB and platelet count)	Hematology / Oncology
85060	Blood smear, peripheral, interpretation by physician with written report	Hematology / Oncology
85610	Prothrombin time	
85651	RBC sedimentation rate; non-automated	Ophthalmology
85652	RBC sedimentation rate; automated	Ophthalmology
86403	Particle agglutination; screen, each antibody	Infectious Disease
86485	Skin test; candida	Infectious Disease
86486	Skin test, unlisted antigen, each	
86510	Skin test; histoplasmosis	
86580	Skin test; tuberculosis	
86701-QW	OraQuic rapid HIV-1 antibody test	
86703-QW	HIV-1 and HIV-2 single assay	
86735	Antibody; mumps	Infectious Disease
87210	Smear; wet mount, eg. saline, India ink, KOH preps (for suspected vaginitis when doing pelvic exam)	
87220	Smear; tissue exam by KOH preps	
87430	Streptococcus, group A (detection by enzyme immunoassay technique)	

IN-OFFICE TESTING LIST - COMPREHEALTH EPO (RETIRED AUGUST 1, 2018)/HIP/VYTRA EXPIRED OCTOBER 31, 2010 (TO BE USED FOR BACK BILLING ONLY.)		
Code	**Description**	**Specialty**
87804	Influenza rapid test	
87880	Streptococcus, group A (detection by immunoassay with direct optical observation)	
89060	Joint fluid crystals - crystal identification by light microscopy with or without polarizing lens analysis	Orthopedics / Rheumatology
89300	Semen analysis; Huhner test	Urology / Reproductive Endocrinology
89310	Semen analysis; motility and count	Urology / Reproductive Endocrinology
89320	Semen analysis; complete	Urology / Reproductive Endocrinology
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test	Urology / Reproductive Endocrinology

HOSPITAL AND FACILITY PROCEDURES

The care 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, prior approval of facility admissions, concurrent management in the hospital, use of alternate care facilities and post-discharge follow-up.

Elective Inpatient Procedures - Admitting Physicians

The admitting network physician is required to obtain prior approval for elective inpatient procedures at least 10 business days in advance of the desired hospital admission date. This allows us sufficient 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 prior approval status of an admission for a HIP-, CompreHealth EPO (Retired August 1, 2018) - or EmblemHealth-managed member by signing in to **www.emblemhealth.com** or calling **1-866-447-9717**.

If the admitting physician is out-of-network, the member is responsible for contacting the plan for prior approval. For more information, see the **How To Obtain a Prior Approval** and **Referrals and Elective Hospital Prior Approvals by Plan** tables in this chapter.

Elective Admission Procedures - Hospitals and Facilities

(Including Acute, Inpatient Rehabilitation and Psychiatric Facilities)

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

In the event the facility is aware that the planned admission/procedure date has changed within a 90-day period, the facility should notify the plan of the new date(s) and ask the plan to modify the date(s) of the prior approval. An anticipated care report will be faxed daily to the facility listing those days/services that have been approved. If no services were approved for the facility, no report will be sent. (See the **sample report** at the end of this chapter.)

The facility must ask to see the member's ID card upon admission. The ID card will provide line of business information as well as the managing entity's information for requesting prior approval and submitting claims. The facility must verify member benefit and eligibility information by signing in to **www.emblemhealth.com** or as indicated in the Confirm Member Eligibility table in the **Your Plan Members** chapter.

If no prior approval has been issued where one is required, the claim submitted will be denied. Please see the Dispute Resolution chapters - **Commercial/CHP**, **Medicaid**, and **Medicare** - for information on denial determinations.

Should the facility feel that an overnight stay is warranted for an outpatient service, the plan must re-evaluate the admission for medical necessity. All necessary information must be submitted to the managing entity 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 to notify the member's managing entity listed on the back of the ID card within 24 hours or as soon as practicable thereafter. Following are ways to notify us of an emergency admission:

A. Contracted hospitals may notify HIP and the managing entities, HealthCare Partners and Montefiore CMO, electronically of all admissions through the emergency room by signing in to **www.emblemhealth.com** for HIP, GHI HMO, CompreHealth EPO (Retired August 1, 2018) and Medicare HMO members. Benefits of electronic notifications are:
   1. 24/7 access.
   2. Automatic date/time-stamped receipt immediately sent back as proof of the notification.
   3. Immediate confirmation of member eligibility.
   4. Automatic and immediate routing for those cases managed by another entity on HIP's behalf; includes date/time stamp of notification to HIP.
   5. PCP name and contact information provided.
   6. Ability to follow status of inpatient case at **www.emblemhealth.com**. 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 prior approval inquiry features. All cases appear in a pended status until all necessary information is received and concurrent review is performed.

B. Contacted hospitals may notify HIP of emergency admissions for HIP, GHI HMO,

CompreHealth EPO (Retired August 1, 2018) and Medicare HMO members by calling **1-866-447-9717** or faxing the notification to **1-866-215-2928**.

C. Contracted hospitals may notify Vytra by calling **1-888-288-9872**.
D. Contracted hospitals must notify GHI EPO/PPO and EmblemHealth EPO/PPO plans by calling **1-800-223-9870** or faxing the notification to **1-212-563-8391**.

Note: Our plans do not require prior approval for an admission through the emergency room; rather, we require notification so that the case may be reviewed on a concurrent basis. No authorization number is required, and the managing entity will not issue an authorization and/or case number until the case has been reviewed for medical necessity.

If the facility fails to notify the managing entity of an admission through the emergency room, the managing entity will request medical records upon receipt of the claim and conduct a retrospective utilization review for medical necessity. Please see the Dispute Resolution chapters - **Commercial/CHP**, **Medicaid**, and **Medicare** - for more details.

A member's PCP should respond to the hospital emergency room page 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. The responding managing entity will obtain all relevant clinical information about the member.

Inpatient transfers between acute care hospitals/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	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**

When contacting us, please 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 will review and refer all requests to an EmblemHealth Medical Director for a determination based on the clinical urgency of the specific situation. A decision will be 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 will contact the transferring facility and issue 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 chapter – **Commercial**, **Medicaid**, or **Medicare**.

Concurrent Review

Once a member is admitted to a facility, the applicable Managing Entity will reach out to the facility for clinical information to evaluate the on-going medical necessity of the in-patient stay. Facilities are allowed 24 hours to provide the requested information. Decisions will be made based upon available information. EmblemHealth follows industry standard medical care guidelines (found at **www.MCG.com**) to determine the appropriate review frequency. On-going requests for clinical information will be 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. If the requested information is not provided, the day will be denied with a provider/facility denial. The member may not be billed for this day.

Concurrent Review Status Report

The **Concurrent Review Status Report** (see an example at the end of this chapter) will be posted to our secure website at **www.emblemhealth.com**, Monday through Friday (excluding holidays), twice a day at around 10 am and 5 pm. 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 will be denied with a provider/facility denial. The member may not be billed for this day.

Emergency Services for Out-of-Area

Medicaid and Commercial members are covered for emergency care in all 50 United States, Canada, Puerto Rico and the United States Territories of the Virgin Islands, Guam, American Samoa and the Northern Marianna Islands. Medicare members are covered for emergency care worldwide. In an emergency that meets this definition, members in one of these areas can go to the nearest emergency room or call **911**.

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 the **Care Management** chapter.

Medicare Outpatient Observation Notice MOON

On August 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which 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. A standardized Medicare Outpatient Observation Notice (MOON), form CMS-10611 was developed to inform all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH.

In accordance with the statute, 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 no later than March 8, 2017. The notice and accompanying instructions are available at:

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

Discharge Planning

The discharge planning process should begin as soon as possible to allow time for the arrangement of appropriate resources for the member's care.

For post-acute care based services, which may include acute rehabilitation, skilled nursing facility stay, home care, durable medical equipment (DME), hospice care and transportation, the concurrent review nurse will facilitate prior approvals of medically necessary treatments if the member's benefit plan includes these services.

Readmission Policy

Concurrent Reviews (Effective June 1, 2018)

On a concurrent basis, any medically necessary readmission to the same facility/hospital /hospital system within 30 calendar days of a member's discharge for the same or similar diagnosis will be subject to a clinical review.

For facilities that bill under diagnosis-related groups (DRGs) or case rates:

- Relapse of conditions noted on the first admission
- Complications of treatment or diagnostic investigations
- Insufficient stabilization of patient's condition prior to discharge

The admission will be denied and a benefit denial will be issued. The facility will be advised of its grievance rights. In the event that 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.

For facilities that bill per diem (by the day):

- We will not make any changes or additions to the first hospital admission. The second admission will only be approved if we decide it's a separate event from the first admission.
- If the second admission is deemed a continuation of the first admission, it will be denied. A benefit denial will be sent with instructions about how to file a grievance (complaint).

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 will review the claim and decide if the second admission is related to the first.

Concurrent Reviews (In Effect August 1, 2017 to May 31, 2018)

On a concurrent basis, any medically necessary readmission to the same facility/hospital /hospital system within 14 calendar days of a member's discharge for the same or similar diagnosis will be subject to a clinical review.

For facilities that bill under diagnosis-related groups (DRGs) or case rates:

- Relapse of conditions noted on the first admission
- Complications of treatment or diagnostic investigations
- Insufficient stabilization of patient's condition prior to discharge

The admission will be denied and a benefit denial will be issued. The facility will be advised of its grievance rights. In the event that 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.

For facilities that bill per diem (by the day):

- We will not make any changes or additions to the first hospital admission. The second admission will only be approved if we decide it's a separate event from the first admission.
- If the second admission is deemed a continuation of the first admission, it will be denied. A benefit denial will be sent with instructions about how to file a grievance (complaint).

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 will review the claim and decide if the second admission is related to the first.

Concurrent Reviews (Retired July 31, 2017)

On a concurrent basis, any medically necessary readmission to the same facility within three calendar days following discharge from a medically necessary admission will be reviewed for the circumstances of the admission. The readmission will not be authorized for facility payment if due to one of the following:

- Relapse of conditions noted on the first admission
- Complications of treatment or diagnostic investigations
- Insufficient stabilization of patient's condition prior to discharge

The admission will be denied and a benefit denial will be issued. The facility will be advised of

its grievance rights. In the event that 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.

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.

SKILLED NURSING HOME OR REHABILITATION FACILITY PROCEDURES

Prior to Admission

For applicable HIP Members after January 1, 2018, see new chapter: **SNF IRF LTAC**

For applicable HIP members until December 31, 2018, and all members not managed by eviCore follow these procedures: Prior to Admission

The skilled nursing facility (SNF) staff is required to notify the managing entity of a member's admission. For EmblemHealth-managed members, contact the EmblemHealth SNF/rehabilitation nurse assigned to the facility. The call must be made **prior** to the member's admission. Notification of admission is **not** prior approval for the admission.

For all admissions, the SNF should check member eligibility, benefits and prior approval by signing in to **www.emblemhealth.com** or by otherwise contacting the member's plan/managing entity as provided in the **Your Plan Members** chapter.

Facilities that do not know the number of their SNF/rehabilitation nurse should call the plan/managing entity.

At the Time of Admission

SNFs receiving patients who have not been given prior approval 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. For EmblemHealth-managed members, the SNF should contact the EmblemHealth/SNF rehabilitation nurse assigned to the facility. (See the Dispute Resolution chapters of the manual - **Commercial/CHP**, **Medicaid** or **Medicare** for guidelines regarding claims submitted without prior approval.) The SNF representative must have the following information available when contacting the plan:

- Member ID number
- Member name
- Admission date
- Clinical documentation supporting the appropriateness of the admission
- Copy of the hospital discharge summary and 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 prior approval will result in claim denial. Please see the Dispute Resolution chapters - **Commercial**, **Medicaid** and **Medicare**.

Concurrent Review

Authorization for admission and continued stay is based on medical appropriateness and necessity of services. We evaluate every request for prior approval and make coverage decisions by applying generally accepted medical standards as well as applicable Medicare and InterQual guidelines. The managing entity (e.g., the EmblemHealth concurrent review nurse assigned to the case) will evaluate the patient's ability to function prior to admission to the skilled care setting, the event that necessitated the skilled care admission, the patient's progress to date, and long- and short-term goals and objectives.

The managing entity will not issue a prior approval 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 (e.g., the EmblemHealth concurrent review nurse) with the necessary clinical updates, no less than every seven days, to authorize additional days. The benefit for SNF care varies according to line of business. Plan members' benefits may be verified after signing in to **www.emblemhealth.com**.

Concurrent Review Status Report

The **Concurrent Review Status Report** (an example of which is provided at the end of the chapter) will be posted to **www.emblemhealth.com**, Monday through Friday (excluding holidays), twice a day around 10 am and 5 pm. This report lists each admitted member and whether the current day is approved, denied or pending further information. Pending information means that we require additional information to make a determination. If the requested information is not provided, the day will be denied with a provider/facility denial. The member may not be billed for this day.

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 our website at **www.emblemhealth.com** for GHI HMO, 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: **1-877-482-3625**
GHI: **1-800-223-9870**

Skilled nursing facilities that fail to provide clinical updates and/or progress notes to the managing entity (concurrent review nurse) will not be reimbursed for unauthorized days.

Permanent Placement Process for Medicaid Members

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

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

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

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, should the member choose to reside permanently in the SNF (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 is responsible for coordinating all medical care provided to the member at the SNF. 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 **www.emblemhealth.com** 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 for the arrangement of appropriate resources for the member's care.

For post-acute care based services, which may include acute rehabilitation, skilled nursing facility stay, home care, durable medical equipment (DME), hospice care and transportation,

the concurrent review nurse will facilitate prior approvals of medically necessary treatments if the member's benefit plan includes these services.

For Medicare members, SNFs are responsible for notifying the member's plan of the planned discharge date so that the plan can issue a Medicare notice of non-coverage (MNONC) in accordance with CMS guidelines at least two days prior to discharge. The SNF is responsible for delivering the MNONC to the member on the day the letter 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 it, the SNF staff member who informed the proxy of the end date and appeal rights is to sign and date the form 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 days a week to take appeal information.

Medicare Outpatient Observation Notice MOON

On August 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which 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. A standardized Medicare Outpatient Observation Notice (MOON), form CMS-10611 was developed to inform all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH.

In accordance with the statute, 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 no later than March 8, 2017. The notice and accompanying instructions are available at:

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

AMBULATORY SURGERY PROCEDURES FOR FACILITIES

Prior to Procedure

It is the responsibility of the physician or surgeon who will be performing the procedure in the

ambulatory surgical facility to obtain prior approval (if required). The practitioner must provide all the required clinical information to the managing entity to obtain the prior approval for the procedure or surgery. The facility must confirm that a prior approval has been issued to HIP, CompreHealth EPO (Retired August 1, 2018) and Medicare HMO members by signing in to **www.emblemhealth.com**. For all other members, please call **Customer Service** as indicated in the **Directory** chapter.

At the Time of Procedure

Ambulatory surgery facilities must verify member eligibility by signing in to **www.emblemhealth.com**.

EmblemHealth will not issue a prior approval and/or case number until the admission or procedure has been reviewed and either approved or denied. Facilities may check the status of a prior approval request by signing in to **www.emblemhealth.com** or by calling **Customer Service** for EmblemHealth-managed members as indicated in the **Directory** chapter or, for all other members, the managing entity 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

Failure to get prior approval may result in claim denial. Please see the Dispute Resolution chapters - **Commercial/CHP**, **Medicaid** and **Medicare**.

Ambulatory surgery claims will be processed as outpatient care pursuant to the prior approval. (See the "Facility Appeals" sections of the Dispute Resolution chapters - **Commercial/CHP**, **Medicaid** and **Medicare** - for guidelines surrounding claims submitted without prior approval.)

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 PROCEDURES

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) Medicare.

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 that require such an inpatient facility admission.

Although the treating physician is responsible for arranging hospice services for the patient, we will continue 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. Therefore, 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 also include the member's name and the plan ID number.

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

EmblemHealth
Dignified Decisions Program
55 Water Street
New York, NY 10041-8190
Fax: **1-646-733-9312** or **1-646-733-9324**

Prior Approval 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 prior approval should contact EmblemHealth's Prior Authorization department at **1-866-447-9717** to obtain or verify the approval prior to admitting the member to the service or facility. (See the Dispute Resolution chapters of this manual for guidelines regarding claims submitted without prior approval.)

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

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

The physician (PCP or consultant) attending the patient 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 the plan. A letter will be sent to the hospice specifying the level and number of units (days) approved. The hospice may call Customer Service for any plan member. The hospice may also check status of a HIP member's case by signing in to **www.emblemhealth.com**.

Timeliness in obtaining approval ensures appropriate claims payment. Failure to get prior

approval will result in the claim being denied. Please see the Dispute Resolution chapters of this manual.

Care Provided During Hospice Election Period

Hospice agencies or facilities are responsible for all care related to the terminal illness during the period of hospice election for Commercial and Child Health Plus members. This includes emergency and non-emergency situations. EmblemHealth must be notified of all care provided to the member.

To modify the level of hospice care (e.g., from home care to inpatient), medical necessity must be reviewed.

Hospice agencies or facilities that fail to provide clinical updates and/or progress notes to the Continuing Care Manager will not be reimbursed for unauthorized days.

Hospital Transfers

Admission into a hospital does not automatically revoke the hospice election. As stated above, 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 the member's plan by calling **Customer Service** immediately, or as soon as possible thereafter. In the event that circumstances prevent immediate contact with the plan, 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.

UTILIZATION REVIEWS - INPATIENT CARE

EmblemHealth and utilization review health care professionals make initial utilization review determinations for requested health care services that require prior approval. A "pre-service request" is a request for a service that must be pre-authorized by EmblemHealth.

Standard Pre-Service Review

Commercial/Child Health Plus

We will notify the member, their designee and their health care provider regarding a pre-service request within three business days after our receipt of the request if the information provided is or becomes complete. Notification will be in writing and by telephone to the member and provider. If EmblemHealth requires more information to make a determination, EmblemHealth will request such information within 15 days after its receipt of the request. EmblemHealth will provide at least 45 days to supply the information. At the end of the 45-day period, if the complete information is not received a determination will be made based on the information received within 15 calendar days from the expiration of the 45-day period.

Medicaid

We will notify the member, their designee and their health care provider regarding a pre-service request within three business days after our receipt of all the necessary information, but no more than 14 calendar days from receipt of request. Notification will be in writing and by telephone to the member and provider. This may be extended for up to 14 calendar days.

Medicare

Providers and members will be notified in writing of a determination within 14 calendar days after we receive the request. This may be extended for up to 14 calendar days.

Urgent/Expedited Review

Commercial/Medicaid/Child Health Plus

EmblemHealth may reasonably require the provider or member to explain the medical reasons that give rise to a need for urgent care. If care has not yet been initiated, EmblemHealth will notify the provider and member of its decision regarding the urgent care claim within 72 hours from receipt of the request. Notification will be in writing and by telephone to the member and provider.

If we require more information to make a decision, then we will request the additional information within 24 hours after we receive the request. We will provide at least 48 hours to supply the information. Notification of our determination will occur within 48 hours of our receipt of the information or within 48 hours of the end of the time period we provide to supply the information. For Medicaid members this time frame may be extended for up to 14 calendar days.

Medicare Advantage

Providers and members will be notified of a determination within 72 hours after we receive the request. If the request does not meet the criteria for an expedited request, the individual will be notified and the request will automatically be transferred to a standard request. A determination will be made within 14 days of the date that the request becomes a standard request.

Failure to make an initial utilization review determination within the specified times may be deemed as an adverse determination and subject to appeal/action appeal.

To be considered for payment, approval for elective services must be completed before services are rendered.

Admission Review and Concurrent Review

Once an initial inpatient stay or hospitalization has been issued, it is the responsibility of the facility to provide the managing entities (e.g., the EmblemHealth concurrent review nurse) with the necessary clinical updates. Facilities may submit concurrent review information to EmblemHealth via secure email or fax.

We may conduct concurrent reviews for members who are receiving care in an inpatient setting from the date of admission or for members who are receiving on-going care in an

outpatient setting. Such concurrent review may result in our denial of payment based on eligibility, coverage or medical necessity for such covered care. For admissions that are reimbursed under a DRG methodology, concurrent utilization review may be conducted to determine medical necessity for quality purposes and discharge planning.

Once we have been notified of the admission, the concurrent review process will begin. The member's case will be assigned to a concurrent review nurse who will be responsible for requesting and initially reviewing all pertinent clinical information, including consulting with the treating physician and reviewing medical records, to determine the medical necessity of the services being provided. Concurrent review nurses perform telephonic or fax reviews with contracted hospitals. Concurrent review of the hospital stay may occur daily, depending upon the patient's acuity status.

The review frequency for any given case is determined by contractual agreements, payment methodology, discharge planning activity and the complexity of the patient's clinical condition. Concurrent review will not be conducted more frequently than is reasonably required to assess whether the health care services under review are medically necessary.

During the concurrent review, the concurrent review nurse maintains contact with the attending physician, hospital discharge planner, care manager if needed, patient and/or family members to address any anticipated medical services or sub-acute options (such as home care) and coordinates the appropriate referrals to participating alternate care facilities.

If the review does not meet medical necessity criteria, the concurrent review nurse reviews the case with an EmblemHealth medical director who will render 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/or fax within one working day of making the decision, and gives members and practitioners written or electronic confirmation within 24 hours if the request is received 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 will be made within one business day of receipt of all necessary information but no more than 72 hours from receipt of request.

Hospital utilization reports are reviewed by the Care Management department for analysis and system-wide action plan recommendations to the Quality Improvement Committee (QIC) through the Care Management Committee.

If the review is for post-acute hospital care and it meets medical necessity criteria and the member has the benefit, the service will be approved and would be monitored by either the Post-Acute Services department or the Continuing Care Services program.

The status of each case (whether approved, denied or pended) is included on the Concurrent Review Status Report posted to the secure provider site at **www.emblemhealth.com** for HIP-contracted hospitals and skilled nursing facilities.

Note: Medicare members do not require prior approval for hospice care. Hospice services are covered by FFS Medicare for Medicare members. 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 the Plan to receive care related to their terminal illness.

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

Commercial/Child Health Plus
When a claim is submitted for an admission through the emergency department without the plan having received timely notification, records will be requested from the facility for an initial retrospective clinical review by the plan's Post-Service Review department. Upon the plan's request for medical records, the facility is given 30 days to submit the records. If records are received within that 45 calendar days from receipt of request, they are reviewed for medical, and 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 will be included.

Medicaid/Medicare
When a claim is submitted for an admission through the emergency department without the plan having received timely notification, records will be requested from the facility for an initial retrospective clinical review by the plan's Post-Service Review department. Upon the plan's request for medical records, the facility is given 30 days to submit the records. A clinical determination will be made within 30 calendar days from receipt of request and is 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 will be included.

Failure by the plan or the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be adversely determined and subject to appeal.

Adverse Determination Process
If the Care Management program does not make an initial determination within the specified regulatory time frames of receiving all necessary information, the member, member's designee or the clinician on behalf of the member may exercise their next level of appeal rights regarding their service request.

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

When the decision is made to deny coverage of a service or further service for an episode of care, an attempt will be made to contact the treating physician by telephone. The treating physician will be given the telephone number of the EmblemHealth physician reviewer or

utilization review agent and is afforded the opportunity to speak with the reviewer about the denial.

The appropriate parties (physician, facility representative, patient, patient's family or legal guardian) will be notified in writing of an adverse determination. The notification will include the reasons for the adverse determination, including the clinical rationale and instructions on how to appeal the determination. This notice will also inform the clinician of the availability, upon request of the member or the member's designee, of the clinical review criteria relied upon to make the determination and specifies what, if any, additional information must be provided for the Plan or the review agent to render a decision upon the appeal. The adverse determination letter advises the physician about the opportunity to speak with the EmblemHealth medical director or utilization review agent who rendered the decision to discuss the denial along with a phone number where the medical director can be contacted.

Reconsideration Process

Whenever an adverse determination is rendered, with or without the input of the clinician, the clinician has the opportunity to request a reconsideration of the adverse determination. Such reconsideration shall occur within one business day of receipt of the request (except retrospective) for reconsideration and shall be conducted by discussion between the clinician and the EmblemHealth medical director who rendered the decision or a designated clinical peer reviewer. **Note:** This process does not apply to Medicare members. An actual appeal must be submitted for Medicare members. Please see the Dispute Resolution chapters for more information.

Medicare Member Notices of Non-Coverage (GRIJALVA Process)

If the member no longer meets medical necessity criteria, notice of Medicare non-coverage will be issued to the Medicare member for continued skilled nursing facility (SNF) stays, home health care services or certified outpatient rehabilitation facility (CORF) services. If the notice of non-coverage is issued to a Medicare patient and the patient objects to the notice of non-coverage, the notice becomes effective two days after the day of issuance, unless the Medicare patient requests 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 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 will become liable for all costs commencing at noon of the day following receipt of the QIO determination.

Restrospective Utilization Review

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

- Whoever is responsible for managing the case (i.e., the managing entity) will perform the facility retrospective utilization review.
- The managing entity will render 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.

Adverse Determination Based on Information Submitted

The following applies in the scenarios outlined below when we have received the necessary information to review the case for medical necessity:

Prior to Discharge (Facility Reconsideration)

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

- Plan/managing entity will perform concurrent review and uphold or rescind decision as indicated
- Reconsideration will be for all days for which information is supplied

Expedited Appeal Process

See the Dispute Resolution chapters of this manual: **Commercial/CHP**, **Medicaid** or **Medicare**.

Risk Identification and Management

The objectives of risk identification and management are to identify and create an awareness of possible risks that may be potentially harmful to members, visitors, or employees, and to 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.

URGENT CARE CENTERS

Hospital emergency departments are for conditions that meet the layperson's definition of emergency. For urgent conditions that do not meet the layperson's definition of an emergency, all EmblemHealth plan members have access to network urgent care centers.

Urgent care centers enable members to receive the care they need in a more expeditious manner, eliminating long waits in emergency rooms. To facilitate continuity of care, PCPs are advised of member visits to participating urgent care centers. A copy of the encounter record and any test results will be provided to the PCP.

We encourage physicians to refer our members to network urgent care centers for urgent care when the physician or covering physician is not available. All non-urgent care services should be referred back to the member's PCP.

To find a list of network urgent care centers, use the **Find a Doctor** tool on our website at

www.emblemhealth.com/find-a-doctor. You may also call **Member Customer Service** to obtain this information.

Vytra members should visit **www.emblemhealth.com** or call the EmblemHealth Customer Service line at **1-866-409-0999**.

URGENT AND IMMEDIATE CARE PROVIDERS	
Category	**Details**
Retail Convenience Health Clinic	These are quick access clinics staffed by nurse practitioners (NPs), physician assistants (PAs) and sometimes physicians and designed to offer immediate, limited in-scope treatment for health conditions that are not severe enough to require services in an urgent care or emergency care setting. These clinics are typically located in retail stores and offer members a lower cost alternative. Common conditions treated include sore throats, sprains, strains and colds. For example, members may choose to visit either a MinuteClinic or DR Walk-in Medical Care clinic for treatment.
Walk-In Medical Office	No appointment necessary. A practice that treats patients without requiring them to be an existing patient or having an appointment and that can provide routine primary care and immediate treatment of common family illnesses for adults and/or children.
Urgent Care Center	These medical facilities offer immediate evaluation and treatment for health conditions that are not severe enough to require treatment in the hospital or a hospital emergency room. Billed place of service (POS) 20.

	Conditions treated through urgent care centers include common medical ailments such as sore throats, flu, earaches, respiratory infections, small cuts, sprains and minor broken bones. Urgent care centers provide care and treatment through qualified physicians, PAs and NPs when care needs fall outside of the physician's regular office hours or before an appointment is available with a primary physician. Emergency room copays can be three to five times as much as a standard office visit, so visiting an urgent care center offers members lower copays and lower overall care costs.	

MinuteClinics and DR Walk-in Medical Care

When EmblemHealth plan members or their children 18 months or older need to see a health care provider for a minor ailment, such as an ear infection, allergies, bronchitis, or strep throat, they may choose to visit a MinuteClinic or DR Walk-in Medical Care clinics for treatment.

MinuteClinics are owned by CVS Corporation and accredited by The Joint Commission. DR Walk-in Medical Care is owned by Duane Reade, a Walgreen's company. There are nationally-based MinuteClinics in CVS pharmacies and other retail locations. DR Walk-in Medical Care is located in New York City-based clinics in seven Duane Reade pharmacies.

These clinics are providers of "retail-based" health care and offer quick and convenient (no appointment required) health care during business hours, many with seven days a week and extended hour service. MinuteClinics are staffed by certified advanced practice nurse practitioners and DR Walk-in Medical Care is staffed with licensed medical doctors. They offer treatment for common family illnesses, as well as vaccinations.

They are intended to be a complement to, not a replacement for, our members' ongoing relationship with their PCP. We encourage members to have these clinics send their medical records to their PCP to ensure continuity of care. The clinic practitioners also stress that patients should obtain a regular medical exam from their PCP.

Copays for visiting these clinics are determined by the terms of the member's individual health insurance plan and would be equivalent to the member's copay for a PCP visit.

MinuteClinic has many locations in EmblemHealth's service area. EmblemHealth plan members may also be treated at MinuteClinic locations throughout the United States. To find a convenient location, members may visit the MinuteClinic website at **www.minuteclinic.com** or call them at **1-866-389-2727**.

Please note that visits to a DR Walk-in Medical Care facility do not require a referral.

Although there may be other locations listed on their website, our members may only visit one of the credentialed DR Walk-in Medical Care facility locations listed in our **Find A Doctor** tool at **www.emblemhealth.com/find-a-doctor**.

CASE MANAGEMENT

Overview

EmblemHealth's Case Management program assesses, plans, implements, coordinates, monitors and evaluates benefit options and services to meet member's health care needs. The Case Management program also has an educational component to ensure members understand their health conditions and the impact those conditions have on their daily lives.

The EmblemHealth Case Management program is a member-centric approach to supporting the member's self management in their journey to wellness. EmblemHealth supports this member-centric approach to case management and utilizes a multidisciplinary team to support all aspects of the member's needs. As part of an interdisciplinary team, the member's primary care physician helps to determine the health care needs of the member in collaboration with nurses, case managers, social workers, physicians and ancillary support staff.

We offer the following specialty case programs to assist clinicians in meeting the complex needs of their patients:

- **Frail and elderly**
- **Government programs** (for Medicaid members with acute exacerbation of chronic conditions in addition to catastrophic injuries)
- **HIV/AIDS**
- **Neonatal**
- **Transplants**

Frail and Elderly Case Management

This program supports the care needs of frail and elderly individuals in Medicare and special needs plans by helping them maximize their benefits and providing resources that help keep them in their communities.

The goals of the program include:

- Maximizing the functionality and independence of frail elder adults living in the community
- Facilitating the delivery of health care services in the most appropriate setting

The processes for referring and being involved in this case management program are as follows:

1. Physicians and/or members may refer Medicare members to the program.
2. Case managers will contact members telephonically to explain the program and its benefits.
3. Upon the member's agreement, the member is enrolled in the program.
4. A team consisting of a case manager and a social worker performs a telephonic assessment designed to identify the member's needs.
5. After the assessment, an individualized plan of care is developed to meet any care gaps or needs the member may have.
6. Notification by letter is sent to the PCP to ensure the PCP is aware that the member is enrolled in the case management program.
7. Ongoing monitoring of the member's status and plan of care is performed to address any changes in the member's medical condition.
8. Ongoing communication with the PCP and other health care disciplines is established to ensure that support for services needed by the member occurs.

The case manager and social workers' functions are to:

- Coordinate the member's health care services
- Educate members regarding their health (e.g., chronic medical conditions, home safety, aging processes, correct use of medications)
- Serve as liaisons between the member, physician and other members of the health care team
- Make referrals to community resources (e.g., senior centers, meals-on-wheels, home attendant and transportation services and entitlement programs)

To make a referral to this program or for more information, please call 1-800-447-0768 or the managing entity listed on the member's ID card.

Government Programs Case Management

Government Programs Case Management focuses its efforts on Medicaid children and members who have an acute exacerbation of chronic conditions in addition to catastrophic injuries. The goal is to help members understand their conditions for their optimal management. The interdisciplinary team of nurses and social workers work to coordinate members' health care needs, support educational needs, and promote home and community-based services through access to local, state and federal agencies.

To request these case management services for Medicaid members, providers and members may call us at 1-800-447-0768.

HIV/AIDS Case Management

By collaborating with the member and the member's health care team, EmblemHealth's HIV/AIDS case management program helps members living with HIV/AIDS to self-manage their disease and health care needs.

In an effort to improve care and treatment adherence, the HIV/AIDS case manager:

- Assesses medication compliance
- Assesses viral load and CD4 counts
- Assesses compliance with the prescribed treatment plan
- Assists with referrals to HIV specialists and New York State-designated AIDS treatment

centers
- Provides educational material to clinicians and members

The department is staffed by a registered nurse and supported by a medical director and a pharmacist.

Learn more about our **HIV/AIDS case management program**. To request HIV/AIDS case management services, members or providers may call us at **1-800-447-0768**.

Neonatal Case Management
EmblemHealth offers a program to address the needs of newborns that have had difficulties at birth. Neonatal intensive care unit (NICU) nurse case managers monitor the progress of the newborn confined to the NICU. These nurses work with the attending neonatologist and EmblemHealth case managers to coordinate and facilitate a safe and supportive hospital discharge plan that meets the needs of the baby and the family.

To request neonatal case management services, members and providers may call **1-800-447-0768**.

Transplant Program Case Management
EmblemHealth's transplant program manages members with health care needs associated with having or preparing for a solid organ or bone marrow transplant. All transplant services are reviewed with the medical director assigned to support the transplant case management program. All requested transplant services are reviewed for medical necessity and evidence-based criteria are utilized to support the best care coordination and outcomes for EmblemHealth transplant members.

To request transplant case management services for the EmblemHealth transplant program, members and providers may call **1-800-447-0768**.

EXPERIMENTAL DRUGS, NEW DRUGS OR MEDICAL TECHNOLOGIES

We are committed to providing members with current, safe, appropriate and effective medical care consistent with the professional standard of care available in our service area. We are dedicated to holding premium costs at low levels for all subscribers. To achieve these goals, we generally exclude coverage for treatments of an experimental or investigational nature that have not been proven safe and/or effective.

To make a coverage determination in an individual patient case, the professional staff in EmblemHealth's Care Management department 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 that follow.

Any coverage decisions reached are subject to review according to our grievance and appeal procedures.

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.

A drug, treatment, device or procedure is considered experimental and investigational if any of the following applies:

- It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use. **Exception**: If FDA approval of a drug has been granted for treatment of a certain type of cancer, the law may require coverage of that drug even if it is prescribed for treatment of a different type of cancer.
- It is the subject of a current investigational new drug (IND) or new device application (NDA) on file with the FDA.
- It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.
- It is being provided pursuant to a written protocol that describes among its objectives, determinations of safety, efficacy or efficacy compared with conventional alternatives, and toxicity.
- It is being delivered, or should be delivered, subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS).
- The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings.
- If the predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary to define safety, maximum tolerated dose, toxicity, effectiveness or effectiveness compared with conventional alternatives.
- It is not investigational in itself pursuant to the above, and would not be medically necessary, but for the provision of a drug, device, treatment or procedure that is investigational or experimental.

In determining whether any drug, treatment, device or procedure is considered experimental or investigational, the Plan relies on the following sources of information:

- The member's medical records
- The protocol(s) pursuant to which the treatment is to be delivered
- Any consent document the member has executed or will be asked to execute to undergo the treatment
- The published authoritative medical or scientific literature regarding the treatment as applied to the member's injury or illness
- Regulations and other actions and publications issued by the FDA and HHS

Clinical Trials for Medicare Members

Fee-for-service Medicare covers the routine costs of qualifying clinical trials if a Medicare

member elects to participate in a CMS-approved clinical trial, and claims should be sent to fee-for-service Medicare. If a member wishes to enroll in a qualifying clinical trial, EmblemHealth Case Management must be notified.

DELINEATION OF RESPONSIBILITY

EmblemHealth and our utilization 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 the Centers for Medicare & Medicaid Services, NCQA and URAC. The responsibilities and authority of the parties associated with the Plan's utilization management activities are outlined below.

Board of Directors

The Board of Directors is the entity accountable for care management activities. The Board endorses the written **Care Management** program and receives and reviews care management statistical reports on a quarterly basis. The Board is responsible for considering and acting upon 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 underutilization patterns and trends, physician performance profiling, and a variety of data that monitor the effectiveness and efficiency of the Care Management processes.

The committee is responsible for approval of EmblemHealth's Care Management policies and procedures, both current and proposed.

Chief Medical Officer/Plan Medical Directors

EmblemHealth's chief medical officer has overall accountability for the Care Management program and provides oversight and direction for all quality improvement and care management functions including establishing long- and short-range Care Management program goals relative to EmblemHealth's overall strategic plan.

Medical directors serve as resource persons for physicians and Care Management nurses on clinical issues.

Care Management Department

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

Clinical Personnel

Where procedures are used for prior approval and concurrent review, qualified health care professionals supervise utilization review decisions.

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

Plan Utilization Review Agents

A utilization review (UR) agent is often called a delegate. We jointly refer to EmblemHealth Care Management staff and the delegates as "managing entities." A UR agent or delegate is an entity (i.e., management services organization, independent practice association and/or hospital) that has been authorized by EmblemHealth to assume the authority and responsibility to perform certain utilization management and/or utilization review services.

MEMBER AND CLINICIAN SATISFACTION

Our goal is to have our Care Management program use a synergistic approach with members and clinicians to achieve excellent quality of and access to health care for all plan members. Our Care Management program provides a valuable service to plan members by assisting and facilitating coordination of their health care services, ensuring health care services are rendered in the most medically appropriate and cost-effective setting, and monitoring the quality of health service rendered. Effectiveness is measured through clinician and member satisfaction surveys conducted annually. Member satisfaction surveys are conducted at the time of discharge from contracted hospitals. Clinician surveys and member surveys are also conducted on a plan-wide basis. Medicare members are surveyed directly by Centers for Medicare & Medicaid Services contractors. The results of these surveys are analyzed and actions are taken to address identified sources of dissatisfaction.

INFORMATION SYSTEMS REPORTING

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. We generate care management reports used to identify areas of over- and underutilization. The Care Management Committee reviews the reports to determine the need for focused studies and/or intervention activities targeted at clinicians identified with utilization and/or quality concerns. Consistent with the established utilization management reporting structure, relevant care management findings and recommendations are reported to the Care Management Committee, Quality Improvement Committee and Board of Directors of the organized delivery systems.

INTERVENTION STRATEGIES

When patterns of questionable or inappropriate utilization and/or quality concerns are identified, intervention strategies are planned and implemented. Our Care Management Committee reviews these issues and reports to the Quality Improvement Committee.

MAINTENANCE OF RECORDS

Documentation of 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 prior approval and concurrent management processes.

CONFLICT OF INTEREST POLICY

No practitioner in Care Management may review any case in which there is professional involvement. As a managed care organization, we are dedicated to providing quality care and service to each of our members. We do not specifically reward practitioners 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 that would result in the underutilization of services or rendering of adverse determination.

ANNUAL REVIEW AND APPROVAL

The EmblemHealth Care Management program, including the written plan and criteria, is evaluated and approved at least annually, or as necessary, by the Quality Improvement Committee, EmblemHealth's Board of Director's Quality Improvement subcommittee and the Board of Directors.

HEALTH CARE PROVIDER PERFORMANCE EVALUATIONS

EmblemHealth maintains the methods and information used to evaluate the performance of network practitioners in meeting the objectives of the Quality Improvement Program. This includes the methods of assessment and the criteria against which the performance of the practitioner is evaluated. We will disclose the process, including the profiling data and other relevant information used to perform the evaluation of the practitioner.

We will make available (on a periodic basis and upon the request of the health care professional) the information, profiling data and analysis used to evaluate the practitioner's performance. Each practitioner will be given the opportunity to discuss the unique nature of their professional patient population, which may have bearing on the practitioner's profile and the evaluation of their performance.

HIP and CompreHealth Concurrent Review Report

Facility Name: GENERAL HOSPITAL
Facility Id: 546784
Generated On: Tuesday, March 29, 2011 10:19:28 AM

Patient Id	Case #	Patient Name	DOB	LOB	Dx Code	Diagnosis Description	Admit Date	Notify Date	Source	Gap Days	Dates of Service	Status	Days	Bed Type
50678543	0004867543	SARAH JONES	04/14/1975	MR	V3000	SINGLE LIVEBORN, BORN IN HOSPITAL, DELIVERED WITHOUT MENTION OF CESAREAN DELIVERY	03/23/2011	03/24/2011	ER					
										3/28/2011 – 3/29/2011	03/23/2011 – 03/27/2011	A (Approved) P (Pended)	2	MD
											Review Days:		**2**	
49574321	0004856732	JOHN BROWN	03/12/1945	MD	5609	UNSPECIFIED INTESTINAL OBSTRUCTION	03/21/2011	02/09/2011	ER					
										03/22/2011 – 03/29/2011	03/21/2011 – 02/31/2011	A (Approved) P (Pended)	1	MD
											Review Days:		**1**	
38560342	0003856743	MOLLY PETERS	02/03/1981	MD	486	PNEUMONIA, ORGANISM UNSPECIFIED	03/18/2011	03/21/2011	ER					
										3/21/2011 – 3/29/2011	03/18/2011 – 03/20/2011	A (Approved) P (Pended)	3	MD
											Review Days:		**3**	
45976843	0004735273	GLENN BLACK	08/02/1935	MD	74685	CORONARY ARTERY ANOMALY, CONGENITAL	03/27/2011	03/28/2011	ER					
										3/28/2011 – 3/29/2011	03/27/2011 – 03/27/2011	A (Approved) P (Pended)	1	MD
											Review Days:		**2**	

This report is system generated. The data it contains is not a guarantee of payment. All claims are subject to review for medical necessity, member eligibility and all other coverage plan provisions in effect at the time services are rendered.