EmblemHealth

Online Provider Manual

This manual applies to all EmblemHealth plans and is an extension of your Provider Agreement. It includes detailed information about your administrative responsibilities, and contractual and regulatory obligations. It also details best practices for interacting with our plans and helping our members navigate their health care.

**The online manual is updated regularly. Please do not refer to any previously downloaded PDF.

Search the Provider Manual

EmblemHealth

Chapter 1: Overview

This manual applies to all EmblemHealth, GHI, HIP, HIPIC and Vytra plans, and it replaces all provider manuals published before November 2009. It includes detailed information about your administrative responsibilities, contractual and regulatory obligations, and best practices for interacting with our plans and helping our members navigate our delivery systems.

You will also find information on our wellness programs, which foster disease prevention and healthier living. These services support our mission of providing a choice of products and services, so that our members have access to the medical care they need when they need it at prices they can afford. More Information on our member's Protections for Out-of-Network Emergency Services and Surprise Bills.

Keep your email address with us current so that you can receive electronic communications with new and updated operational information. To update your email address and directory information, sign in.

This manual is an extension of your Provider Agreement and is amended as our operational policies change. We regularly communicate these updates and other important information through available communication channels, including:

- Targeted mailings to directly-impacted providers.
- New Policy & Alerts, Claims Corner and Clinical Corner postings to our Provider Resources section.
- Our monthly eNewsFlashes are available via email and also on our Provider Resources webpage..

Note: This copy of the EmblemHealth Provider Manual was last updated on October 27, 2015. Updates to the Provider Manual occur as policies are reviewed and updated, new programs are introduced and contractual and regulatory obligations change. Please visit the Provider Manual for the most current information.

Disclaimer

EmblemHealth and its companies Group Health Incorporated (GHI), HIP Health Plan of New York, HIP Insurance Company of New York and Vytra Health Plans Managed Systems (together referred to as EmblemHealth) arrange for the delivery of health care services in accordance with, and subject to, the terms of the certificates of coverage and benefit packages purchased either by our members or on their behalf. We do not directly provide these services or supplies. Rather, these services and supplies are provided by independent contractors. The health care providers listed in the various provider directories who deliver health care services are not the employees or agents of our companies. EmblemHealth will not be liable for any negligent act or omission by any of the providers listed in the directory, or any of their employees or agents, who may from time to time provide medical services to EmblemHealth members. EmblemHealth expressly disclaims any agency relationship, actual or implied, with any health care provider. Any decisions made by EmblemHealth concerning appropriateness of setting or whether any services or supply is medically necessary, pursuant to the certificate of coverage, will be deemed to be made solely for the purpose of determining whether benefits are due under the agreement between the member and EmblemHealth, and not for the purpose of recommending any medical treatment or nontreatment. EmblemHealth does not exercise any control or directory over the medical judgment or clinical decision of any health care provider listed in their directory, and does not interfere with the physician-patient relationship between the provider and EmblemHealth member.

Note

This provider manual links to websites as a convenience as well as an educational and informational service to our providers. These links are not intended to provide medical or professional advice. All medical information, whether from

these links or from any other source, needs to be reviewed carefully by the practitioner. The opinions and information expressed therein are not necessarily EmblemHealth's. EmblemHealth does not guarantee or warrant that the links referenced in this manual, or any information therein contained, are complete, accurate or up to date since the date of this manual's publication or last update.

EmblemHealth

Claims Contacts

Paper claims (CMS 1500 forms) may be sent to the addresses indicated, unless otherwise noted on the member's ID card.

Plans	Type of Claim	EDI or Payor ID	Clearing House	Paper Claim Submission Address	Contact for Inquiries
HIP	Medical claims	HIP: 55247 GHI HMO: 25531	Vendor or direct submission	EmblemHealth PO Box 2845 New York, NY 10116-2845	emblemhealth.com or (866) 447-9717
HIP	Hospital claims	HIP: 55247 GHI HMO: 25531	Vendor or direct submission	EmblemHealth PO Box 2803 New York, NY 10116-2803	emblemhealth.com or (866) 447-9717
GHI	Medical claims, member-submitted	13551	Vendor or direct submission	EmblemHealth PO Box 3000 New York, NY 10116-3000	emblemhealth.com or (212) 501-4444
GHI	Medical claims, provider-submitted	13551	Vendor or direct submission	EmblemHealth PO Box 2832 New York, NY 10116-2832	emblemhealth.com or (212) 501-4444
GHI	Hospital claims	13551	Vendor or direct submission	EmblemHealth PO Box 2833 New York, NY 10116-2833	emblemhealth.com or (212) 501-4444
GHI	Dental claims	Not applicable	Vendor or direct submission	EmblemHealth PO Box 2838 New York, NY 10116-2838	emblemhealth.com or (212) 615-4EMC
Vytra	All claims	22264	Vendor or direct submission	Vytra Health Plans Attn: Claims Department PO Box 9091 Melville, NY 11747-9091	emblemhealth.com or (888) 288-9872
CCI	CCI VIP Medicare Advantage claims	78375	Vendor	ConnectiCare PO Box 4000 Farmington, CT 06034-4000	(877) 224-8230

Montefiore CMO	HIP claims for members managed by Montefiore CMO	13174	Vendor	CMO 200 Corporate Drive Yonkers, NY 10701	(877) 447-6668
HealthCare Partners (HCP) [except for members in HCP Cohort 2]	HIP claims for members managed by HCP	11328	Vendor	HealthCare Partners Attn: Claims Department 501 Franklin Avenue Suite 300 Garden City, NY 11530-5807	(516) 746-2200 or (888) 746-2200
HCP Cohort 2	HIP claims for members managed by HCP Cohort 2	55247	Vendor or direct submission	EmblemHealth PO Box 2845 New York, NY 10116-2845	emblemhealth.com or 1-866-447-9717
Palladian Muscular Skeletal Health	HIP professional claims for PT/OT services members managed by Palladian and claims billable under the Chiropractic program	37268	Vendor	Palladian Health PO Box 366 Lancaster, NY 14086	palladianhealth.com
EviCore	HIP and GHI claims billable as part of the Radiology program	14182	Vendor/Relay Health	EviCore 400 Buckwalter Place Blvd. Bluffton, SC 29910	(800) 420-3471
Beacon Health Options	HIP and GHI claims billable as part of the Emblem Behavioral Health Services (HIP members) and EmblemHealth Behavioral Management (GHI members) Programs	FHC &Affiliates	Vendor	EmblemHealth PO Box 1850 Hicksville, NY 11802-1850	Beacon Health Options or (800) 235-3149

EmblemHealth

EmblemHealth Contact Information

Customer Service is available seven days a week (excluding major holidays), 8 am to 8 pm. Teletypewriter (TTY/TDD) services can be reached by calling 711.

EmblemHealth Contact Information				
Company	Provider Network	Customer Service (Members)	Provider Customer	Website
GHI	Commercial: CBP, National & Tristate Networks Network Access Network	NYC: 1-212-501-4444 Outside NYC: 1-800-624-2414	NYC: 1-212-501-4444 Outside NYC: 1-800-624-2414	Sign in to emblemhealth.com and use the Message Center
	Medicare: Medicare Choice PPO Network	1-866-557-7300	1-866-557-7300	
HIP/ HIPIC	Commercial: Prime Network	1-800-447-8255	1-866-447-9717	
	Prime Network	1-877-244-4466		
	Select Care Network	1-888-447-7703		
	State Sponsored Programs: Enhanced Care Prime Network (Including Child Health Plus)	1-855-283-2146		
	Medicare: VIP Prime Network	1-877-344-7364		

EmblemHealth

Provider Manual

Chapter 2: Directory

This chapter contains contact information for parties within EmblemHealth, our delegated relationships and other external resources.

EmblemHealth Headquarters

EmblemHealth
55 Water Street
New York, NY 10041-8190

EmblemHealth Contact Information

Customer Service is available seven days a week (excluding major holidays), 8 am to 8 pm. Teletypewriter (TTY/TDD) services can be reached by calling 711.

Company	Provider Network	Customer Service (Members)	Provider Customer	Website
GHI	Commercial: CBP, National & Tristate Networks Network Access Network	NYC: 1-212-501-4444 Outside NYC: 1-800-624-2414	NYC: 1-212-501-4444 Outside NYC: 1-800-624-2414	Sign in to emblemhealth.com and use the Message Center
	Medicare: Medicare Choice PPO Network	1-866-557-7300	1-866-557-7300	
	Commercial: Prime Network	1-800-447-8255		
	Prime Network	1-877-244-4466		
HIP/	Select Care Network	1-888-447-7703	1-866-447-9717	

HIPIC	State Sponsored Programs: Enhanced Care Prime Network (Including Child Health Plus)	1-855-283-2146		
	Medicare: VIP Prime Network	1-877-344-7364		

Claims Contacts

For Claims Contacts please go here

How to Obtain 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.

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.

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

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. Pre-Certifications may be submitted via emblemhealth.com by calling (800) 223-9870 or faxed to (212) 563-8391.

Pharmacy Services

Retail Pharmacy Services (Pharmacies)

EmblemHealth Pharmacy Services:
(877) 793-6253, 24 hours a day, 7 days a week

Clinical Pharmacy Services (Providers)

EmblemHealth:
(877) 362-5670, Monday through Friday, 8 a.m. to 6 p.m.

Express Scripts, Inc. (ESI):
(home delivery for all plan members except for state and federal employees and retirees with GHI coverage)
Physicians may call in new prescriptions to Express Scripts at (888) 327-9791.

Specialty Pharmacy Program:
(888) 447-0295, Monday through Friday, 8:30 a.m. to 5 p.m.

Accredo:
855-216-2166, Monday to Friday, 8 a.m. to 11 p.m.; Saturdays, 8 a.m. to 5 p.m.

Pharmacy Benefit Services (Members)

EmblemHealth:
(for all members with the exception of GHI retirees and city, state and federal employees with GHI coverage)
(877) 793-6253 , Monday through Friday, 8 a.m. to 8 p.m.
TTY/TDD: 711

Medicare Pharmacy Line:
(for providers and Medicare members excluding retirees and city, state and federal employees with GHI coverage)
(877) 444-7097, Monday through Sunday, 8 a.m. to 8 p.m.
TTY/TDD: 711

Medicaid Pharmacy Line:
(for providers and Medicaid members)
(888) 447-7364 , Monday through Friday, 8 a.m. to 8 p.m.
TTY/TDD: 711

GHI Customer Service:
(for GHI retirees and city, state and federal employees with GHI coverage)
(800) 624-2414, Monday through Friday, 8 a.m. to 8 p.m.
If calling from New York City, members may also call (212) 615-4444.
TTY/TDD: 711

Express Scripts, Inc. (ESI):
(home delivery for all plan members except for state and federal employees and retirees with GHI coverage)

- (877) 866-5798 (Commercial members excluding all City of New York Commercial members)
- (877) 866-5828 (EmblemHealth Medicare members excluding all City of New York Medicare members)
- (877) 866-4165 (EmblemHealth Medicaid members)
- (866) 211-8379 (New York State of Health)
- (877) 534-3682 (City of New York Commercial members)
- (800) 585-5786 (City of New York Medicare members)
- 711 (for users of TDD/TTY)

24 hours a day, 7 days a week

Physicians may call (888) 327-9791 for instructions on how to fax a prescription to ESI. In addition, members can speak to a registered pharmacist for medication counseling.

Mobile In-Office Anesthesia/Sedation

The table below includes a list of anesthesia groups whose doctors are available to come to your office so you can keep member care in-network.

Mobile In-Office Anesthesia/Sedation

Physician Group	Service Area	Commercial Plans (HIP/GHI)	Medicaid Plans (HIP)	Medicare Plans (HIP/GHI)	Contact Information
CADS Anesthesia Services PLLC	Kings & Richmond Counties	Yes	Yes	Yes	201–804–2800
Long Island Anesthesia Physicians	Nassau & Suffolk Counties	Yes	Yes	Yes	631–744–3671, Press 2
NAPA (North American Partners in Anesthesia)	Kings, Nassau, Queens, Ulster & Suffolk Counties	Yes	Yes	Yes	516–626–6366

SOMNIA Inc.	Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan & Ulster Counties	Yes	Yes	Yes	914–637–3510

Health Homes

A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home."

It is very important for our physical health network practitioners to be aware of their patients' mental health and substance use disorders. We ask our PCPs to screen their patients for depression and other potential issues and to take these diagnoses into consideration when developing treatment plans. Where possible, please identify and coordinate care with your patient's behavioral health providers.

The following Enhanced Care Prime Network Health Homes support our Medicaid Managed Care, and HARP benefit plans.

EmblemHealth Medicaid Health Homes

Health Home/ DBA Partnerships	Counties	Contact
Bronx Accountable Healthcare Network(BAHN)	Bronx,Westchester	Antonette Mentor (914) 378-6086 amentor@montefiore.org Christine Whang (914) 378-6151 chwwhan@montefiore.org Mary Fernandez (914) 378-6554 maryfern@montefiore.org

Brooklyn Health Home(Maimonides) (under Southwest Brooklyn Health Home)	Brooklyn	Sara Kaplan Levenson (718) 283-7858 slevenson@maimonidesmed.org Danielle Cuyuch (718) 283-6194 dcuyuch@maimonidesmed.org
Community Care Management Partners LLC (under Visiting Nurse Service of New York Home Care)	Counties serving Adults: Bronx, Manhattan Counties serving Children: Bronx, Kings, Manhattan, Queens	Hillel Hirshbein (212) 609-1536 Hillel.hirshbein@ccmphealthome.org Nathan Smith ((212) 609-1543 Nathan.smith@ccmphealthhome.org
Community Health Care Network	Bronx, Brooklyn, Manhattan, Queens, Staten Island	Alyssa Lord (212) 545-2469 alord@chnnyc.org Carmen Plaja-Cordero (212) 545-6226 cpcordero@chnnyc.org
Coordinated Behavioral Care Inc. (DBA Pathway to Wellness)	Counties serving Adults: Brooklyn, Manhattan, Staten Island Counties serving Children: Bronx, Brooklyn, Manhattan, Queens, Staten Island	Amanda Semidey (646) 930-8835 asemidey@cbcare.org Melissa Martinez (646) 930-8831 Mmartinez@cbccare.org
Hudson River Healthcare Inc. (DBA Community Health Care Collaborative)	Counties serving Adults: Nassau, Suffolk, Westchester Counties serving Children: Nassau, Suffolk, Westchester	Kathleen Clay (914) 734-8513 kclay@hrhcare.org Christina Turiano (914) 829-5162 cturiano@cbccare.org
Hudson Valley Care Coalition (under Open Door Family Medical Centers)	Westchester	Stephanie Griffith (914) 488-6595 sgriffith@hvcare.net Sean Allen (914) 488-6610 seallen@hvcare.net

Mt. Sinai Health Home (under St. Luke's-Roosevelt Hospital Center)	County serving Adults: Manhattan Counties serving Children: Bronx, King, Manhattan, Queens, Staten Island	Lynette Verges (212) 731-7931 Lynnette.verges@mountsinai.org Alicia Korpi (212) 731-7841 Alicia.korpi@mountsinai.org
New York City Health and Hospital Corporation	Bronx, Brooklyn, Manhattan, Queens	Katherine Redfern-Shaw (646) 458-5617 redfernk@nychhc.org Cathleen Gittens (646) 458-6423 Cathleen.gittens@nychhc.org
North Shore (formerly Northshore LIJ)	Nassau, Suffolk, Queens, Staten Island	Hira Ruskin (516) 600-1132 hruskin@northwell.edu Pat McCarrick (516) 600-1129 pmccarrick@northwell.edu
Queens Coordinated Care Partners	Bronx, Brooklyn, Queens, Manhattan	Brian Timmermans (718) 906-6246 Brian.timmermans@mountsinai.org Oscar Laluyan (718) 906-6243 Oscar.laluyan@mountsinai.org
NY Presbyterian	Manhattan	Tiffany Sturdivant-Morrison (212) 342-0542 Tis9034@nyp.org Henley Vargas (212) 342-0590 Hev9012@nyp.org
Collaborative for Children and Families	Bronx, Brooklyn, Manhattan, Queens, Staten Island, Nassau, Suffolk, Westchester	Jodi Saitowitz (646) 459-3971 jsaitowitz@ccfhh.org Alyssa Tosi (646) 459-3975 atossi@ccfhh.org

For more information on Health Homes and other Medicaid covered services, please see the Medicaid section of

the Provider Networks and Member Benefit Plans chapter.
For more information on EmblemHealth's Behavioral Health Services Program, please see the Behavioral Health Services chapter.

Network Laboratory Services

Quest Diagnostics, Inc. is our preferred, independent free standing laboratory and provides most outpatient clinical services to our members. We also contract with other free-standing independent laboratories for certain specialty tests. In addition, physicians may also use network hospitals that have their own lab and pathology group(s) that are contracted with EmblemHealth. Depending on the member benefit plan, the member may have higher cost sharing when accessing these services through a network hospital. For more information on allowable in-office lab tests, please see the Laboratory Services section of the Care Management chapter.

Contracted 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. The nearest Quest Diagnostics Patient Service Center may be found by calling 1-800-377-8448.

EmblemHealth has contracts with laboratories to provide lab services for our EmblemHealth, GHI and HIP plan members. Please use these network laboratories when requesting lab services for our members. All services for out-of-network providers require prior authorization. If you do not have an account with any of our network laboratories, please establish one as needed by calling the applicable phone number(s) below.

EmblemHealth Network Laboratory Services

Laboratory	Plans Covered	Phone Number	Website
Routine Clinical Laboratory Services			
Quest Diagnostics, Inc.	All Networks and Plans	(866) 697-8378	www.questdiagnostics.com
ACM Medical Laboratory	GHI-Underwritten Networks and Plans ONLY	(800) 525-5227	www.acmlab.com
Lab Alliance of Central New York, LLC	GHI-Underwritten Networks and Plans ONLY	(315) 461-3008	www.laboratoryalliance.com
Shiel Medical Laboratory, Inc. - Not Participating as of May 1, 2018	GHI-Underwritten Networks and Plans ONLY	(718) 552-1000	www.shiel.com

Cardiovascular Disease			
Quest Diagnostics, Inc.	All Networks and Plans	(866) 697-8378	www.questdiagnostics.com
Dermatopathology			
Quest Diagnostics, Inc.	All Networks and Plans	(866) 697-8378	www.questdiagnostics.com
AmeriPath New York, LLC (aka Dermpath Diagnostics & Ackerman Academy of Dermatopathology)	All Networks and Plans	Dermpath: (800) 942-3376 Ackerman: (800) 553-6621	www.ameripath.com
InterScience Diagnostics	GHI-Underwritten *Commercial* Networks and Plans ONLY	(718) 698-5461	www.intersciencelabs.net/
Lakewood Pathology Associates (dba PLUS Diagnostics)	GHI-Underwritten Networks and Plans ONLY	(800) 440-7284	www.plusdx.net
Dialysis Testing			
DaVita Labs	All Networks and Plans	(800) 604-5227	www.davita.com
Spectra Laboratories	All Networks and Plans	(800) 522-4662 (800) 433-3773	www.spectra-labs.com
Endocrinology			
Quest Diagnostics, Inc.	All Networks and Plans	(866) 697-8378	www.questdiagnostics.com
Gastroenterology			
Quest Diagnostics, Inc.	All Networks and Plans	(866) 697-8378	www.questdiagnostics.com
AmeriPath New York	All Networks and Plans	(866) 393-7434	www.ameripath.com

Lakewood Pathology Associates (dba PLUS Diagnostics)	GHI-Underwritten Networks and Plans ONLY	(800) 440-7284	www.plusdx.net
Gene-Based Testing			
Quest Diagnostics, Inc.	All Networks and Plans	(866) 697-8378	www.questdiagnostics.com
AmeriPath New York, LLC (aka AmeriPath Northeast)	All Networks and Plans	(866) 436-9631	www.ameripath.com
Genomic Health	All Networks and Plans	(866) 662-6897	www.genomichealth.com
Mount Sinai Genetic Testing Laboratory	All Networks and Plans	(212) 241-7518	www.mssm.edu
Hematology/Oncology			
Quest Diagnostics, Inc.	All Networks and Plans	(866) 697-8378	www.questdiagnostics.com
AmeriPath New York, LLC (aka AmeriPath Northeast)	All Networks and Plans	(800) 440-7284	www.ameripath.com
Lakewood Pathology Associates (dba PLUS Diagnostics)	GHI-Underwritten Networks and Plans ONLY	(800) 440-7284	www.plusdx.net
Neurology			
Quest Diagnostics, Inc.	All Networks and Plans	(866) 697-8378	www.questdiagnostics.com
Pain Management			
Quest Diagnostics, Inc.	All Networks and Plans	(866) 697-8378	www.questdiagnostics.com
American Forensic Toxicology Services	All Networks and Plans	(855) 895-8090	www.aftslabs.com
Urology			
Quest Diagnostics, Inc.	All Networks and Plans	(866) 697-8378	www.questdiagnostics.com

AmeriPath New York	All Networks and Plans	(866) 393-7434	www.ameripath.com
Lakewood Pathology Associates (dba PLUS Diagnostics)	GHI-Underwritten Networks and Plans ONLY	(800) 440-7284	www.plusdx.net

Note: A full list of Provider Networks and Member Benefit Plans may be found in the Provider Networks and Member Benefit Plans Chapter. Providers are encouraged to subscribe to receive updates by clicking the subscribe icon above.

STAT Laboratory Services

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 the Quest Diagnostics Logistics department for STAT specimen pick-up at the number listed below. Practitioners may also consult their local Quest Diagnostics laboratory for more information.

STAT results are reported by telephone as soon as available. Written and/or electronic reports will follow per your routine medical report delivery system.

Please contact your local Quest Diagnostics laboratory to request a STAT service or pick-up:
New York (excluding Long Island): Logistics department: 1-800-223-0570
Long Island (Nassau and Suffolk Counties): Logistics department: 1-800-877-7588
New Jersey: STAT laboratory direct number: 1-800-648-4738

Community Health Centers

The Health Clinics/Community Health Centers' mission is to serve as a focal point for increasing access to both primary and multi-specialty care services to improve the health status of the residents in the communities they serve. Community Health Centers (CHC) include health centers such as Diagnostic & Treatment Centers (DT&C), Federally Qualified Health Centers (FQHC) and other clinics. They are conveniently located within the communities they serve, offer onsite multi-specialty services, and are staffed by personnel that understand the cultural/linguistic and spiritual needs and beliefs of the neighborhoods they serve.

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

Health Centers

Health Centers (Downstate)	Address	Phone Number (Members)	Phone Number (Providers)
Access Community Health Center	83 Maiden Lane, 6th Fl. New York, NY 10038	(212) 895-3410	(212) 895-3410

APICHA Community Health Center	400 Broadway New York, NY 10013	(212) 334-6029	(212) 334-7940
Be Well Family Health Care	2019 Nostrand Ave Brooklyn, NY 11210	(718) 434-0711	(718) 434-0711
Beacon Christian Community Health Center, Inc.	2079 Forest Ave Staten Island, NY 10303	(718) 815-6560	(718) 815-6560
Bedford Medical Family Health	100 Ross St Brooklyn, NY 11211	(718) 387-7628	(718) 387-7628
Bedford Medical Family Health	341 Wallabout St Brooklyn, NY 11206	(718) 218-6089	(718) 218-6089
Bedford-Stuyvesant Family Health Center	1413 Fulton St Brooklyn, NY 11216	(718) 636-4500	(718) 636-4500
Betances Family Health Care	280 Henry St New York, NY 10002	(212) 227-8401	(212) 227-8401
Boriken Neighborhood Health Center	2253 3rd Ave New York, NY 10035	(212) 289-6650	(212) 289-6650
Brooklyn Plaza Medical Center, Inc. (BPMC) - Whitman Ingersoll Farragut Health Center of BPMC	297 Myrtle Ave Brooklyn, NY 11205	(718) 596-8000	(718) 596-8000
Brooklyn Plaza Medical Center, Inc. (BPMC)	650 Fulton St Brooklyn, NY 11217	(718) 596-9800	(718) 596-9800
Brownsville Multi-Service Family Health Center - Bms Institute for Specialty & Integrative Services (isis)	259 Bristol St Brooklyn, NY 11212	(718) 342-0060	(718) 342-0060
Brownsville Multi-Service Family Health Center - Main	592 Rockaway Ave Brooklyn, NY 11212	(718) 345-5000	(718) 345-5000
Brownsville Multi-Service Family Health Center - Bms @ Genesis	360 Snediker Ave Brooklyn, NY 11207	(646) 459-9400	(646) 459-9400

Brownsville Multi-Service Family Health Center - Bms - SBHC	400 Pennsylvania Ave Brooklyn, NY 11207	(718) 345-5000	(718) 345-5000
Callen-Lorde Community Health Center	356 West 18th St New York, NY 10011	(212) 271-7200	(212) 271-7200
Care for the Homeless	30 East 33rd St, 5th Floor New York, NY 10016	(212) 366-4459	(212) 366-4459
Century Medical & Dental Center	260 Ave X Brooklyn, NY 11223	(718) 336-8855	(718) 336-8855
Charles B. Wang Community Health Center	125 Walker St New York, NY 10013	(212) 226-3888	(212) 226-3888
Charles B. Wang Community Health Center	268 Canal St New York, NY 10013	(212) 379-6999	(212) 379-6999
Charles B. Wang Community Health Center	132-26 37th Ave Flushing, NY 11354	(718) 886-1212	(718) 886-1212
Citicare, Inc.	154 W 127th St New York, NY 10027	(212) 749-3508	(212) 749-3507
Community Health Center of Richmond	235 Port Richmond Ave Staten Island, NY 10302	(718) 876-1732	(718) 876-1732
Community Healthcare Network - Dr. Betty Shabazz Health Center	999 Blake Ave Brooklyn, NY 11208	(718) 277-8303	(718) 277-8303
Community Healthcare Network - Bronx, Health Center	975 Westchester Ave Bronx, NY 10459	(718) 320-4466	(718) 320-4466
Community Healthcare Network - CABS Health Center	94-98 Manhattan Ave Brooklyn, NY 11206	(718) 388-0390	(718) 388-0390

Community Healthcare Network - Caribbean House Health Center	1167 Nostrand Ave Brooklyn, NY 11225	(718) 778-0198	(718) 778-0198
Community Healthcare Network - Community League Health Center	1996 Amsterdam Ave New York, NY 10032	(212) 781-7979	(212) 781-7979
Community Healthcare Network - Catherine M. Abate Health Center	150 Essex St New York, NY 10002	(212) 477-1120	(212) 477-1120
Community Healthcare Network - Family Health Center	90-04 161st St Jamaica, NY 11432	(718) 523-2123	(718) 523-2123
Community Healthcare Network - Helen B. Atkinson Health Center	81 W 115th St New York, NY 10026	(212) 426-0088	(212) 426-0088
Community Healthcare Network - Queens Health Center	97-04 Sutphin Blvd Queens, NY 11435	(718) 657-7088	(718) 657-7088
Community Healthcare Network - Tremont Health Center	4215 Third Ave Bronx, NY 10457	(718) 294-5891	(718) 294-5891
Community Healthcare Network - Long Island City Health Center	36-11 21st St Queens, NY 11106	(718) 482-7772	(718) 482-7772
Community Healthcare Network - Manhattan Health Center	60 Madison Ave, 5th Fl. New York, NY 10010	(212) 545-2400	(212) 545-2400
Covenant House	460 W 41st St New York, NY 1003	(212) 613-0300	(212) 613-0300
Damian Family Health Center	137-50 Jamaica Ave Jamaica , NY 11435	(718) 298-5100	(718) 298-5100
Ezra Medical Center	1312 38th St Brooklyn, NY 11218	(718) 686-7600	(718) 686-7600

First Medcare Inc.	8707 Flatlands Ave, Brooklyn, NY 11236	(718) 257-7777	(718) 257-7777
Brightpoint Health (f/k/a Help/Psi)	373 Park Ave New York, NY 10016	(718) 681-8700	(718) 681-8700
Heritage Health Care Center	1727 Amsterdam Ave New York, NY 10031	(212) 862-0054	(212) 862-0054
Health and Hospitals Corporation (HHC) - Cumberland Diagnostic and Treatment Center	100 North Portland Ave Brooklyn, NY 11206	(718) 260-7500	(718) 260-7500
Health and Hospitals Corporation (HHC) - Cumberland Diagnostic and Treatment Center Eleanor Roosevelt Houses Child Health Clinic	388 Pulaski St Brooklyn, NY 11221	(718) 388-5889	(718) 452-1146
Health and Hospitals Corporation (HHC) - Cumberland Diagnostic and Treatment Center Fort Greene Child Health Clinic	295 Flatbush Ave Brooklyn, NY 11201	(718) 388-5889	(718) 643-4487
Health and Hospitals Corporation (HHC) - Cumberland Diagnostic and Treatment Center Jonathan Williams Houses Child Health Clinic	333 Roebling St Brooklyn, NY 11211	(718) 388-5889	(718) 387-6407
Health and Hospitals Corporation (HHC) - Cumberland Diagnostic and Treatment Center Lafayette Houses Child Health Clinic	434 Dekalb Ave Brooklyn , NY 11205	(718) 388-5889	(718) 638-8258
Health and Hospitals Corporation (HHC) - Cumberland Diagnostic and Treatment Center Sumner Avenue Houses Child Health Clinic	47 Marcus Garvey Blvd Brooklyn, NY 11206	(718) 388-5889	(718) 455-4700
Health and Hospitals Corporation (HHC) - East New York Diagnostic and Treatment Center	2094 Pitkin Ave Brooklyn, NY 11207	(718) 240-0400	(718) 240-0400
Health and Hospitals Corporation (HHC) - East New York Diagnostic and Treatment Center Sutter Avenue CHC	1091 Sutter Ave Brooklyn, NY 11212	(718) 647-0800	(718) 647-0800
Health and Hospitals Corporation (HHC) -East New York Diagnostic and Treatment Center Brownsville CHC	259 Bristol St Brooklyn, NY 11212	(718) 495-7283	(718) 495-7283

Health and Hospitals Corporation (HHC) -East New York Diagnostic and Treatment Center Crown Heights Child Health Clinic	1218 Prospect Place Brooklyn, NY 11212	(718) 953-8233	(718) 953-8233
Health and Hospitals Corporation (HHC) -Gouverneur Healthcare Services	227 Madison St New York, NY 10002	(212) 238-7897	(212) 238-7897
Health and Hospitals Corporation (HHC) - East New York Diagnostic and Treatment Center Smith Family Health Clinic	60 Madison St New York, NY 10038	(212) 346-0511	(212) 346-0511
Health and Hospitals Corporation (HHC) - East New York Diagnostic and Treatment Center Judson Health Center	34 Spring St New York, NY 10012	(212) 925-5000	(212) 925-5000
Health and Hospitals Corporation (HHC) -East New York Diagnostic and Treatment Center Roberto Clemente Health Center/Sylvia Del Villard	540 13th St New York, NY 10019	(212) 387-7400	(212) 387-7400
Health and Hospitals Corporation (HHC) - Morrisania Diagnostic and Treatment Center	1225 Gerard Ave Bronx, NY 10452	(718) 960-2777	(718) 960-2777
Health and Hospitals Corporation (HHC) -Morrisania Diagnostic and Treatment Center Daniel Webster Child Health Center	401 E 168th St Bronx, , NY 10456	(718) 538-1982	(718) 538-1982
Health and Hospitals Corporation (HHC) - Renaissance Healthcare Network Diagnostic & Treatment Center (Sydenham Health Center)	264 W 118th St New York, NY 10026	(212) 932-6500	(212) 932-6500
Health and Hospitals Corporation (HHC) -Renaissance Healthcare Network Diagnostic & Treatment Center (Sydenham Health Center) Drew Hamilton Health Center	2698 Frederick Douglas Blvd New York, NY 10039	(212) 939-8950	(212) 939-8950
Health and Hospitals Corporation (HHC) - Renaissance Healthcare Network Diagnostic & Treatment Center (Sydenham Health Center) Grant Houses Health Center	3170 Broadway New York, NY 10027	(212) 678-2420	(212) 678-2420
Health and Hospitals Corporation (HHC) - Renaissance Healthcare Network Diagnostic & Treatment Center (Sydenham Health Center) Washington Heights Child Health Center	600 W 168th St New York, NY 10032	(212) 491-1661	(212) 491-1661
Health and Hospitals Corporation (HHC) - Renaissance Healthcare Network Diagnostic & Treatment Center (Sydenham Health Center) Dyckman Clinica De Las Americas	175 Nagle Ave New York, NY 10034	(212) 544-2001	(212) 544-2001
Health and Hospitals Corporation (HHC) -Renaissance Healthcare Network Diagnostic & Treatment Center (Sydenham Health Center) St. Nicholas Houses Child Health Center	281 W 127th St New York, NY 10027	(212) 865-1300	(212) 865-1300

Health and Hospitals Corporation (HHC) - Segundo Ruiz Belvis Diagnostic and Treatment Center	545 E 142nd St Bronx, NY 10454	(718) 960-2777	(718) 960-2777
Health and Hospitals Corporation (HHC) - Segundo Ruiz Belvis Diagnostic and Treatment Center Melrose Houses Child Health Center	348 E 156th St Bronx, NY 10451	(718) 292-2820	(718) 292-2820
Hill Top Family Health Center	251-12 Hillside Ave Bellerose, NY 11426	(718) 831-1700	(718) 831-1700
Hillside Polymedic Diagnostic and Treatment Center	187-30 Hillside Ave Jamaica, NY 11432	(718) 264-1111	(718) 264-1111
Joseph P. Addabbo Family Health Center, Inc. - Central Avenue, Far Rockaway	1288 Central Ave Far Rockaway, NY 11691	(718) 945-7150	(718) 945-7150
Joseph P. Addabbo Family Health Center, Inc. - Arverne, Queens	6200 Beach Channel Dr Far Rockaway, NY 11692	(718) 945-7150	(718) 945-7150
Joseph P. Addabbo Family Health Center, Inc. - Guy Brewer Boulevard, Jamaica	11811 Guy R Brewer Blvd Jamaica, NY 11434	(718) 945-7150	(718) 945-7150
Joseph P. Addabbo Family Health Center, Inc.	120 Richards St Brooklyn, NY 11231	(718) 945-7150	(718) 945-7150
Acacia Network Community Health Centers - La Casa De Salud Health Center	966 Prospect Ave Bronx, NY 10460	(718) 842-1412	(718) 842-1412
Long Island FQHC - Westbury Family Health Center	682 Union Ave New York, NY 11590	(516) 571-9500	(516) 571-9500
Long Island FQHC Hempstead Family Health Center	135 Main St Hempstead, NY 11550	(516) 572-1300	(516) 572-1300
Long Island FQHC - Elmont Family Health Center	161 Hempstead Tpke Elmont, NY 11003	(516) 571-8200	(516) 571-8200

Long Island FQHC - Roosevelt Family Health Center	380 Nassau Rd Roosevelt, NY 11575	(516) 571-8600	(516) 571-8600
NYU Lutheran Family Health Centers - Brooklyn-Chinese	5008 7th Ave Brooklyn, NY 11221	(718) 210-1030	(718) 210-1030
NYU Lutheran Family Health Centers - Caribbean-American	3414 Church Ave Brooklyn, NY 11203	(718) 630-2197	(718) 630-2197
NYU Lutheran Family Health Centers - Park Ridge	6317 4th Ave Brooklyn, NY 11220	(718) 907-8100	(718) 907-8100
NYU Lutheran Family Health Centers - Park Slope	220 13th St Brooklyn, NY 11215	(718) 832-5980	(718) 832-5980
NYU Lutheran Family Health Centers - Shore Road	9000 Shore Rd Brooklyn, NY 11209	(718) 630-8870	(718) 630-8870
NYU Lutheran Family Health Centers - Sunset Park	5610 2nd Ave Brooklyn, NY 11220	(718) 630-7942	(718) 630-7942
NYU Lutheran Family Health Centers - Sunset Park (55th St)	150 55th St Brooklyn, NY 11220	(718) 630-7095	(718) 630-7095
NYU Lutheran Family Health Centers - Family Physician	5616 6th Ave Brooklyn, NY 11220	(718) 439-5440	(718) 439-5440
NYU Lutheran Family Health Centers - Sunset Terrace	514 49th St Brooklyn, NY 11220	(718) 431-2600	(718) 431-2600
Medcare LLC Health Center	468 Lafayette Ave Brooklyn, NY 11205	(718) 399-6234	(718) 399-6234
Morris Heights Health Center - Main Site	85 W Burnside Ave Bronx, NY 10453	(718) 716-4400	(718) 483-1270
Morris Heights Health Center - MHHC at 137th Street	625 E 137th St Bronx, NY 10454	(718) 716-4400	(718) 401-6578

Morris Heights Health Center - MHHC at 233rd Street	825 East 233 St Bronx, NY 10466	(718) 716-4400	(718) 716-4400
Morris Heights Health Center - MHHC at Harrison Circle	57-69 W Burnside Ave Bronx, NY 10453	(718) 716-4400	(718) 483-1270
Morris Heights Health Center - MHHC at Melrose	77 Melrose Ave Bronx, NY 10451	(718) 716-4400	(718) 716-4400
Morris Heights Health Center - MHHC at Walton Avenue	25 E 183rd St Bronx, NY 10453	(718) 716-4400	(718) 839-8900
Morris Heights Health Center - Women’s Health Pavilion	70 W Burnside Ave Bronx, NY 10453	(718) 716-4400	(718) 716-2229
Mount Sinai Multispecialty Physicians	150 E 77th St New York, NY 10021	(212) 439-6000	(212) 439-6000
ODA	420 Broadway Brooklyn, NY 11211	(718) 384-3475	(718) 384-3475
Pelham Physical Medicine Inc.	2118 Williamsbridge Rd Bronx, NY 10461	(718) 823-3900	(718) 823-3900
Phoenix House	164 W 74th St New York, NY 10023	(800) 378-4435	(800) 378-4435
Project Renewal	200 Varick St New York, NY 10014	(212) 620-0340	(212) 620-0340
Queens Medical Pavilion	69-15 Austin St Forest Hills, NY 11375	(718) 263-3500	(718) 263-3500
St. John's Episcopal Hospital - Episcopal Health Services Inc.	327 Beach 19th St Queens, NY 11691	(718) 869-7000	(718) 869-7000
St. John's Episcopal Medical Services - Ambulatory Care Center At JASA	131 Beach 19th St Far Rockaway, NY 11691	(718) 869-8282	(718) 869-8282

The Floating Hospital - Long Island City	4140 27th St Long Island City, NY 11101	(718) 784-2240	(718) 784-2240
Union Community Health Center Inc. (UCHC)	260 East 188th St Bronx, , NY 10458	(718) 220-2020	(718) 220-2020
Union Community Health Center Inc. (UCHC)	2021 Grand Concourse Bronx, NY 10453	(718) 220-2020	(718) 220-2020
Union Community Health Center Inc. (UCHC)	470 East Fordham Rd Bronx, NY 10458	(718) 220-2020	(718) 220-2020
Union Community Health Center Inc. (UCHC)	4487 Third Ave Bronx, NY 10457	(718) 220-2020	(718) 220-2020
Union Health Center	275 7th Ave New York, NY 10001	(212) 924-2510	(212) 924-2510
The William F. Ryan Community Health Network - William F. Ryan Community Health Center (Upper West Side)	110 W 97th St New York, NY 10025	(212) 749-1820	(212) 749-1820
The William F. Ryan Community Health Network - Ryan/Chelsea-Clinton Community Health Center (Midtown West)	645 Tenth Ave New York, NY 10036	(212) 265-4500	(212) 265-4500
The William F. Ryan Community Health Network - Ryan-NENA Community Health Center (Lower East Side)	279 E 3rd St New York, NY 10009	(212) 447-8500	(212) 447-8500
The William F. Ryan Community Health Network - Ryan/Adair Community Health Center	565 Manhattan Ave New York, NY 10027	(212) 222-5221	(212) 222-5221
The William F. Ryan Community Health Network - The Ryan Women and Children's Center	801 Amsterdam Ave New York, NY 10025	(212) 316-8300	(212) 316-8300
The Institute for Family Health - Family Health Center of Harlem	1824 Madison Avenue New York, NY 10035	(212) 423-4500	(212) 423-4500

The Institute for Family Health - Sidney Hillman/Phillips Family Practice	16 East 16th St New York, NY 10003	(212) 206-5200	(212) 206-5200
The Institute for Family Health - Amsterdam Family Health Center	690 Amsterdam Avenue New York, NY 10025	(212) 865-4104	(212) 865-4104
The Institute for Family Health - Walton Family Health Center and Center for Counseling	1894 Walton Avenue Bronx, NY 10453	(718) 583-3060	(718) 583-3060
The Institute for Family Health - Mt. Hope Family Practice	130 West Tremont Avenue Bronx, NY 10453	(718) 583-9000	(718) 583-9000
The Institute for Family Health - Stevenson Family Health Center	731 White Plains Road Bronx, NY 10473	(718) 589-8775	(718) 589-8775
The Institute for Family Health - Urban Horizons Family Health Center	50 E 168th St Bronx, NY 10452	(718) 293-3900	(718) 293-3900
The Institute for Family Health - Kingston Family Health Center	1 Family Practice Drive Kingston, NY 12401	(845) 338-6400	(845) 338-6400
The Institute for Family Health - New Paltz Family Health Center	279 Main St, Suite 102 New Paltz, NY 12561	(845) 255-2930	(845) 255-2930

Urgent Care Centers

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.

To find a list of network urgent care centers, use the Find a Doctor tool on our website. You may also call Member Customer Service to obtain this information.

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

For more information on urgent care centers, please visit the Urgent Care Centers section of the Care Management chapter.

Complaints, Grievances, and Appeals (Practitioners and Members)

For process terminology, filing instructions and applicable time frames for disputing determinations that result in a denial of payment and/or covered services, please go to the following chapters:

- Dispute Resolution - Commercial & Child Health Plus
- Dispute Resolution - Medicaid, HARP, & Essential Plan
- Dispute Resolution - Medicare

Additional Resources (Providers and Members)

Additional Resources (Providers and Members)

Entity	Address	Phone	Email/Comments
Chiropractic and Physical/Occupational Therapy			
Palladian Muscular Skeletal Health	2732 Transit Road West Seneca, NY 14224	(877) 774-7693	www.palladianhealth.com Delegated for utilization management.
Dental Services			
DentaQuest		(844) 822-8108, Monday to Friday from 8 am to 5 pm.	www.dentaquest.com
Managing Entities			
HealthCare Partners(HCP)	501 Franklin Ave., Suite 300 Garden City, NY 11530-5807	(516) 746-2200 or (888) 746-2200	www.healthcarepartnersny.com Delegated for credentialing, utilization management, claims processing (except for HCP Cohort 2) and first call resolution.

Montefiore CMO	100 Corporate Drive Yonkers, NY 10701	(877) 447-6668	www.montefiore.org Delegated for credentialing, utilization management and claims processing.
Radiology Services			
eviCore	P.O. Box 61022 Anaheim, CA 92803	(800) 918-8924	www.evicore.com
Vision Services -Update for EyeMed			
EyeMed Vision Care For all members with a vision care benefit	4000 Luxottica Place Mason, Ohio 45040	877-324-2791 Medicaid 877-324-4063 Commercial (HMO, PPO, POS) 877-324-6211 On/Off Individual and Group Exchange and Essential Plans	EyeMed conducts claims processing for routine vision claims. There are specific CPT and diagnosis codes that fall under the umbrella of claims paid by EyeMed.

Selected Resources for Members with Special Needs

Language Line: Interpreter Service

Free multi-language interpreter service is available to assist providers and their patients. Services are available in over 200 languages, including English, Spanish, Chinese Mandarin, Chinese Cantonese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi and Japanese. To access an interpreter, providers may call 1-866-447-9717 and a Provider Customer Care Advocate will assist you.

Sign Language Interpreter Services of the Speech and Hearing Impaired

Providers, members or their designee can contact the Customer Service Department via phone at 1-646-447-6534 or Teletypewriter (TTY/TDD) at 1-800-874-9426 to request a sign language interpreter for a provider appointment.

If the member calls, he or she will be asked to have the provider contact EmblemHealth to arrange for the interpreter. If the member is communicating through EmblemHealth's TTY/TDD services by calling 711, the relay agent can contact the Interview Unit with the provider while the member is "holding" to verify the appointment. The Interview Unit will contact the member to confirm the interpreter arrangements. We primarily arrange these services through Deaf & Hard of Hearing Interpreting Services or Mill Neck Interpreter Services.

Services for the Visually Impaired

Lighthouse International

www.lighthouse.org

Lighthouse International is a leading worldwide resource on vision impairment and vision rehabilitation. Through its work in vision rehabilitation services, education, research and advocacy, Lighthouse International enables people of all ages who are blind or partially sighted to lead independent and productive lives.

New York City Headquarters
111 East 59th Street
New York, NY 10022-1202

Westchester County Regional Office
170 Hamilton Avenue
White Plains, NY 10601

Resources for Children with Special Needs

Early Intervention Program (EIP)

New York State law requires that all primary referral sources (e.g., primary care physicians (PCPs), specialists, hospitals, etc.) shall, within two working days of identifying a child under 3 years of age with either a risk factor for developmental delay or an actual developmental delay or disability, refer that child to the Local Early Intervention Agency (LEIA) corresponding to the child's county of residence. In most cases, the LEIA is the County Department of Health. Parental consent is required for referral. The EIP has two components:

- The Infant Child Health Assessment Program (ICHAP) serves as the "child find" component. Only children with a risk factor for developmental delay should be referred to this component. Referred children are tracked to insure that their pediatricians/PCPs conduct periodic developmental assessments and if such assessments indicate developmental delay, the program facilitates referrals to the EIP component.
- The Early Intervention Program (EIP) provides for evaluation and developmental services when a child has or is suspected of having a developmental delay. Services are provided by the LEIA's network of approved EIP providers. The LEIA is under no obligation to use providers in the child's health plan network. When the services rendered are covered by a third party, the LEIA is authorized to bill the third party on behalf of the servicing provider.

For information please call the New York State Growing Up Healthy Hotline at 1-800-522-5006 (TTY/TDD: 1-800-655-1789). You may also call the LEIAs at:

- New York City: 1-800-577-BABY (1-800-577-2229) or 1-212-219-5213
- Nassau County: 1-516-227-8661
- Suffolk County: 1-631-853-3100
- Westchester County: 1-914-813-5094

  Orange County: 1-845-291-2333

- Rockland County: 1-845-364-2625

Preschool Supportive Health Services Program (PSHSP)

When children between 3 and 4 years of age are identified as having or are at risk of developmental disability, pediatricians/PCPs shall, with parental consent, refer the children to the Committee on Special Preschool Education serving the school district in which the children reside. This program ensures that such children are evaluated and receive needed special education and that disability-related health services are provided by PSHSP providers approved by the Committee on Preschool Special Education. The program is under no obligation to use providers in the child's health plan network. The school district bills the state for services rendered to Medicaid managed care members. When the services rendered to non-Medicaid members are covered by a third party, the school district is authorized to bill the third party on behalf of the servicing provider.

School Supportive Health Services Program (SSHSP)

When children between 5 and 21 years of age are identified as at risk for or having a developmental disability, pediatricians/PCPs shall, with parental consent, refer the children to the Committee on Special Education serving the school district in which the children reside. This program ensures that such children are evaluated and receive needed special education and that disability-related health services are provided by SSHSP providers approved by the Committee on Special Education. The program is under no obligation to use providers in the child's health plan network. The school district bills the state for services rendered to Medicaid managed care members. When the services rendered to non-Medicaid members are covered by a third party, the school district is authorized to bill the third party on behalf of the servicing provider.

Physically Handicapped Children's Program (PHCP)

PHCP provides financial assistance for medical care and support services to children that have severe, long-term health problems and chronic disabilities. Eligible conditions include birth defects, physical handicaps and other conditions that can be improved with treatment and early intervention.

PHCP has two components: the Diagnosis and Evaluation Program and the Treatment Program. Diagnostic services are available to all children who are believed to have physically disabling conditions or serious chronic illnesses. To receive diagnostic services, families do not have to satisfy local financial eligibility criteria, but prior authorization from the local PHCP must be obtained. Diagnostic services are provided through approved specialty centers or medical specialists. If the child is covered by health insurance or Medicaid, these funding sources must be billed first. If the child has neither insurance nor Medicaid, then the authorized services are paid for directly by the PHCP.

The treatment component reimburses health care providers for services rendered to eligible children. Inpatient hospital care, physician office visits, durable medical equipment and pharmaceuticals are examples of items covered by the program. PHCP will cover the cost of medically needed care and supplies not covered by some health insurance plans, such as over the counter drugs/supplies and transportation.

Application for the Treatment Program must be made to the county in which the child resides. There are some variations between counties for conditions covered and financial eligibility. Financial criteria are designed to assist families with low incomes or inadequate private health insurance. All services provided under PHCP must have prior authorization from the county health department.

For more information, please call the New York State Growing Up Healthy Hotline at 1-800-522-5006 or:

- New York City: 1-212-676-2950
- Nassau County: 1-516-571-0801
- Suffolk County: 1-631-853-2286
- Westchester County: 1-914-813-5328
- Orange County: 1-845-568-5280
- Rockland County: 1-845-364-2081

Project TEACH - Connecting Primary Care with Child Psychiatry

Primary care physicians (PCPs) such as pediatricians and family practice doctors are often the first place families go to seek help or information about emotional or behavioral concerns with their children. Project TEACH provides all pediatric primary care providers (PCPs) in New York State with access to rapid consultation, education and training, and referral/ linkage services to help them care for children and adolescents with mental health disorders. Additionally, other prescribers who are providing ongoing treatment to children, such as Child and Adolescent Psychiatrists, General Psychiatrists and Psychiatric Nurse Practitioners, may request a second opinion through consultation. For more information about the Project TEACH visit projectTEACHny.com.

EmblemHealth

Council For Affordable Quality Healthcare Universal Provider Datasource

EmblemHealth participates in the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource (UPD).

EmblemHealth requires all applicants for all networks to complete the Council for Affordable Quality Health Care (CAQH) Proview credentialing application form. If you do not have a CAQH number, please register with CAQH ProView. If you have any questions abouthow to obtain a CAQH number, please call CAQH at 1-888-599-1771.

EmblemHealth

Nurse Practitioner Services

The professional services of a nurse practitioner (NP) may be covered in network if he or she is contracted, meets qualifications for NPs and is legally authorized to provide services in the state where the services are performed. Payments are allowed for assistant-at-surgery services and services provided in all areas and settings permitted under applicable state licensure laws.

Note: No separate payment will be made to the nurse practitioner when a facility or other provider charges or is paid any amount for such professional services. A facility or other provider includes a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center or federally qualified health center.

Qualifications for NPs

An NP must meet all three of the following qualifications:

- Be a registered professional nurse who is authorized by the state in which the services are provided to practice as an NP in accordance with state law
- Be certified as an NP by a recognized national certifying body that has established standards for NPs
- Possess a master's degree in nursing

The following organizations are recognized national certifying bodies for NPs at the advanced practice level:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
- Pediatric Nursing Certification Board
- Oncology Nurses Certification Corporation
- AACN Certification Corporation
- National Board for Certification of Hospice and Palliative Nurses

Covered Services

Services are covered if they meet all four of the following criteria:

- Considered physician's services if provided by a doctor of medicine or osteopathy (MD/DO)
- Performed by a person who meets all NP qualifications and is legally authorized to perform the services in the state in which they are performed
- Performed in collaboration with a MD/DO
- Not otherwise precluded from coverage because of statutory exclusions

In general, NPs are paid for covered services at 85 percent of what a physician is paid.

Nurse Practitioners as Attending Physicians

Services provided by an NP that are medical in nature must be reasonable and necessary, be included in the plan of care, and would be performed by a physician in the absence of the NP. If the services performed by an NP can be performed by a registered nurse in the absence of a physician, they are not considered attending physician services and are not separately billable.

Services Otherwise Excluded From Coverage

NP services may not be covered if they are otherwise excluded from coverage even though an NP may be authorized by state law to perform them. For example, the Medicare law excludes from coverage routine foot care and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part. Therefore, these services are precluded from coverage even though they may be within an NP's scope of practice under state law.

Sending Your Application

To submit a request for NP credentialing, print and complete a Credentialing Application Addendum for Nurse Practitioner form, and mail to the applicable address below.

For New York City, Nassau county and Suffolk county, as well as New Jersey and Connecticut applicants, please send your completed application and agreements to:

EmblemHealth
55 Water Street
New York, NY 10041
Attn: Physician Contracting, 7th floor

For all other counties in New York State, as well as all other out-of-state applicants, please send your completed application and agreements to:

EmblemHealth
5015 Campuswood Drive
East Syracuse, NY 13057
Attn: Physician Contracting

Note: All applications must include the signed agreement for the networks you would like to join.

EmblemHealth

Physician Assistant Services

The professional services of a physician assistant (PA) may be covered in network if he or she is contracted, meets qualification for PAs and is legally authorized to provide services in the state where the services are performed. Payments are allowed for assistant-at-surgery services and services provided in all areas and settings permitted under applicable state licensure laws.

Note: No separate payment will be made to the physician assistant when a facility or other provider charges or is paid any amount for such professional services. A facility or other provider includes a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center or federally qualified health center.

Qualifications for PAs

A PA must be licensed by the state to practice as a PA and meet one of following two qualifications:

- Graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs [CAAHEP] and the Committee on Allied Health Education and Accreditation [CAHEA])
- Passed the national certification examination administered by the National Commission on Certification of Physician Assistants (NCCPA)

Covered Services

Services are covered if they meet all four of the following criteria:

- Considered physician's services if provided by a doctor of medicine or osteopathy (MD/DO)
- Performed by a person who meets all PA qualifications and is legally authorized to perform the services in the state in which they are performed
- Performed under the general supervision of an MD/DO
- Not otherwise precluded from coverage because of statutory exclusions

Types of PA Services That May Be Covered

PAs may provide services billed under all levels of CPT evaluation and management codes, and diagnostic tests, if provided under the general supervision of a physician. Examples of services PAs may provide include services traditionally reserved for physicians, such as examinations (including the initial preventive physical examination), minor surgery, setting casts for simple fractures, interpreting X-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. In general, PAs are paid for covered services at 85 percent of what a physician is paid.

Services Otherwise Excluded From Coverage

PA services may not be covered if they are otherwise excluded from coverage even though a PA may be authorized by state law to perform them.

Physician Supervision

The PA's physician supervisor (or a physician designated by the supervising physician or employer as provided under state law or regulations) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present when a service is provided by the PA to a patient and may be contacted by telephone, if necessary, unless state law or regulations require otherwise.

Sending Your Application

To submit a request for PA credentialing, print and complete a Credentialing Application Addendum for Registered Physician Assistant form, and mail to the applicable address below.

For New York City, Nassau county and Suffolk county, as well as New Jersey and Connecticut applicants, please send your completed application and agreements to:

EmblemHealth
55 Water Street
New York, NY 10041
Attn: Physician Contracting, 7th floor

For all other counties in New York State, as well as all other out-of-state applicants, please send your completed application and agreements to:

EmblemHealth
5015 Campuswood Drive
East Syracuse, NY 13057
Attn: Physician Contracting

Note: All applications must include the signed agreement for the networks you would like to join.

State-Designated Providers

State designation of providers will suffice for the EmblemHealth's credentialing process. When contracting with NYS-designated providers, EmblemHealth will not separately credential individual staff members in their capacity as employees of these programs. EmblemHealth will still conduct program integrity reviews to ensure that provider staff are not disbarred from Medicaid or any other way excluded from Medicaid reimbursement. EmblemHealth will still collect and accept program integrity-related information from these providers, as required in the Medicaid Managed Care Model Contract, and will require that such providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

EmblemHealth

Provider Manual

Chapter 3: Credentialing

In this chapter you will find credentialing and recredentialing requirements, including the managed care law requiring provisional credentialing, and the practitioner appeal process for changes in participation. EmblemHealth permits the delegation of credentialing to certain large organizations that are subject to strict oversight protocols. Check with your practice administrator to see if delegation protocols apply to your organization.

Behavoiral Health Credentialing

To see the credentialing requirements for our Behavioral Health Network, please see Beacon Health Option's provider manual. The following provider types should contact Beacon Health Options to address participation:

- Caregiver/Family Supports and Services – behavioral health primary diagnosis
- Community Self-Advocacy Training and Support – behavioral health primary diagnosis
- Habilitation – behavioral health primary diagnosis
- HCBS/SPA services – behavioral health primary diagnosis
- NYS-designated providers of Children's Specialty Services – behavioral health primary diagnosis
- NYS-determined Essential Community Behavioral Health providers for children – behavioral health primary diagnosis
- OMH and OASAS licensed or certified providers
- Psychologists
- Prevocational Services
- Psychiatrists
- Respite – behavioral health primary diagnosis
- School-based mental health clinics

- Social Workers
- Supported Employment

Practitioner Credentialing

Credentialing is an important process that ensures that health care professionals have the requisite qualifications and training needed to deliver care. The credentialing process also ensures the verification and review of individuals with adverse actions against them, such as sanctions, malpractice or fraud. When applicable, written notice will be sent to practitioners whose credentials are being reviewed.

Minimum qualification requirements for participation include, but are not limited to:

- A valid license to practice
- City of New York – non-members
- Appropriate training or board certification
- Clinical privileges in good standing (as applicable)
- Current malpractice insurance coverage
- Acceptable history with regards to malpractice

Note: Providers who are sanctioned or excluded by the New York State Department of Health's (DOH) Medicaid Program will be excluded from participation in all our benefit plans.

Also Note: All providers, professional and facility, inside and outside of New York, who treat our Medicaid, HARP and Child Health Plus members MUST be registered with the DOH for the Medicaid Program. Registration does not obligate providers to see FFS Medicaid members. The DOH offers an option for participation to be limited to Medicaid Managed Care.

During the credentialing process, practitioners maintain the following rights:

- The right to review information obtained in support of their credentialing applications, excluding references, recommendations or other peer review protected material.
- The right to correct erroneous information in written form to the credentialing department within 10 days of receipt of EmblemHealth's notification.
- The right to be informed of the status of his/her credentialing/recredentialing application. Requests may be made to EmblemHealth via written or telephone inquiry.

Per New York State law, initial applications are reviewed by the Credentialing department within 90 days of receiving a fully completed application, and the applicant is notified within that time period if credentialing has been approved or if additional time is needed. We will make our best effort to obtain any missing documentation from third parties in a timely manner.

Decision

Following completion of the application and all applicable verifications, the Credentialing/ Recredentialing Committee (CRC) will consider all information gathered on the provider and evaluate in light of the criteria. At that time, the CRC decides to approve or disapprove the provider's application. The provider is advised accordingly.

The provider will generally be credentialed for a three year period. However, the CRC may recommend credentialing for a period less than three years based on the results of its review. If so, the provider is advised of the decision and the reason for the shorter approval period.

If a provider has been disapproved but had been providing care to plan members, the CRC will direct appropriate plan and medical group staff to develop a transition plan for developing alternative providers or may recommend immediate cessation of referrals to the provider.

Provider Data Validation During the Credentialing Process

New York State and Federal regulations require EmblemHealth to maintain the accuracy of its provider file data, to ensure its Provider Directories meet basic information requirements and accuracy.

Through the initial credentialing and periodic recredentialing processes, EmblemHealth validates the accuracy of a provider's service location data by reviewing against the provider's data in CAQH ProView™ and performing telephone outreach.

CAQH ProView, formerly the Universal Credentialing Datasource®, was founded in 2002 to address the biggest challenge with provider credentialing. Data collection had been the most inefficient step of the credentialing process, placing unnecessary burden on providers. Previously, providers completed separate credentialing forms for each payer.

EmblemHealth's data validation process leverages the data in CAQH ProView as the "source of truth" for service location data. Only service locations listed on CAQH Proview are eligible for validation, enrollment at initial credentialing or continued participation at recredentialing. Service locations not listed in CAQH ProView will be subject to validation by phone call and possible termination if unreachable or non-responsive.

To avoid a failed validation, denial of enrollment or possible break in service, please ensure your CAQH profile is up to date with all service addresses and telephone numbers where you take appointments.

Practitioner Provisional Credentialing

In accordance with New York State Public Health Law, EmblemHealth allows newly licensed or recently relocated out-of-state practitioners to apply for provisional credentialing, which would take effect prior to completion of the full 90-day credentialing process. This provisional status is available only to practitioners who apply within six months of licensing or out-of-state relocation, who join a group practice that already participates with EmblemHealth's HMO networks and whose group practice agrees to any necessary repayment noted below. Provisionally credentialed practitioners may not be assigned to members as a primary care provider.

Should an application for provisional credentials be denied, EmblemHealth will consider any work performed by the provisional practitioner to be an out-of-network service, and the practitioner (or their group practice) shall repay to EmblemHealth the difference between the in- and out-of-network fees payable under each member's coverage plan. Under no circumstances may the practitioner (or group practice) attempt to recover this difference from the member, except to collect copayment or coinsurance that would otherwise be payable had the member received services from a health care professional in the EmblemHealth network.

Practitioner Recredentialing

EmblemHealth requires all practitioners to undergo recredentialing every three years.

Practitioners must maintain the same minimum qualification requirements as applicable for the initial credentialing. In addition, the recredentialing process will evaluate each practitioner on:

- Access/availability
- Under/over utilization data
- Quality of care
- Primary and secondary prevention
- Disease management
- Member satisfaction
- Site/medical record audit scores
- Member concerns
- Peer review
- Continuity of care

Six months prior to the credential's expiration, practitioners will receive a letter from either EmblemHealth's Recredentialing Department or Aperture CVO (our contracted credentials verification organization). The letter will direct them to update their application on file with the Council for Affordable Quality Healthcare's (CAQH) Universal Provider Datasource (UPD).

Practitioners should make any changes to their information on the CAQH UPD, update the malpractice claims history accordingly, and include updated copies of their curriculum vitae, State License, Drug Enforcement Agency certification and proof of malpractice insurance coverage with the application.

Practitioners with a complete application on file with CAQH UPD can advise EmblemHealth or Aperture CVO to retrieve all documentation from that source. More information on our relationship with CAQH can be found in this chapter in the section on Council for Affordable Quality Healthcare Universal Provider Database.

To ensure continued participation with EmblemHealth, it is important to return all recredentialing materials as soon as possible. Failure to respond in a timely manner may result in termination from EmblemHealth's provider networks. Reapplication to our provider networks will then be subject to network need.

The Recredentialing Department will review the updated application for completeness and present it to EmblemHealth's CRC for a determination. Occasionally, an EmblemHealth staff member may call the practitioner's office for missing or additional information. The practitioner will then be notified of continued participation or termination.

Midwifery Services

On July 30, 2010, New York State passed into law updates to the definition of and requirements for midwives and midwifery. (See §6951 at http://public.leginfo.state.ny.us/menuf.cgi.) The law changes the requirement that midwives must enter into formal written agreements with obstetricians, gynecologists or health care facilities, including hospitals; instead they are now required to have a collaborative relationship with these entities.

As of November 1, 2010, EmblemHealth requires midwives to have a collaborative relationship with a participating physician that practices obstetrics and gynecology. Midwives must document this collaborative relationship and must make this information available to their patients. Failure to comply with this directive may result in professional misconduct charges as set forth in the law. Participating midwives, or those applying for participation with EmblemHealth, must furnish proof of their collaborative relationship with a participating obstetrics and gynecology physician.

Lactation Consultant Services

EmblemHealth has adopted the policy guidance from the New York State Medicaid program to ensure appropriate designation of participating practitioners as breast feeding, education and lactation counselors. Physicians, nurse practitioners, midwives, physician assistants and registered nurses seeking this credential must have the following minimum requirements, as defined in the EmblemHealth Credentialing Policy:

- Current and valid medical license
- Current and valid DEA certificate (as applicable)
- Current malpractice coverage within acceptable limits
- Hospital privileges in good standing with a plan-contracted facility
- Acceptable work history
- Acceptable malpractice history
- Acceptable adverse action history

In addition to these minimum credentialing requirements, applicants must also be International Board Certified Lactation Consultants (IBCLCs) credentialed by the International Board of Lactation Consultant Examiners (IBLCE) .

Nurse Practitioner Services

The professional services of a nurse practitioner (NP) may be covered in network if he or she is contracted, meets qualifications for NPs and is legally authorized to provide services in the state where the services are performed. Payments are allowed for assistant-at-surgery services and services provided in all areas and settings permitted under applicable state licensure laws.

Note: No separate payment will be made to the nurse practitioner when a facility or other provider charges or is paid any amount for such professional services. A facility or other provider includes a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center or federally qualified health center.

Qualifications for NPs

An NP must meet all three of the following qualifications:

- Be a registered professional nurse who is authorized by the state in which the services are provided to practice as an NP in accordance with state law
- Be certified as an NP by a recognized national certifying body that has established standards for NPs
- Possess a master's degree in nursing

The following organizations are recognized national certifying bodies for NPs at the advanced practice level:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
- Pediatric Nursing Certification Board
- Oncology Nurses Certification Corporation

- AACN Certification Corporation
- National Board for Certification of Hospice and Palliative Nurses

Covered Services

Services are covered if they meet all four of the following criteria:

- Considered physician's services if provided by a doctor of medicine or osteopathy (MD/DO)
- Performed by a person who meets all NP qualifications and is legally authorized to perform the services in the state in which they are performed
- Performed in collaboration with a MD/DO
- Not otherwise precluded from coverage because of statutory exclusions

In general, NPs are paid for covered services at 85 percent of what a physician is paid.

Nurse Practitioners as Attending Physicians

Services provided by an NP that are medical in nature must be reasonable and necessary, be included in the plan of care, and would be performed by a physician in the absence of the NP. If the services performed by an NP can be performed by a registered nurse in the absence of a physician, they are not considered attending physician services and are not separately billable.

Services Otherwise Excluded From Coverage

NP services may not be covered if they are otherwise excluded from coverage even though an NP may be authorized by state law to perform them. For example, the Medicare law excludes from coverage routine foot care and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part. Therefore, these services are precluded from coverage even though they may be within an NP's scope of practice under state law.

Sending Your Application

To submit a request for NP credentialing, print and complete a Credentialing Application Addendum for Nurse Practitioner form, and mail to the applicable address below.

For New York City, Nassau county and Suffolk county, as well as New Jersey and Connecticut applicants, please send your completed application and agreements to:

EmblemHealth
55 Water Street
New York, NY 10041
Attn: Physician Contracting, 7th floor

For all other counties in New York State, as well as all other out-of-state applicants, please send your completed application and agreements to:

EmblemHealth
5015 Campuswood Drive
East Syracuse, NY 13057
Attn: Physician Contracting

Note: All applications must include the signed agreement for the networks you would like to join.

Physician Assistant Services

The professional services of a physician assistant (PA) may be covered in network if he or she is contracted, meets qualification for PAs and is legally authorized to provide services in the state where the services are performed. Payments are allowed for assistant-at-surgery services and services provided in all areas and settings permitted under applicable state licensure laws.

Note: No separate payment will be made to the physician assistant when a facility or other provider charges or is paid any amount for such professional services. A facility or other provider includes a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center or federally qualified health center.

Qualifications for PAs

A PA must be licensed by the state to practice as a PA and meet one of following two qualifications:

- Graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs [CAAHEP] and the Committee on Allied Health Education and Accreditation [CAHEA])
- Passed the national certification examination administered by the National Commission on Certification of Physician Assistants (NCCPA)

Covered Services

Services are covered if they meet all four of the following criteria:

- Considered physician's services if provided by a doctor of medicine or osteopathy (MD/DO)
- Performed by a person who meets all PA qualifications and is legally authorized to perform the services in the state in which they are performed
- Performed under the general supervision of an MD/DO
- Not otherwise precluded from coverage because of statutory exclusions

Types of PA Services That May Be Covered

PAs may provide services billed under all levels of CPT evaluation and management codes, and diagnostic tests, if provided under the general supervision of a physician. Examples of services PAs may provide include services traditionally reserved for physicians, such as examinations (including the initial preventive physical examination), minor surgery, setting casts for simple fractures, interpreting X-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. In general, PAs are paid for covered services at 85 percent of what a physician is paid.

Services Otherwise Excluded From Coverage

PA services may not be covered if they are otherwise excluded from coverage even though a PA may be authorized by state law to perform them.

Physician Supervision

The PA's physician supervisor (or a physician designated by the supervising physician or employer as provided under state law or regulations) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present when a service is provided by the PA to a patient and may be contacted by telephone, if necessary, unless state law or regulations require otherwise.

Sending Your Application

To submit a request for PA credentialing, print and complete a Credentialing Application Addendum for Registered Physician Assistant form, and mail to the applicable address below.

For New York City, Nassau county and Suffolk county, as well as New Jersey and Connecticut applicants, please send your completed application and agreements to:

EmblemHealth
55 Water Street
New York, NY 10041
Attn: Physician Contracting, 7th floor

For all other counties in New York State, as well as all other out-of-state applicants, please send your completed application and agreements to:

EmblemHealth
5015 Campuswood Drive
East Syracuse, NY 13057
Attn: Physician Contracting

Note: All applications must include the signed agreement for the networks you would like to join.

State-Designated Providers

State designation of providers will suffice for the EmblemHealth's credentialing process. When contracting with NYS-designated providers, EmblemHealth will not separately credential individual staff members in their capacity as employees of these programs. EmblemHealth will still conduct program integrity reviews to ensure that provider staff are not disbarred from Medicaid or any other way excluded from Medicaid reimbursement. EmblemHealth will still collect and accept program integrity-related information from these providers, as required in the Medicaid Managed Care Model Contract, and will require that such providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Organizational Provider Credentialing

Organizational providers contracting with EmblemHealth must apply for credentialing. They must go through the recredentialing process in much the same way as individual practitioners.

Minimum qualification requirements for facility participation include, but are not limited to:

- Current accreditation or an acceptable site visit
- Appropriate licensure
- Current Medicare and Medicaid certification status
- Malpractice insurance coverage
- Acceptable history with regards to malpractice

Organizational providers requiring credentialing include:

- Ambulatory surgery facilities
- Clinical laboratories
- Comprehensive outpatient rehabilitation facility (CORF) providers
- Dialysis centers
- Federally qualified health centers/NYS Article 28 Certified Health and Treatment Centers
- Freestanding imaging centers
- Freestanding outpatient alcohol/drug abuse centers

- Freestanding outpatient mental health centers
- Home health agencies
- Home infusion agencies
- Hospices
- Hospitals
- Outpatient diabetes self-management training (DSMT) providers
- Outpatient physical therapy and speech language pathology (OPT/SLP) providers
- Portable X-ray suppliers
- Psychiatric hospitals
- Rural health clinics
- School-based health centers (effective 1/1/21 or other official start date of the Medicaid carve-in)
- Skilled nursing facilities
- Substance abuse residential rehabilitation services
- Urgent care facilities

Site Visits

Site visits are completed for non-accredited entities, as applicable. Although the Centers for Medicare and Medicaid Services (CMS) or state review or certification does not serve as accreditation of an institution, a CMS or state review can be accepted in lieu of the required site visit. The actual report from the institution must be retrieved to verify that the review was performed and that the report meets acceptable standards; however, a letter from CMS which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report.

Decision

Following completion of the application and all applicable verifications, the CRC will consider all information gathered on the organizational provider and evaluate in light of the criteria. At that time, the CRC decides to approve or disapprove the application. The provider is advised accordingly.

The organizational provider will generally be credentialed for a three year period. However, the CRC may recommend credentialing for a period less than three years based on the results of its review. If so, the provider is advised of the decision and the reason for the shorter approval period.

If an organizational provider has been disapproved but had been providing care to plan members, the CRC will direct appropriate plan and medical group staff to develop a transition plan for identifying alternative providers or may recommend immediate cessation of referrals to the provider.

Organizational Provider Recredentialing

EmblemHealth has a process for the periodic recredentialing of organizational providers previously approved by the CRC. All organizations are recredentialed every three years.

Scope

All organizations participating in the HMO networks and the Medicare Advantage network that were required to obtain initial approval from the CRC are also subject to the recredentialing process.

Review Criteria

The review criteria for recredentialing are the same as the credentialing criteria.

Decision

The decision-making process for recredentialing is the same as for initial credentialing.

Accrediting Bodies

Acceptable accrediting bodies include, but are not limited to:

- The Joint Commission (TJC)
- Det Norske Veritas (DNV)
- The Accreditation Association for Ambulatory Health Care (AAAHC)
- The Commission on Accreditation of Rehabilitation Entities (CARF)
- The Council on Accreditation, the Community Health Accreditation Program (CHAP)
- The Continuing Care Accreditation Commission
- American Association of Diabetes Educators (AADE)
- American College of Radiology (ACR)
- American Institute of Ultrasound in Medicine (AIUM)
- Intersocietal Commission on Accreditation of Nuclear Laboratories (ICANL)
- American Association of Clinical Endocrinologists (AACE)
- Nuclear Medicine Technology Certification Board (NMTCB)

The Credentialing/ Recredentialing Committee

EmblemHealth's Credentialing/ Recredentialing Committee (CRC) is charged with examining the qualifications of participating clinicians and facilities against the professional standards established by our Quality Improvement Committee (QIC).

The CRC performs the initial approval and credentialing of clinicians and facilities for participation with EmblemHealth. The CRC is assisted by the Credentialing department, which is responsible for reviewing and verifying completeness of every provider's application. Primary source verification is done of the provider's licensure and accreditation, where applicable. CMS requires primary source verification of education and training records and board certification. They reassess said clinicians and organizational providers every three years (at minimum) to assure that all credentialed clinicians and organizations remain qualified and continue to meet the established criteria.

Members of the CRC include an EmblemHealth designee or our Medical Director (acting as the Committee Chair), at least one physician from each primary care specialty and any high volume specialists as designated by the Committee Chair. The Committee Chair ensures that the CRC has a meaningful range of participating practitioners serving on the Committee with additional specialties added on an ad-hoc basis. All practitioners in the voting membership of the Committee must maintain a current credentials file with EmblemHealth.

The Committee Chair leads discussions concerning potential quality issues and explains and/or clarifies credentialing policy and procedure when required. The CRC is required to conduct a review of the credentialing file prior to credentialing or recredentialing an applicant.

For Medicare Advantage health care services, the provider shall cooperate with the plan's credentialing and recredentialing process. The credentials of medical professionals covered by an agreement with one of EmblemHealth's companies will either be reviewed by EmblemHealth directly or where delegated, the credentialing process will be reviewed and approved by EmblemHealth who must audit the credentialing process on an ongoing basis.

The Alliance

EmblemHealth is part of The Alliance, a collaboration between health plans which allows practitioners who participate in two or more plans to use a single application for credentialing. Alliance-based applications are performed by Aperture CVO and the results are shared with all participating and applicable health plans.

Council For Affordable Quality Healthcare Universal Provider Datasource

EmblemHealth participates in the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource (UPD).

EmblemHealth requires all applicants for all networks to complete the Council for Affordable Quality Health Care (CAQH) Proview credentialing application form. If you do not have a CAQH number, please register with CAQH ProView. If you have any questions abouthow to obtain a CAQH number, please call CAQH at 1-888-599-1771.

Practitioner Reporting Responsibilities

The following events may affect the credentialing of a practitioner or practitioner's employee and shall be immediately reported to EmblemHealth:

- Any voluntary or involuntary diminishment, suspension, termination or relinquishing of licensing and/or hospital privileges initiated by a hospital.
- Any voluntary or involuntary diminishment, suspension, revocation, or relinquishing of a DEA certificate.
- The initiation of any proceeding by a state licensing authority.
- The initiation of any legal or criminal proceeding pertaining to practitioner or any individual employed by practitioner.
- Any proceeding which could affect Medicaid or Medicare participation of either practitioner or any licensed employee of the practitioner.
- Any report made to the National Practitioner Data Bank (NPDB) or other reporting agency concerning a licensed professional employed by the practitioner.
- Any notice given regarding the commencement of a professional liability action involving the practitioner or any entity, other than a publicly traded company, in which the practitioner has an ownership interest.
- Any member complaint concerning the covered services rendered.

Reporting To Outside Agencies

In the event that a practitioner is de-credentialed for quality issues by the CRC, the Recredentialing Committee or an Ad Hoc Appellate Board, EmblemHealth is required by law to report such misconduct to the appropriate data collection service(s). Reporting shall occur within 30 days from the decision date, unless the practitioner requests an appeal.

Reportable Actions

Actions reportable to the National Practitioners Data Bank (NPDB) include:

- Any professional review based on reasons related to professional competence or conduct which adversely affects EmblemHealth participation for a period longer than 30 days.
- Voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation.

Actions reportable to the Healthcare Integrity and Protection Data Bank (HIPDB) include:

- Health care related civil judgments entered in federal or state court.
- Any other adjudicated actions or decisions that the CMS Secretary shall establish by regulation.

Actions reportable to the applicable state office with oversight of professional conduct, e.g., New York State Office of Professional Medical Conduct (NYSOPMC) includes:

- Termination of credentials based upon member complaints or peer review findings.

In the event that a practitioner is de-credentialed for quality issues by the CRC, the Recredentialing Committee or an Ad Hoc Appellate Board, EmblemHealth is required by law to report such misconduct to the appropriate data collection service(s). Reporting shall occur within 30 days from the decision date, unless the practitioner requests an appeal.

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Actions reportable to the Healthcare Integrity and Protection Data Bank (HIPDB) include:

- Health care related civil judgments entered in federal or state court.
- Any other adjudicated actions or decisions that the CMS Secretary shall establish by regulation.

Actions reportable to the applicable state office with oversight of professional conduct, e.g., New York State Office of Professional Medical Conduct (NYSOPMC) includes:

- Termination of credentials based upon member complaints or peer review findings.

Termination and Appeal

The CRC and PRS have the authority to terminate practitioners from servicing EmblemHealth members. The

committee and subcommittee make such a determination based on, in the case of the CRC, quality or credentials issues arising at recredentialing or, in the case of the PRS, complaints about quality of care. The procedures for termination and appeal are managed through our Credentialing department and apply to actions by either the CRC or PRS.

Actions that may cause termination include, but are not limited to:

- Engaging in acts of gross incompetence or gross negligence on a single occasion, or negligence or incompetence on more than one occasion.
- Refusing to provide a client or patient service or medical care because of race, creed, color or national origin.
- Practicing beyond the scope of the profession.
- Failing to return or provide copies of records upon request.
- Being sexually or physically abusive.
- Abandoning or neglecting a patient in need of immediate care.
- Performing unnecessary work or unauthorized services.
- Practicing under the influence of alcohol or other drugs.
- Promoting the sale of services, goods, appliances or drugs in a manner that exploits the patient.
- Refusing to provide medical care because of race, creed, color or national origin.
- Guaranteeing a cure.
- Performing professional services not authorized by the patient.
- Willfully harassing, abusing or intimidating a patient.
- Ordering excessive tests or treatments.
- Permitting or aiding an unlicensed person to perform activities which require a license.
- Practicing the profession with a suspended or inactive license.
- Revealing personally identifiable facts, data or information without consent of the patient, except as authorized or required by law.
- Any conviction of a criminal offense related to a participating provider or that provider's managing employee involvement in any Medicare, Medicaid or Title XX services program.
- Any provider denied credentialing for program integrity-related reasons such as being on a government program-excluded provider list and/or having existing fraud, licensing or OPMC issues.
- Voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation.
- A finding of mental or physical impairment.
- A finding of imminent harm to patient health, safety and welfare.
- The voluntary or involuntary termination of a contract, employment or other affiliation to avoid the imposition of disciplinary measures.
- Determination of fraud.
- Determination of misconduct.
- Releasing confidential information without authorization or as otherwise legally permitted.
- Being convicted of a crime.
- For other reasons, such as business decisions that are other than quality of care concerns.

The CRC and PRS make decisions, except for termination for egregious reasons, at regularly scheduled meetings. The practitioner will receive a termination notice explaining the reasons for the proposed action, a termination date and a detailed explanation of the appeal process. Termination shall be effective no earlier than 60 days from the practitioner's receipt of the termination notice.

Throughout the process, the CRC and PRS make every effort to ensure that the practitioner has adequate opportunity to contribute to any discussion on recredentialing or quality of care.

Decisions of the practitioner's termination shall be effective not less than 60 days after the receipt by the practitioner of the termination notice.

Appeal of Disciplinary Decisions

The practitioner may appeal any formal CRC/PRS disciplinary action to a CRC Ad Hoc Appellate Board. Written notice of appeal must be sent to CRC within 30 days of receiving the termination notice. If no appeal is submitted within 30 days, the action will be reported to NPDB.

If an appeal is requested, the practitioner will be contacted and, once a date is confirmed, will be notified by certified mail of the date and time of the appeal hearing. Said hearing shall take place no later than 30 days from the date of receipt of the provider's request for a hearing.

The notice of hearing must be accompanied by copies of all documents, reports, cases or materials on which the Ad Hoc Appellate Board intends to rely. The practitioner may submit additional information (in writing) for consideration by the Ad Hoc Appellate Board within 30 days of filing the appeal. Additional materials must be received before the scheduled date of the hearing.

The practitioner has the right to appear before the Ad Hoc Appellate Board through counsel.

This hearing may be postponed only once, unless there are extenuating circumstances. If the practitioner elects to postpone the second hearing without extenuating circumstances, the Ad Hoc Appellate Board will convene as scheduled and make a decision based upon the information available.

If the Ad Hoc Appellate Board upholds the original Committee's decision, EmblemHealth will proceed with reporting the action to appropriate regulatory agencies.

Ad Hoc Appellate Board

The Ad Hoc Appellate Board shall be compiled by EmblemHealth and shall contain three credentialed practitioners, at least one of whom specializes in the field appropriate to the review. The panel may consist of more than three provided that the number of clinical peers constitutes one-third or more of the total membership. Members of the CRC may serve on this board. However, no physician can vote on both an initial decision and an appeal for the same practitioner.

The Ad Hoc Appellate Board decision may include reinstatement, provisional reinstatement with conditions set by the Board or termination. The Hearing Panel will render a decision in a timely manner. The practitioner will be notified by mail within five business days of the decision. A decision for termination shall be effective not less than 30 days after the practitioner's receipt of the Hearing Panel's decision.

EmblemHealth will permit members to continue an on-going course of treatment for a transition period of up to ninety (90) days, and post-partum care, subject to the provider's agreement, pursuant to PHL §4403(6)(e).

Termination For Egregious Reasons

EmblemHealth can initiate an immediate termination in the event of:

- Knowledge of a member's imminent harm by a clinician.
- Determination of fraud by EmblemHealth's Special Investigations Unit (SIU).
- Action by the NYSOPMC or other recognized regulatory agency, such as license suspension or revocation, or CMS sanction.

A termination for any of the above reasons is reported to the NPDB and is not eligible for a hearing or a review.

EmblemHealth will immediately remove any provider from the network who is unable to provide health care services due to a disciplinary action.

Practitioner's Rights

We recognize that practitioners have the following rights which may not justify termination or decredentialing:

- To advocate on behalf of our members.
- To file a complaint against EmblemHealth.
- To appeal any decision made by EmblemHealth.
- To provide information or file a report to PHL § 4406-c regarding prohibitions made by EmblemHealth.
- To request a hearing or review.

Radiology Privileging List By Specialty

Practitioners with certain types of credentialing may be eligible to provide in-house radiology imaging through our Radiology Privileging Program. Additional certification may be required. See the Radiology Privileging chapter for more details. The Radiology Privileging Program applies to members with the following benefit plans and to practitioners who provide care to these members:

- EmblemHealth EPO/PPO
- GHI
- Vytra

GHI HMO members and practitioners are not eligible for this program. Protocols for HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018) and EmblemHealth Medicare HMO appear in the HIP Outpatient Diagnostic Imaging Self-Referral Payment Policy chapter.

ADA Accessibility Attestation

The Americans with Disabilities Act (ADA) is a federal statute that requires public accommodations to provide goods and services to people with disabilities on an equal basis as that provided to the general public. Structural barriers to access should be removed only when the correction is readily achievable, which is defined by the law as easily accomplished and able to be carried out without much difficulty or expense. EmblemHealth is required to report aggregate statistics by geographic area and specialty on the percentage of providers that practice in ADA-compliant facilities.

A new EmblemHealth ADA Accessibility Attestation Form needs to be completed and submitted to EmblemHealth each time a provider joins a new office or has moved to a new location. Please note that the information provided here will in no way affect your affiliation with EmblemHealth.

All providers who participate in either the EmblemHealth Dual Assurance Network or Associated Dual Assurance Network must have a signed ADA Accessibility Attestation Form on file with EmblemHealth for each service location.

Providers must notify EmblemHealth within 10 business days of any change in their ability to meet the ADA Accessibility standards as outlined in the signed ADA Accessibility Attestation Form.

EmblemHealth

Provider Manual

Chapter 4: Member Identification Cards

Members and their spouses and dependents, age 19 and older, receive a member identification (ID) card. The card provides members and providers with important health plan information, including covered riders and copayments. Please note, for HIP-underwritten plans, each dependent child under age 19 will receive his or her own personal ID card.

All Enhanced Care Prime Network and Child Health Plus members will receive their own personal member ID cards.

Unique non-Social Security number-based identification numbers are issued to our members to protect their confidentiality. This practice also protects our members from potential identity theft and fraud. All Medicaid members receive their own personal member ID card that includes a unique Medicaid Client Identification Number.

Diagrams to help you quickly locate key coverage details and contact information when inspecting a member ID card appear in the “Sample ID Cards” section of this chapter.

Ask to see a member’s ID card at each appointment, emergency visit, or inpatient stay. Do not make a decision to provide care only on whether a member has a member ID card. A member ID card does not guarantee eligibility or payment of benefits. Providers should verify member eligibility on our secure website at

emblemhealth.com/providers.

Member Eligibility

Providers should verify member eligibility as outlined in the chart below.

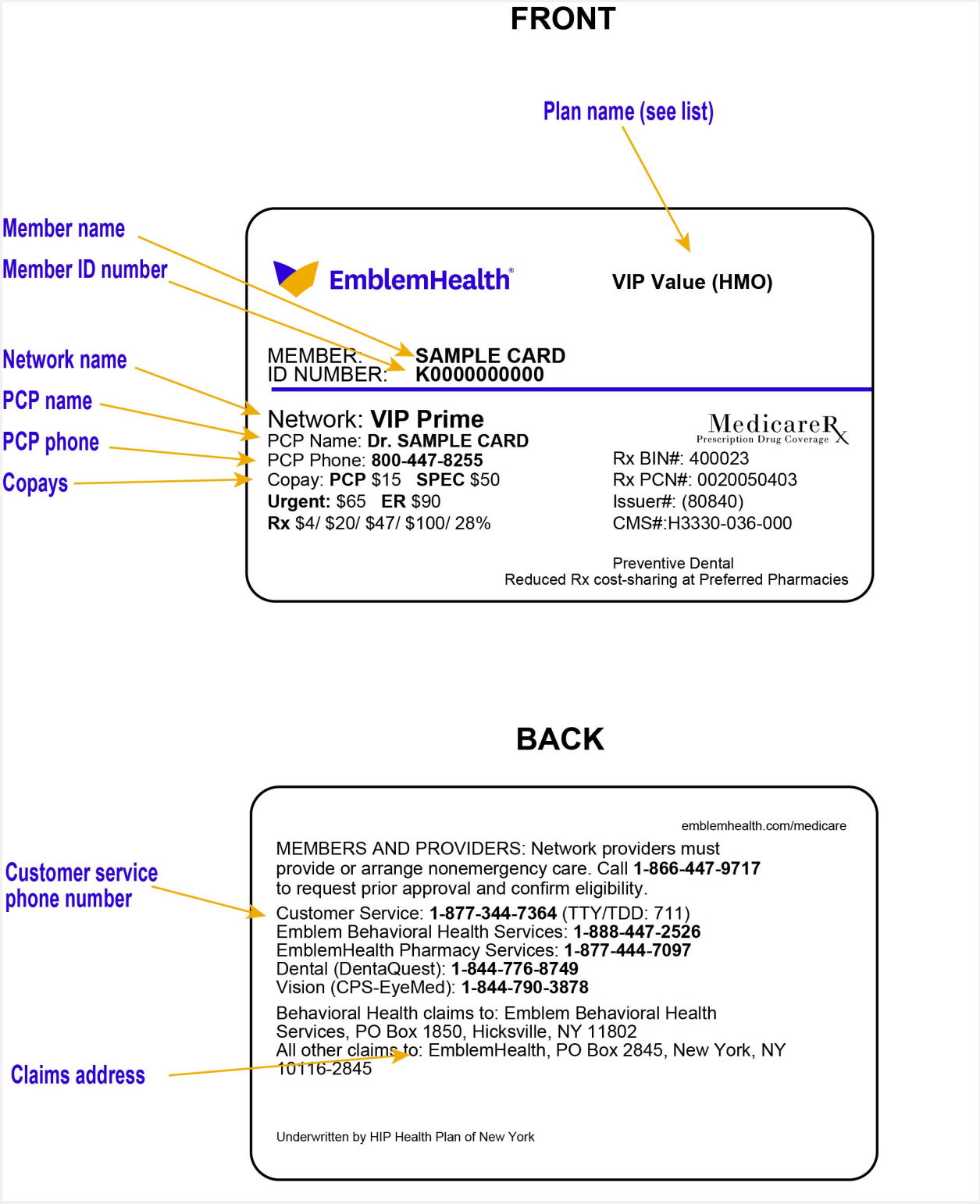
Confirm Member Eligibility

Provider Network	Instructions (Choose one of the bulleted options) Have your TIN ready before calling the IVR system
Select Care Network Prime Network Bridge Network Enhanced Care Prime Network VIP Prime Network	- Check eligibility at emblemhealth.com - PCPs may also check their Panel Reports - Speak to a representative or call the IVR phone system at 866-447-9717 - Providers with eMedNY access may check the enrollment of their Medicaid members on ePACES.
CBP, National & Tristate Networks Network Access Network	- Check eligibility at emblemhealth.com - Speak to a representative or call the IVR phone system: NYC: 212-501-4444 Outside NYC: 800-624-2414
Medicare Choice PPO Network	- Check eligibility at emblemhealth.com - Speak to a representative or call the IVR phone system at 866-557-7300

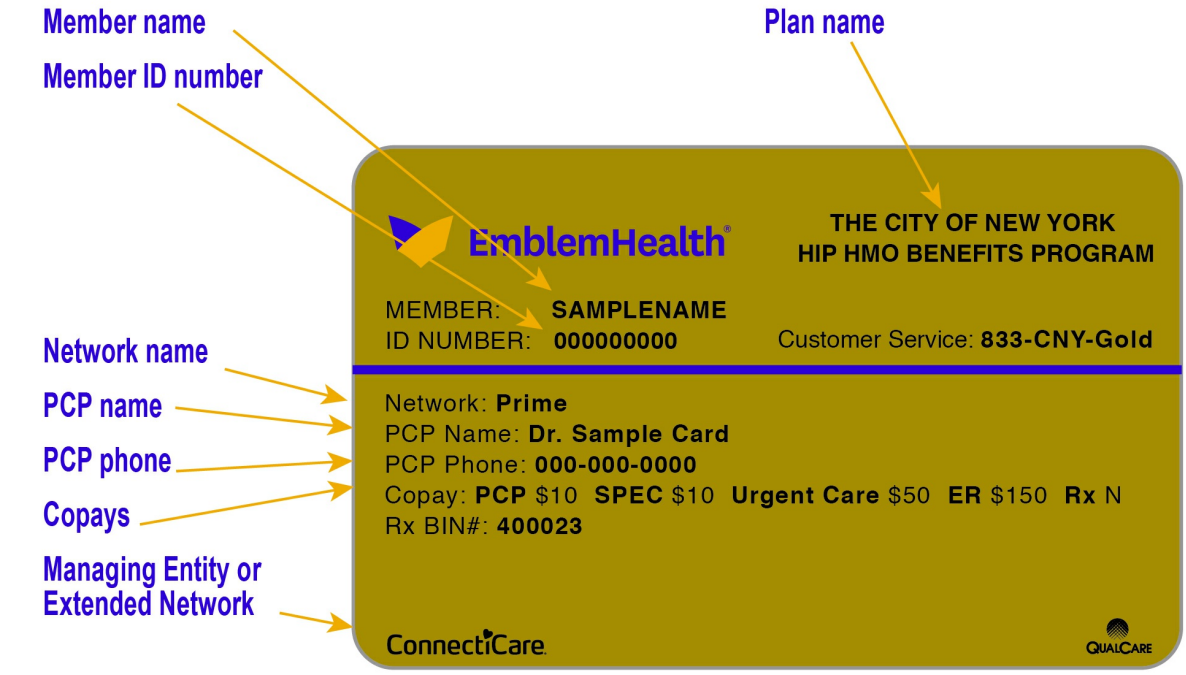
Sample ID Cards

This section includes a helpful guide to member ID cards that you may see for members enrolled in our various plans. These are examples of the templates we use on the dozens of member ID cards in circulation. These diagrams are meant to help you quickly locate key coverage details and contact information when inspecting a member's ID card, but do not capture all the information you may see. Please refer to the member's ID card presented at the point of service for specific addresses, telephone numbers, plan names, plan restrictions etc. Member ID cards may also contain logos for managing entities or extended networks that affect utilization management, member access to specific networks, and more. A list of these managing entities and networks, as well as some important information about each, appears below the Member ID diagrams.

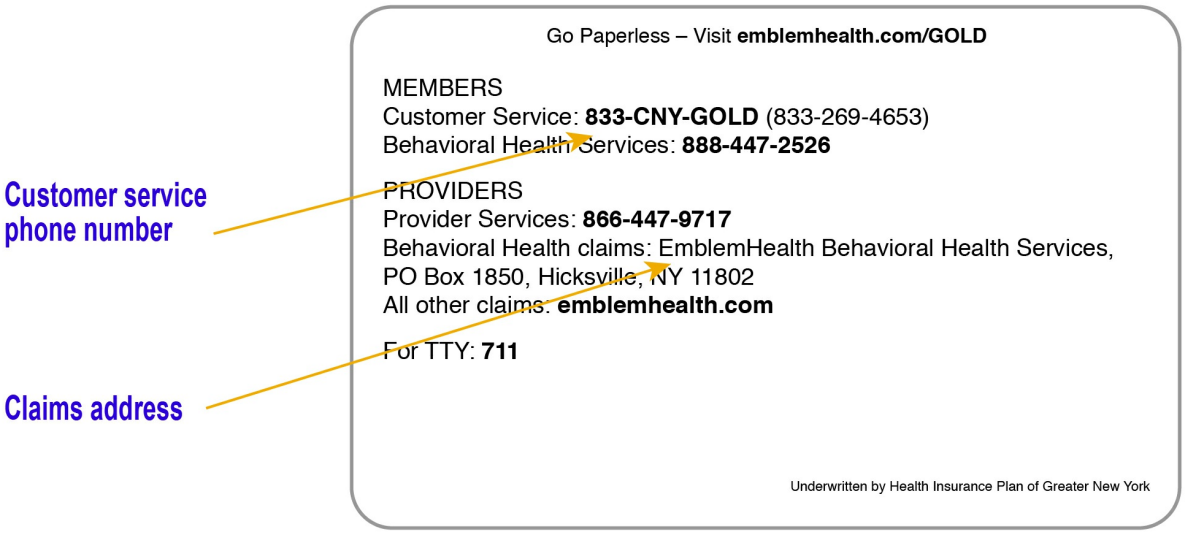
Please note: This first example is an ID card template used for most EmblemHealth Plans, including the new Affinity plans introduced in 2019. It is likely to be the most common design you will see, though the information on each card will be customized to the member's plan and benefits.



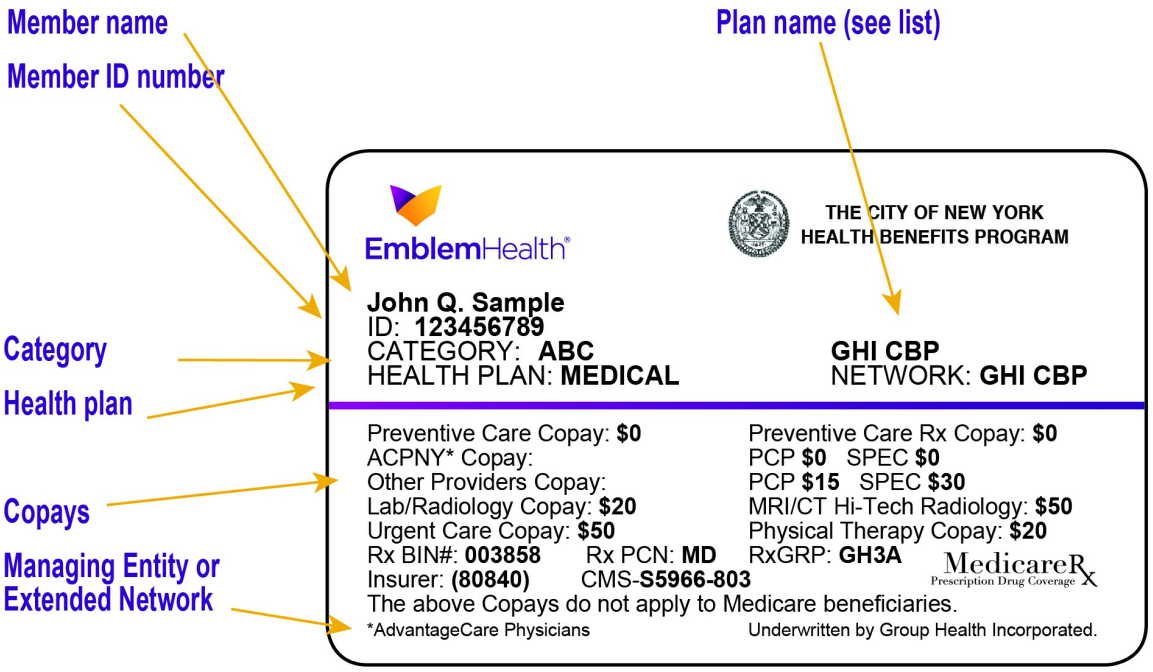
FRONT


Member name
Member ID number
Plan name
EmblemHealth
THE CITY OF NEW YORK
HIP HMO BENEFITS PROGRAM
MEMBER: SAMPLENAME
ID NUMBER: 000000000
Customer Service: 833-CNY-Gold
Network name
PCP name
PCP phone
Copays
Managing Entity or Extended Network
Network: Prime
PCP Name: Dr. Sample Card
PCP Phone: 000-000-0000
Copay: PCP $10 SPEC $10 Urgent Care $50 ER $150 Rx N
Rx BIN#: 400023
ConnectiCare
QUALCARE

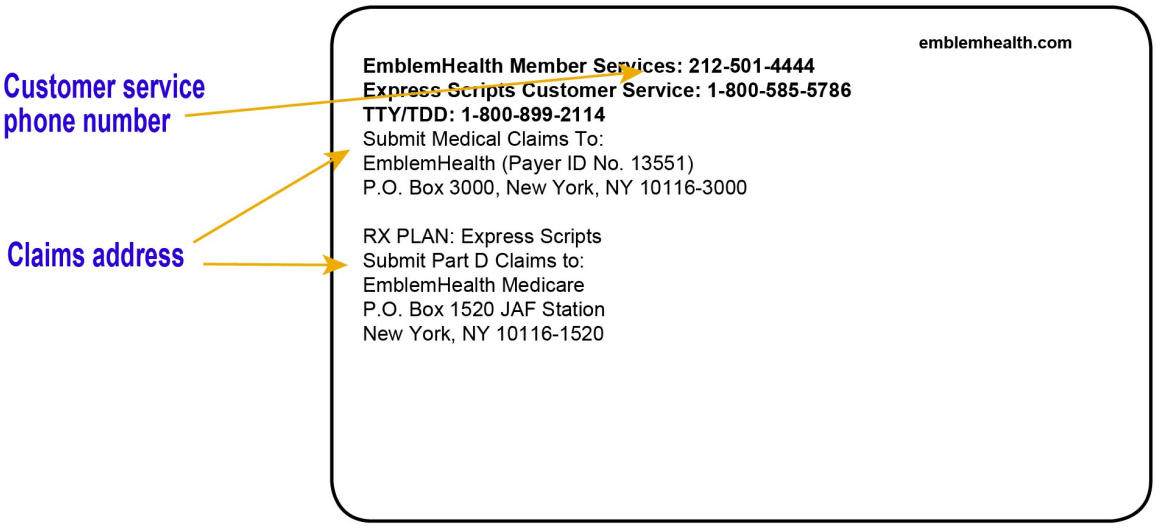
BACK


Customer service phone number
Claims address
Go Paperless – Visit emblemhealth.com/GOLD
MEMBERS
Customer Service: 833-CNY-GOLD (833-269-4653)
Behavioral Health Services: 888-447-2526
PROVIDERS
Provider Services: 866-447-9717
Behavioral Health claims: EmblemHealth Behavioral Health Services,
PO Box 1850, Hicksville, NY 11802
All other claims: emblemhealth.com
For TTY: 711
Underwritten by Health Insurance Plan of Greater New York

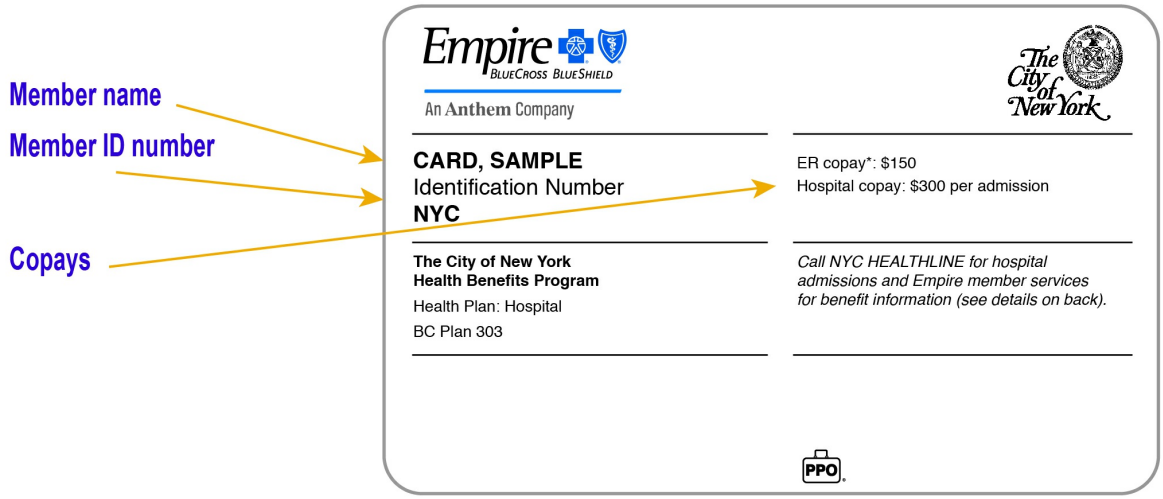
FRONT


Member name
Member ID number
Plan name (see list)
Category
Health plan
Copays
Managing Entity or Extended Network
EmblemHealth
THE CITY OF NEW YORK
HEALTH BENEFITS PROGRAM
John Q. Sample
ID: 123456789
CATEGORY: ABC
HEALTH PLAN: MEDICAL
GHI CBP
NETWORK: GHI CBP
Preventive Care Copay: $0
ACPNY* Copay:
Other Providers Copay:
Lab/Radiology Copay: $20
Urgent Care Copay: $50
Rx BIN#: 003858 Rx PCN: MD RxGRP: GH3A
Insurer: (80840) CMS-S5966-803
Preventive Care Rx Copay: $0
PCP $0 SPEC $0
PCP $15 SPEC $30
MRI/CT Hi-Tech Radiology: $50
Physical Therapy Copay: $20
MedicareRx
Prescription Drug Coverage
The above Copays do not apply to Medicare beneficiaries.
*AdvantageCare Physicians
Underwritten by Group Health Incorporated.

BACK


Customer service phone number
Claims address
emblemhealth.com
EmblemHealth Member Services: 212-501-4444
Express Scripts Customer Service: 1-800-585-5786
TTY/TDD: 1-800-899-2114
Submit Medical Claims To:
EmblemHealth (Payer ID No. 13551)
P.O. Box 3000, New York, NY 10116-3000
RX PLAN: Express Scripts
Submit Part D Claims to:
EmblemHealth Medicare
P.O. Box 1520 JAF Station
New York, NY 10116-1520

FRONT



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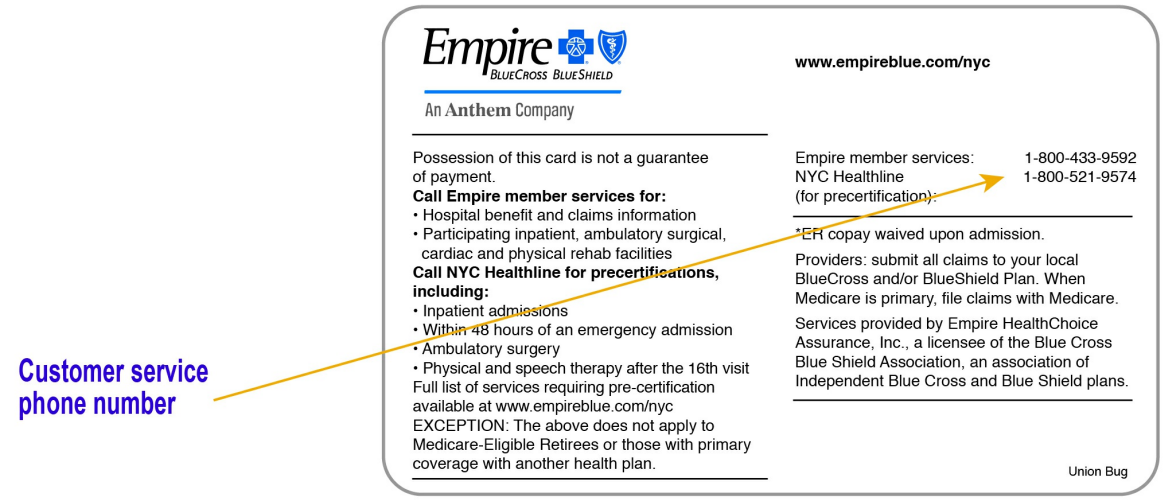

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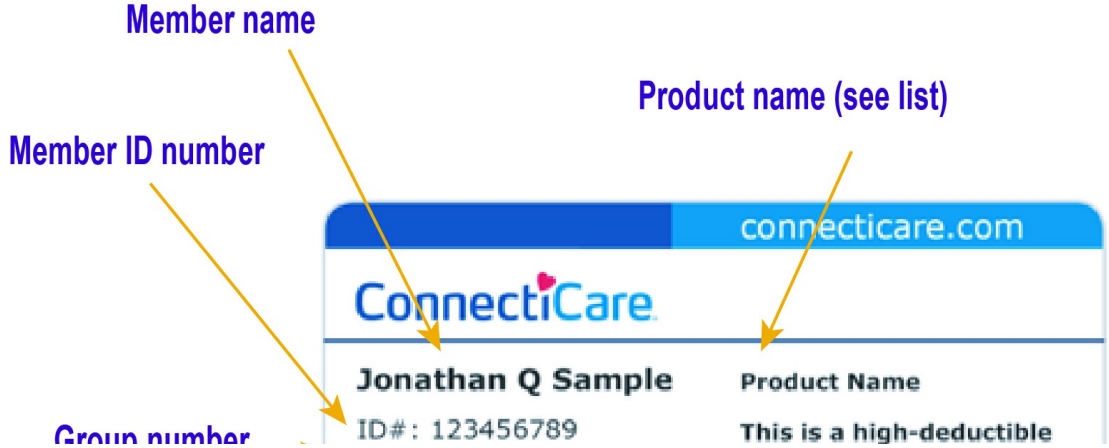
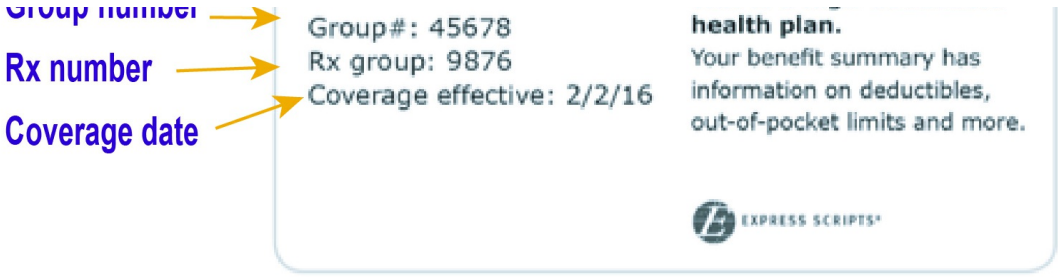
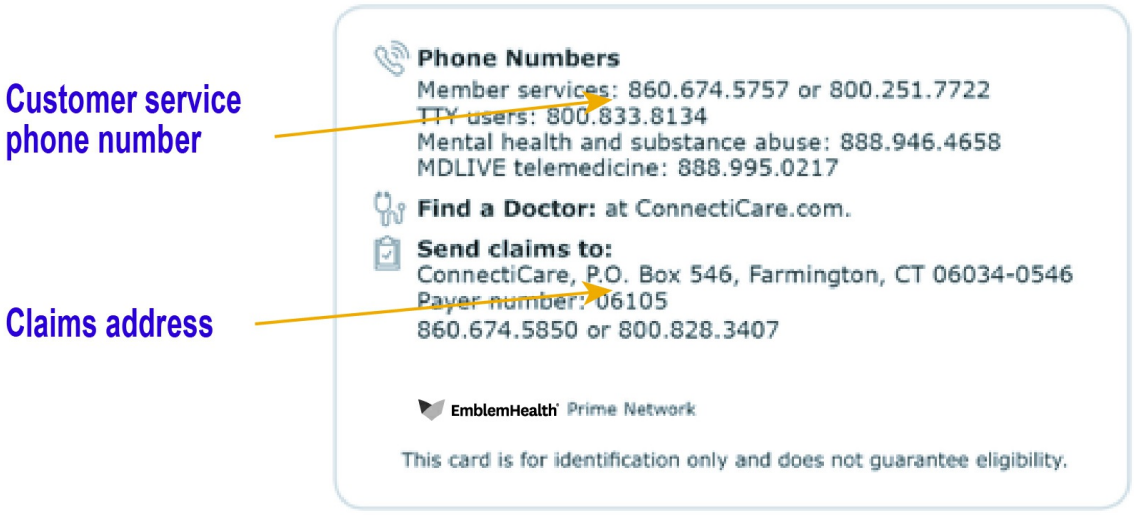


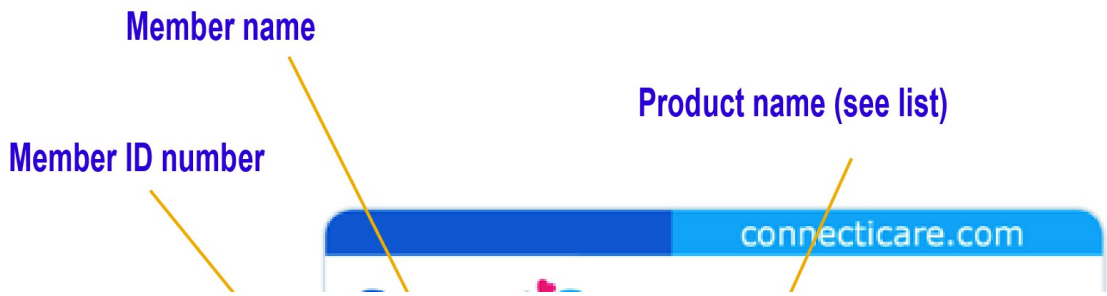

Group number
Rx number
Coverage date
Group#: 45678
Rx group: 9876
Coverage effective: 2/2/16
health plan.
Your benefit summary has information on deductibles, out-of-pocket limits and more.
EXPRESS SCRIPTS

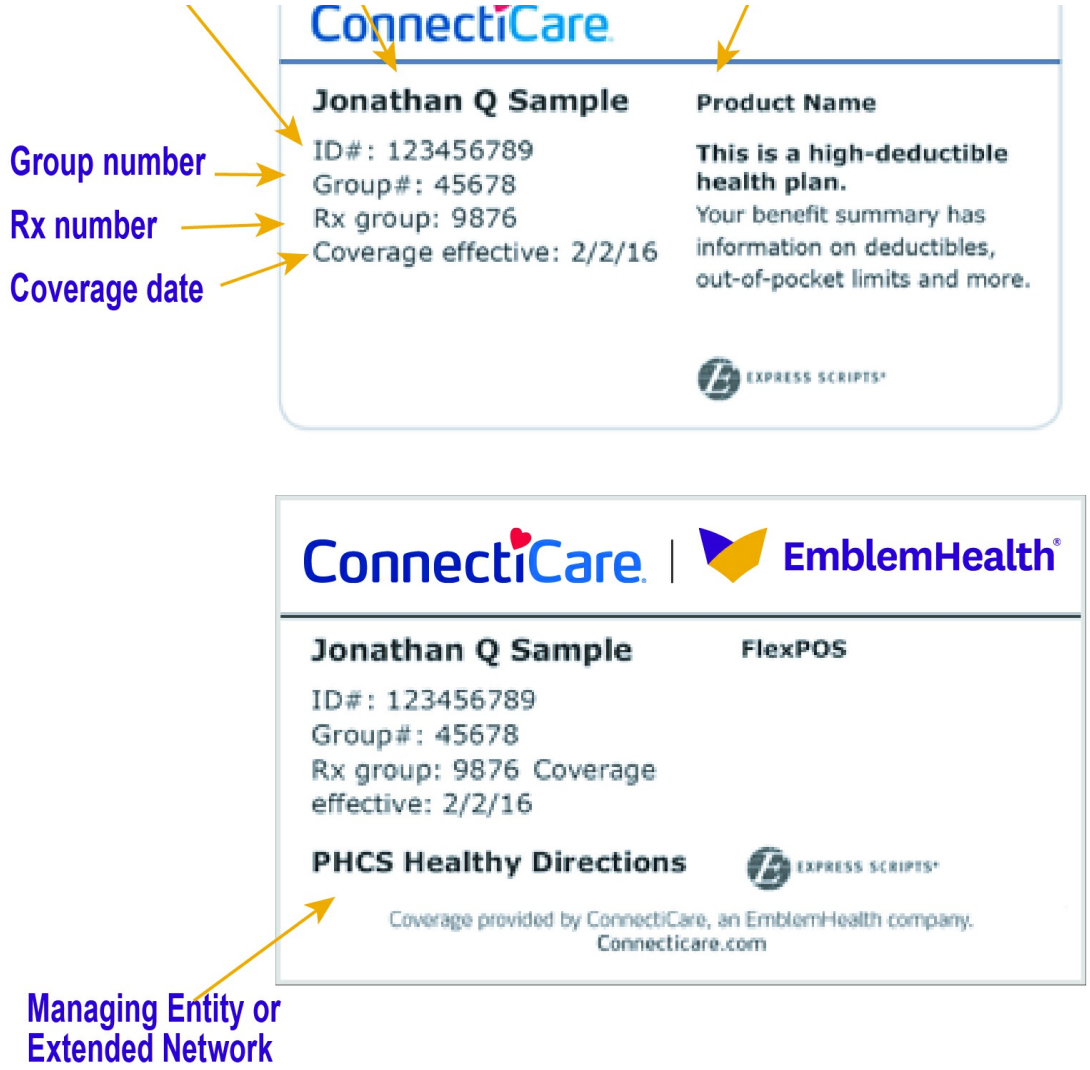

ConnectiCare | EmblemHealth
Jonathan Q Sample
FlexPOS
ID#: 123456789
Group#: 45678
Rx group: 9876 Coverage effective: 2/2/16
PHCS Healthy Directions
EXPRESS SCRIPTS
Coverage provided by ConnectiCare, an EmblemHealth company.
Connecticare.com
Managing Entity or Extended Network

BACK


Customer service phone number
Claims address
Phone Numbers
Member services: 860.674.5757 or 800.251.7722
TTY users: 800.833.8134
Mental health and substance abuse: 888.946.4658
MDLIVE telemedicine: 888.995.0217
Find a Doctor: at ConnectiCare.com.
Send claims to:
ConnectiCare, P.O. Box 546, Farmington, CT 06034-0546
Payer number: 06105
860.674.5850 or 800.828.3407
EmblemHealth Prime Network
This card is for identification only and does not guarantee eligibility.

FRONT


Member name
Member ID number
Product name (see list)
connecticare.com



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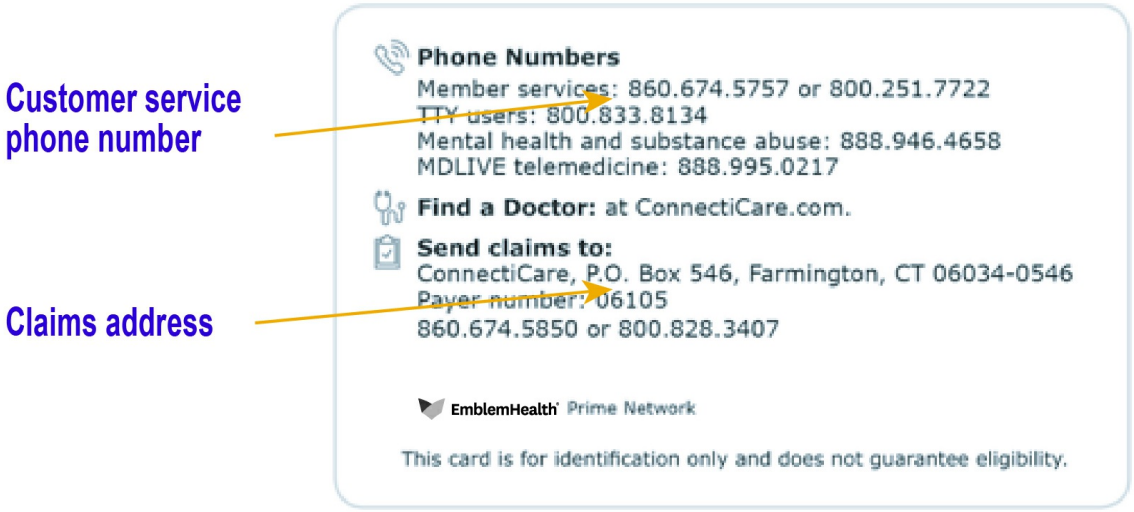

Managing Entities

HealthCare Partners: The member is assigned to an HCP primary care physician. The managing entity is responsible for utilization management for assigned members.

Montefiore Medical Center: The member is assigned to a Montefiore primary care physician. The managing entity is

responsible for utilization management for assigned members.

Extended Networks

Bridge Network: Members who have the Bridge Network on their member ID cards belong to self-funded employer groups for which EmblemHealth and ConnectiCare are providing administrative services and access to our commercial networks. For information on the Bridge Network, click here. To see the quick reference guide which includes an image of a Bridge Network Member ID card, click here.

ConnectiCare: Some members who access care through the Prime Network may also access care through ConnectiCare in Connecticut. Similarly, some ConnectiCare members may access care through EmblemHealth's Prime Network. See the 2019 Provider Networks and Member Benefit Plans chapter for applicable plans.

First Health Network: MultiPlan is being replaced by First Health Network for both EmblemHealth and ConnectiCare. This will be a rolling transition as member plans renew starting January 1, 2020. Member ID Cards will be redistributed with the First Health logo.

PHCS/MultiPlan: Members in the National Network have access to PHCS/MultiPlan outside of New York.

QualCare: Certain members in the Prime Network have access to QualCare's network in New Jersey. Likewise, HMO members have access to the QualCare HMO network; other plans have access to QualCare PPO network. See the 2019 Provider Networks and Member Benefit Plans chapter for applicable plans.

EmblemHealth

Cultural Competency Continuing Education and Resources

Free **Continuing Education Programs**

Think Cultural Health Continuing Education Programs. Earn free CME credits while learning about cultural competency in health care. These programs are provided by the US Department of Health & Human Services.

A Physician's Practical Guide to Culturally Competent Care is offered by the US Department of Health & Human Services. This e-learning program will equip health care providers with competencies to better treat the increasingly diverse U.S. population.

The Office of Minority Health, Health Resources and Services Administration, and National Center for Cultural Competence offer resources for physician education and to use with patients.

Quality Care for Diverse Populations is a program offered by the American Academy of Family Physicians (AAFP). This web-based program, geared toward physicians and other health care professionals, offers a series of five video vignettes depicting physician-patient visits as a means to explore cultural and ethnic issues found in the health care environment.

Continuing Education Programs (for a fee)

Cross Cultural Health Care - Case Studies, developed by Pediatric Pulmonary Centers, is an interactive self-study program consisting of a series of five tutorials in cultural competence, aimed at familiarizing health care providers with common issues that arise while working with people of diverse cultures.

Quality Interactions® is an e-learning program that provides case-based instruction on cross-cultural health care.

Reference Material for Cultural Competency

The Medical Manual for Religio-Cultural Competency, written by Tanenbaum Center for Interreligious Understanding in partnership with EmblemHealth, is the most comprehensive guide to religion and health care available. It provides practical information to help the practitioner understand how a patient's medical decisions may be influenced by their religious observances.

As a leader in providing information on innovative and evidence-based approaches to health care, EmblemHealth is pleased to offer this first-of-its-kind publication at no cost to our network practitioners.

Sign in to EmblemHealth's secure provider site to get a copy of *The Medical Manual* at no cost.

Working Together to End Racial and Ethnic Disparities: One Physician at a Time Kit (DVD, CD-ROM and facilitation guide), offered by the American Medical Association (AMA), is a resource for physicians and their staff to improve awareness and skills in addressing the inequities in care that patients from diverse racial and ethnic backgrounds receive.

Critical Measures, a training and management consulting company, has a website that contains a useful fact sheet defining cultural competence, why it is important, and how health care practitioners can obtain cultural competency training. Critical Measures also offers CME courses that can be accessed from their site.

Askme3®, licensed to the National Patient Safety Foundation, is a health literacy education program designed to improve communication between patients and health care providers, encourage patients to become more active members of their health care team, and promote improved health outcomes.

Substance Abuse and Mental Health Services Administration (SAMHSA)
has various publications to assist practitioners and clinicians in providing sensitive and effective mental health services to people of diverse cultural backgrounds. From SAMHSA's publications-ordering website, enter "cultural competence" in the search box.

EmblemHealth

When it comes to cultural competency, religion is one of the largest - if not the largest - component.

Don't miss out on a chance to provide even better care to your patients.

Properly addressing religion is a key element of providing patient-centered care and improving health outcomes and patient and family satisfaction. That's why we partnered with the Tanenbaum Center for Interreligious Understanding, a secular nonprofit organization dedicated to overcoming religious bias and intolerance, to create resources that help medical practitioners understand how religious beliefs and practices intersect with medical science.

The Medical Manual for Religio-Cultural Competency is the most comprehensive guide to religion and health care available. It provides practical information to help the practitioner understand how a patient's medical decisions can be influenced by their religious observances.

As a leader in providing information on innovative and evidence-based approaches to health care, EmblemHealth is pleased to offer this first-of-its-kind publication at no cost to our network practitioners. Read an excerpt of The Medical Manual now.

Sign on to the secure provider site to get a copy of *The Medical Manual*.

"This very useful book will prove a great help in the office of medical caretakers who practice where diversity has become the rule. Given the surprisingly ubiquitous location of many immigrants, a copy will probably be well-thumbed almost anywhere. The discussions in this 228 page manual run the gamut from Judaism and Christianity to Islam, Buddhism, Hinduism, Sikhism, Shinto, traditional Chinese, American Indian and Alaskan native, and Afro-Caribbean traditions."

Dr. Howard Spiro, MD
Read the entire review in the *Yale Journal for Humanities in Medicine*.

"Religious competence is a critical part of cultural competence, and one that is underrepresented in medical training. The Medical Manual is an invaluable resource for our students, residents, attending physicians including subspecialists, nurses and all of those involved with patient care. It is an important tool to help us continue to provide excellent patient care and truly comprehensive family centered care."

Michael Gewitz, MD
Physician-in-Chief/Executive Director
Maria Fareri Children's Hospital at Westchester Medical Center

"The Manual is a remarkable resource for the practicing physician and for physicians-in-training. It is eminently readable, comprehensive, and, best of all, an absolutely practical tool. Every physician in today's global community should have this book in their office. It will improve patient satisfaction, their own professional satisfaction, and enhance their practice of medicine."

David Muller, MD
Dean of Medical Education
Mt. Sinai School of Medicine

"The patients I encounter in New York come from the most diverse religious and cultural backgrounds...The Medical Manual provides a practical guide of medically pertinent religious beliefs and practices that enhances my ability to have comfortable conversations about even the most complex medical issues. The information and communication skills contained in the manual will certainly become an indispensable tool for providing the best care to patients and their families. I also believe that the principles taught in the manual should become part of the medical education of physicians and other health care providers."

Alessandro Di Rocco, M.D.
Chief, Division of Movement Disorders
New York University School of Medicine

EmblemHealth

Provider Manual

Chapter 5: Member Policies and Rights

In the chapter, you will find information on our member copay policy and procedures, along with members' rights and responsibilities, including privacy right.

Copayment Policy and Procedures

Some plan members have required copayment (copay) charges. Copays should be collected from members by the provider's office at the time of service. The copay, in conjunction with an office visit, is part of the provider's remuneration and its collection is the provider's responsibility.

In the event that the copay is not collected from the member, the provider may not seek reimbursement of the copay from EmblemHealth. If the contracted fee under the participating provider agreement with the EmblemHealth companies is less than the copay amount, the participating provider is not permitted to collect the difference between the contracted fee and the copay and must refund such difference to the member if it was collected.

Members with a Select Care Network-based benefit plan may have a deductible for in-network services. When collecting a copay at an office visit, please note that this amount may actually be a payment towards the member's deductible and that a true copay will not apply until after the deductible is met. Please see the remittance statement for the member's actual out-of-pocket responsibility.

Patient-specific copay information is listed on the member's ID card. It can also be obtained from our secure website at emblemhealth.com in the member's Summary of Benefits or from our Customer Service departments as listed in the Directory chapter.

Important things to note:

- Copays may not be collected from Medicare members for the preventive care services as defined by CMS and listed in Appendix C.
- Members enrolled in Dual Eligible PPO SNP, Dual Eligible HMO SNP and GuildNet Gold plans may not be charged cost-sharing greater than what would have been charged if the member was enrolled in NYS Medicaid.
- Medicaid members do not have copays for the following services:
  - Emergency room visits for needed emergency care
  - Family planning services, drugs and supplies

  - Mental health visits
  - Chemical dependency visits
  - Drugs to treat mental illness
  - Drugs to treat tuberculosis
  - Prescription drugs for residents of adult care facilities

- The following Medicaid members do not have copays for any services:
  - Children under age 21
  - Pregnant women (through 60 days postpartum)
  - Permanent residents of nursing homes
  - Residents of community-based residential facilities licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disability
  - Those who are financially unable to make copays at any time and who tell the provider they are unable to pay
  - Medicaid members in a Comprehensive Medicaid Case Management (CMCM) or service coordination program
  - Medicaid members in an OMH or OPWDD Home and Community-Based Services (HCBS) waiver program
  - Medicaid members in a DOH HCBS waiver program for persons with traumatic brain injury (TBI)
  - Medicaid members cannot be denied health care services based on their inability to pay the copay at the time of service. However, providers may bill these members or take other action to collect the owed copay amount.
  - Members with Medicaid have only pharmacy copays and an annual $200 maximum copay obligation.

- There are no plan copay requirements for CHPlus members.
- Copays may not exceed the amount payable under the participating provider agreement.

Preventive Services Covered Under the Affordable Health Care Act

The Affordable Health Care Act dictates that any person who has a new insurance plan or policy as of September 23, 2010 must have certain preventive services covered without having to pay a copay or coinsurance or meet a deductible. Our Preventive Health Guidelines booklet helps members learn more about the screenings, tests and immunizations that they and their family need every year.

Rights and Responsibilities of EmblemHealth Plan Members

The rights and responsibilities listed below indicate what members can expect of EmblemHealth and what responsibilities our members have to EmblemHealth.

EmblemHealth plan members have the right to:

- Be treated without discrimination, including discrimination based on race, color, religion, gender, national origin, disability, sexual orientation or source of payment.
- Participate with physicians in making decisions about their health care.
- A non-smoking environment.
- Be treated with fairness and respect at all times, and in a clean and safe environment.

- Receive, upon request, a list of the physicians and other health care providers in our participating provider network.
- Change their physician.
- Information about our plans and networks and their covered services.
- Be assured that our participating health care providers have the qualifications stated in our Professional Standards, established by the EmblemHealth Credentialing Committee, which are available upon request.
- Know the names, positions and functions of any participating provider's staff and to refuse their treatment, examination or observation.
- Timely access to covered services and drugs.
- Obtain from their physician, during practice hours, comprehensive information about their diagnosis, treatment and prognosis, regardless of cost or benefit coverage, in language they can understand. When it is not medically advisable to give them such information, or when the member is a minor or is incompetent, the information will be made available to a person who has been designated to act on that person's behalf.
- Receive from their physician the information necessary to allow them to give informed consent prior to the start of any procedure or treatment and to refuse to participate in, or be a patient for, medical research. In deciding whether to participate, they have the right to a full explanation.
- Know any risks involved in their care.
- Refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of refusing it.
- Have all lab reports, X-rays, specialists' reports and other medical records completed and placed in their chart so they may be available to their physician at the time of consultation.
- Be informed about all medication given to them, as well as the reasons for prescribing the medication and its expected effects.
- Receive, from their provider, all information they need to give informed consent for an order not to resuscitate. They also have the right to designate an individual to give this consent if they are too ill to do so.
- Request a second opinion from a participating physician.
- Privacy concerning their medical care. This means, among other things, that no person who is not directly involved in their care may be present without their permission during any portion of their discussion, consultation, examination or treatment. We will give them a written notice, called a "Notice of Privacy Practice," that describes their rights.
- Expect that all communications, records and other information about their care or personal condition will be kept confidential, except if disclosure of that information is required by law or permitted by them.
- Request that copies of their complete medical records be forwarded to a physician or hospital of their choice at their expense. However, information may be withheld from them if, in the physician's judgment, release of the information could harm them or another person. Additionally, a parent or guardian may be denied access to medical records or information relating to a minor's pregnancy, abortion, birth control or sexually transmitted diseases if the minor's consent is not obtained.
- Have a person of their choice accompany them in any meeting or discussion with medical or administrative personnel.
- Give someone legal authority to make medical decisions for them.
- Consult by appointment, during business hours, with our responsible administrative officials and their participating physician's office to make specific recommendations for the improvement of the delivery of health services.
- Make a complaint or file an appeal related to the organization or a determination about seeking care or about care and services they have received. See information on filing member appeals.

- Receive an explanation from us if a provider has denied care that they believe they should receive. To receive this explanation, they will need to ask us for a copy of the written decision.
- Receive from us information in a way that works for them, in languages other than English or other alternate formats, in accordance with company policy and regulatory rules.
  IMPORTANT: State and federal laws give adults in New York State the right to accept or refuse medical treatment, including life-sustaining treatment, in the event of catastrophic illness or injury. EmblemHealth makes available materials on advance directives with written instructions, such as a living will or health care proxy containing the members' wishes relating to health care should they become incapacitated. If members live in another state, they should check with their local state insurance department, if available, for information on additional rights they may have.
- Receive information about our organization, our services and our provider networks and about member rights and responsibilities.
- Make recommendations regarding our member rights and responsibilities policies.

EmblemHealth plan members have the responsibility to:

- Provide us and our participating physicians and other providers with accurate and relevant information about their medical history and health so that appropriate treatment and care can be rendered. They should tell their doctors they are enrolled in our plan and show them their membership card.
- Keep scheduled appointments or cancel them, giving as much notice as possible in accordance with the provider's guidelines for cancelation notification.
- Update their record with accurate personal data, including changes in name, address, phone number, additional health insurance carriers and an increase or decrease in dependents within 30 days of the change.
- Treat with consideration and courtesy all of our personnel and the personnel of any hospital or health facility to which they are referred.
- Be actively involved in their own health care by seeking and obtaining information, by discussing treatment options with their physician and by making informed decisions about their health care.
- Participate in understanding the member's health issues and to follow through with treatment plans agreed upon by all parties in the member's health care: the member, EmblemHealth and participating physicians.
- Follow plans and instructions for care that they have agreed to with their practitioner.
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- Understand our benefits, policies and procedures as outlined in their Contract or Certificate of Coverage and handbook, including policies related to prior approval for all services that require such approval.
- Pay premiums on time and to pay copayments, if applicable, at the time services are rendered.
- Abide by the policies and procedures of their participating physician's office.
- Notify us if they have any other health insurance or prescription drug coverage in addition to our plan.
- Be considerate. We expect them to respect the rights of other patients and act in a way that helps the smooth running of their doctors' office, hospitals and other offices.

The protection and security of our members' personal information is a major objective of EmblemHealth. Our Notice of Privacy Practices describes how medical information about our members may be used and disclosed and how our members can get access to this information. Our member handbook tells members how to give consent to the collection, use and release of personal health information, how to obtain access to their medical records and what we do to protect access to their personal information. We are also committed to serving our members in a culturally competent and nondiscriminatory manner.

Confidentiality of Personal Information

As members consider joining an EmblemHealth plan, we want them to know that we make the protection of personal information a high priority. Our members entrust us with information that is personal, sensitive and highly confidential. Our employees and other authorized individuals working for us are accountable for exercising a high degree of care in safeguarding the confidentiality of that information.

Indeed, our employees and other authorized individuals are prohibited from:

- Accessing or trying to access personal information, except on a "need to know" basis and only when authorized to do so.
- Disclosing personal information to any person or organization within or outside the Plan, unless that person or organization has a "need to know" and is authorized by us to receive that information.

Confidentiality of Health Information for Minors Enrolled in Medicaid Managed Care Plans

Effective September 1, 2016, EmblemHealth will suppress all Explanation of Benefits (EOBs) for Medicaid minors 0 – under 18 years of age, with the exception of dental-related services and situations where the member may be financially responsible. New York State Department of Health (DOH) requires Medicaid Managed Care Plans, including EmblemHealth, to establish an effective, uniform and systemic mechanism to comply with confidentiality protections for health care services provided to minors who are enabled by statute to consent to their own heath care.

Member Consent

Providers should be aware of who may and may not consent for care. Public Health Law section 2504 specifically states the following:

- Any person who is 18 years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person is necessary.
- Any person who has been married or who has borne a child may give effective consent for medical, dental, health and hospital services for his or her child. Any person who has been designated by law as a person in parental relation to a child may consent to any medical, dental, health and hospital services for such child for which consent is otherwise required. The above excludes (a) major medical treatment as defined in the mental hygiene law; (b) electroconvulsive therapy; and (c) the withdrawal or discontinuance of medical treatment that is sustaining life functions.
- Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care.
- Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in a delay of treatment that would increase the risk to the person's life or health.
- Where not otherwise already authorized by law to do so, any person in a parental relation to a child as defined by law as well as (i) a grandparent, an adult brother or sister, or an adult aunt or uncle, any of whom has assumed care of the child and (ii) an adult who has care of the child and has written authorization to consent from a person in a parental relation to a child as defined by law may give effective consent for the immunization of a child. However, a person other than one in a parental relation to the child cannot give consent under this subdivision if he or she has reason to believe that a person in parental relation to the child (as defined by law) objects to the

immunization.

- Anyone who acts in good faith based on the representation by a person that he or she is eligible to consent pursuant to the terms of this section shall be deemed to have received effective consent.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA requires providers to take reasonable and appropriate measures to protect member/patient information. Examples of measures considered reasonable and appropriate to safeguard the patient chart include limiting access to certain areas, ensuring that the area is supervised, escorting non-employees in the area, and placing the patient chart in the box with the front cover facing the wall so that protected health information is not visible to anyone who walks by. An office sign-in sheet may not display medical information that is unnecessary for the purpose of signing in (e.g., information about symptoms or treatment). In addition, while providers may leave messages for members on home answering machines, they should consider leaving only the member's name on the machine along with information necessary to confirm an appointment, or simply asking the individual to call back.

Confidentiality of HIV-related Information

The provider must develop policies and procedures to assure confidentiality of HIV-related information. These policies and procedures must include:

- Initial and annual in-service education of staff and contractors
- Identification of staff allowed access and limits of access
- Procedures to limit access to trained staff (including contractors)
- Protocols for secure storage (including electronic storage)
- Procedures for handling requests for HIV-related information
- Protocols to protect persons with or suspected of having HIV infection from discrimination

Confidentiality of Behavioral Health and Substance Use Information

Each provider must develop policies and procedures to assure confidentiality of mental health and substance related information. These policies and procedures must include:

- Initial and annual in-service education of staff and contractors
- Identification of staff allowed access and limits of access
- Procedures to limit access to trained staff (including contractors)
- Protocols for secure storage (including electronic storage)
- Procedures for handling requests for BH/SU information protocols to protect persons with behavioral health and/or substance use disorder from discrimination

Routine Consent

Before releasing personal information, consent must first be obtained from the member or a qualified person, unless release of that information is required by law. In many cases, when new members enroll in an EmblemHealth plan, routine consent for release of information is obtained on the enrollment application. The consent authorizes the use of personal information for general treatment, coordination of care, quality assessment, utilization review and fraud detection. The consent also authorizes the use of personal information for oversight reviews, such as those performed by the state or for accreditation purposes. In addition, it covers future routine use of such information. HIPAA permits the disclosure of information for payment, treatment and health care operations.

Authorization to Release Information

Authorization must be obtained from the member or qualified person before any personal health information can be

released to an outside organization or agency, unless release of that information is legally required or permitted.

Special restrictions apply to the release of information relating to alcohol and drug abuse, abortion, sexually transmitted disease, adoption, psychiatric treatment, psychotherapy notes and HIV/AIDS.

Access to Medical Records

Our providers maintain medical records for the benefit of our members. A member has the right to review, copy and request amendments to his or her medical record. Any member or qualified person who desires a copy of the medical record may obtain one by submitting a written request to his or her network or facility.

A member or qualified person may challenge the accuracy of the information in the medical record. In addition, he or she may require that a statement describing the challenge be added to the record.

Access by a member or qualified person to information in the medical record may be denied, but only if the network provider or facility determines that:

- Access can reasonably be expected to cause substantial harm to the member or to others
- Access would have a detrimental effect on the network practitioner's or facility's professional relationship with the member, or on their ability to provide treatment

Nondiscrimination

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

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

Cultural Competency

The US Department of Health & Human Services defines cultural and linguistic competence as a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals and enable effective work in cross-cultural situations. Delivering quality, sensitive care to a diverse cross-cultural population promotes respectful and responsive health care without cultural communication differences hindering the relationship.

For additional information regarding cultural and linguistic competence, as well as educational materials and online courses, the following resources are available:

- US Department of Health & Human Services: The Office of Minority Health
- AHRQ: Setting the Agenda for Research on Cultural Competence in Health Care
- America's Health Insurance Plans: Tools to Address Disparities in Health
- EmblemHealth Learn Online: Cultural Competency

In addition, EmblemHealth encourages its providers (medical, physical, behavioral, long term services and support [LTSS] and pharmacy) to consider how people's religious beliefs and practices intersect with medical science. We recognize that cultural competence is particularly important to the diverse cultural and religious identities of our members and the communities we serve.

That is why we sponsored Tanenbaum Center for Interreligious Understanding to write The Medical Manual for Religio-Cultural Competency. It is user-friendly and filled with information for the busy health care practitioner who

wants to be religio-culturally competent. Its wide-ranging chapters not only include practical information on the various religions, but also spiritual assessment forms and tools and tips for working effectively with people of diverse religious backgrounds and points of view. As a leader in providing coverage of innovative and evidence-based approaches to health care, EmblemHealth is pleased to offer this first-of-its-kind publication to our network practitioners. Log on to emblemhealth.com to access The Medical Manual.

Notice of Privacy Practices

See the following page for our Notice of Privacy Practices.

EmblemHealth

Commercial and Child Health Plus Networks

Commercial Networks Covered by Agreements

The table that follows summarizes the benefit plans our commercial members use to receive their health care benefits and services. EPO/PPO plans typically allow members to self-refer to network specialists for office visits; however, prior approval is still required before certain procedures can be performed.

GHI Commercial Network and Plan Summary for 2019
(CBP, National, Network Access, & Tristate Networks)

Network	Plan Name	Plan Type	PCP Req'd	Referral Req'd	Deductibles (Individual/ Family)	PCP/ Special/ ER Copay	OON Coverage	MOOP (Ind/ Family)	Co-ins.
CBP Network	Federal Employee Health Benefit (FEHB)[1]	EPO	No	No	N/A	$30/ $30/ $150	No	$6,850/ $13,700	No
CBP Network	Federal Employee Health Benefit (FEHB)[1]	PPO	No	No	IN: N/A OON: $150	$20/ $20/ $150	Yes	$6,850/ $13,700	OON only
Network Access Network	Network Access	EPO/ PPO network lease	No	No	Various	Various	EPO: No PPO: Yes	Up to $7,350/ $14,700	EPO: No PPO: Yes
CBP Network	City of New York	PPO (medical only)	No	No	IN: N/A OON: $175/$500	Preferred PCP/Specialist $0/$0 All other PCP/Specialists $15/$30/ N/A $25/$25/ $150	Yes	$4,550/ $9,100	No
CBP Network	DC 37 Med-Team	PPO	No	No	IN: N/A OON: $1,000/ $3,000	$25/ $25/ $150	Yes	$7,150/ $14,300	OON only

National Network	EmblemHealth EPO	EPO	No	No	N/A	Various	No	Up to $7,350/ $14,700	No
National Network	EmblemHealth PPO	PPO	No	No	IN: N/A OON: Various	Various	Yes	Up to $7,350/ $14,700	OON only
National Network	EmblemHealth ConsumerDirect EPO	EPO	No	No	Various (includes Rx)	No	No	Up to $7,350/ $14,700	Yes
National Network	EmblemHealth ConsumerDirect PPO	PPO	No	No	Various (includes Rx)	No	Yes	Up to $7,350/ $14,700	Yes
National Network	EmblemHealth HealthEssentials Plus	EPO	No	No	N/A	$40 (limited to 3 outpatient visits only)	No	$3,000/ $6,000	No
National Network	EmblemHealth InBalance EPO	EPO	No	No	Various on facility/ non-preventive surgical services	Various	No	Up to $7,350/ $14,700	Yes
National Network	EmblemHealth InBalance PPO	PPO	No	No	IN: Various on facility/ non-preventive surgical services OON: Various	Various	Yes	Up to $7,350/ $14,700	Yes

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; Req'd = Required; Co-ins. = Co-insurance.

[1]Copays are $10 for telemedicine physicians [and $5 for dietitians/nutritionists] for Federal Employee Health Benefit (FEHB) plans' telemedicine coverage.

Note: Member ID cards for plans associated with the Comprehensive Benefits Plan (CBP) Network may display the network name as CBP, EPO, EPO1, EPO2, PPO, PPO1, or PPO4.

GHI Plan Descriptions

EmblemHealth HDHP Programs: ConsumerDirect EPO and ConsumerDirect PPO

To meet the growing demand for consumer-directed health care, EmblemHealth has two high-deductible health plans (HDHP), ConsumerDirect EPO and ConsumerDirect PPO. These benefit plans allow employers and employees more power and choice in how to spend their health care dollars and make health care decisions.

Depending on the HDHP selected and other factors, members may also establish a separate health savings account (HSA) to pay for qualified medical expenses with tax-free dollars. Individual HSAs are member owned, and contributions, interest, and withdrawals are generally tax-free.

For members, ConsumerDirect EPO and ConsumerDirect PPO benefit plans feature:

- Lower monthly premiums based on higher annual deductibles.
- Network and out-of-network coverage for the PPO plan.
- No non-emergent coverage for out-of-network services for the EPO plan.
- No out-of-pocket costs for covered preventive care in network.

HealthEssentials

HealthEssentials is an EmblemHealth EPO plan designed for people seeking health coverage primarily for catastrophic injury or illness. Its core benefits are hospital and preventive care services and three additional office visits.

The HealthEssentials plan features:

- Network hospital or ambulatory surgical center benefits.
  - Inpatient and outpatient hospital services provided in and billed by a network hospital or facility.
  - Well-Baby and Well-Child Care provided by a network practitioner.
  - Emergency room services (provided in and billed by a hospital or facility).
  - Inpatient and outpatient mental health and chemical dependency services provided in and billed by a network hospital or facility.
- Covered preventive care services consistent with guidelines of the Patient Protection and Affordable Care Act.
  - Preventive care services covered at 100 percent when provided by a network practitioner.
  - Sick visits not covered.
- Pharmacy benefit.
  - $15 generic drug card.

Note: With the exception of preventive care services provided by network practitioners, services billed by a practitioner are not covered under this plan except for three office visits.

HIP Commercial Networks

Commercial Networks Covered by Agreements with HIP Health Plan, HIP Health Plan of New York, Health Insurance Plan of Greater New York, HIP Network Services, IPA. and HIP Insurance Company of New York

Our HMO plans only offer in-network coverage for non-emergent services. If you see a member who is NOT in a plan associated with your participating network(s), and no prior approval has been given, the member may incur a surprise bill or avoidable expenses. So when a member calls for an appointment, be sure to check that you participate in the member's plan at that location. If you do not participate in their plan, please refer them back to our online directory, Find-A-Doctor, to find a provider in their network.

Prime Network

Large Group: The Prime Network includes a robust network of practitioners, hospitals, and facilities in 28 New York state counties: Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester. New Jersey Qualcare HMO Network services a variety of HMO and POS plans. ConnectiCare Network services a variety of HMO, POS, and EPO plans.

Small Group: The Prime Network includes a robust network of practitioners, hospitals, and facilities in 28 New York state counties. Small Group plan members also have access to providers in New Jersey via Qualcare's network, and Connecticut via ConnectiCare's network.

Small Group Standard plans follow the plan designs established by New York state, and Nonstandard plans can change the cost-sharing required in any benefit category.

*Providers must have an open panel (accepting new members), and be a provider that can be considered a primary care physician (PCP) following all existing business rules.

Select Care Network

The Select Care Network is located in the following New York state counties: Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland,

Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester.

The Select Care Network, a subset of our existing Prime Network, is a tailored network that helps keep costs down and supports an integrated model of care. Providers in the Select Care Network are chosen on measures such as geographic location, hospital affiliations, and sufficiency of services. The network includes a full complement of physicians, hospitals, community health centers, facilities, and ancillary services. Urgent care and immediate care are also available.

EmblemHealth offers six Small Group plans on the Select Care Network.

EmblemHealth offers seven individual plans on the Select Care Network. These benefit plans are offered both on and off the NY State of Health: The Official Health Plan Marketplace. EmblemHealth Silver Value and EmblemHealth Gold Value plans, both non-standard plans, provide a specific number of primary care physician (PCP) visits at no cost before the deductible. The plans offer acupuncture, dental, and vision benefits for adults and children.

Individual and Small Group Standard plans follow the plan designs established by New York state, and Nonstandard plans can change the cost-sharing required in any benefit category.

Our Select Care Network plans are HMOs. All non-emergency care must be provided by Select Care Network providers. Most plans require referrals and prior authorization for certain services. To locate the closest care for your patient, please use the-Find A-Doctor online directory at emblemhealth.com/find-a-doctor.

Note: Most of these plans have a deductible that applies to in-network services.

Wellness Visits: Large Group and Small Group plan members are eligible for an annual wellness visit once every benefit plan year. Individual plan members are eligible for an annual wellness visit once every calendar year. Please log in to emblemhealth.com/providers to check the member's Benefit Summary.

Telemedicine: EmblemHealth Small Group Prime Network plans, Individual and Small Group Select Care Network plans both on- and off-exchange and the Essential Plan offer telemedicine services at no cost. EmblemHealth Basic plan off-exchange offers telemedicine at 0% after deductible.

HIP Commercial and Child Health Plus Networks and Plan Summary for 2019

(Prime Network and Select Network)

Network	Plan Name	Plan Type	PCP Req'd	Referral Req'd	Deductibles (Ind/Family)	PCP/ Special/ ER Copay	OON Coverage	MOOP (Ind/ Family)	Co-ins.
Prime Network	HIP Prime® POS	POS	Yes	Yes	IN: N/A OON: Various	Various	Yes	Up to $7,350/ $14,700	OON only
Prime Network	HIP Prime® PPO	PPO	No	No	IN: N/A OON: Various	Various	Yes	Up to $7,350/ $14,700	OON only
Prime Network	HIPaccess® II	POS	Yes	No	IN: N/A OON: Various	Various	Yes	Up to $7,350/ $14,700	OON only
Prime Network	HIP Prime® HMO	HMO	Yes	Yes	N/A	Various	No	Up to $7,350/ $14,700	No
Prime Network	HIPaccess® I	HMO	Yes	No	N/A	Various	No	Up to $7,350/ $14,700	No

Prime Network	HIP Select® PPO	PPO	No	No	IN: Various on facility services OON: Various	Various	Yes	Up to $7,350/ $14,700	Yes
Prime Network	Child Health Plus	HMO	Yes	Yes	N/A	No	No	N/A	No
Prime Network	GHI HMO	HMO	Yes	Yes	N/A	Various	No	Up to $7,350/ $14,700	No
Prime Network	Vytra HMO	HMO	Yes	Yes	N/A	Various	No	Up to $6,850/ $13,700	No
Prime Network	EmblemHealth EPO Value	EPO	No	No	Various	Various	No	Up to $7,350/ $14,700	No
Prime Network	EmblemHealth HMO Plus	HMO	Yes	Yes	Various	Various	No	Up to $7,350/ $14,700	No
Prime Network	EmblemHealth HMO Preferred Plus	HMO	Yes	Yes	Various	Various	No	Up to $7,350/ $14,700	No
Prime Network	HMO Preferred (City)	HMO	Yes	Yes	No	$0/ $0/ $150 $10/ $10/ $150	No	$7,150/ $14,300	No
Select Care Network	EmblemHealth Platinum	HMO	Yes	Yes	IN:$0	$15/ $35 /$100	No	Up to $2,000/ $4,000	No
Select Care Network	EmblemHealth Gold	HMO	Yes	Yes	IN: $600/ $1,200	$25/ $40/ $150	No	Up to $4,000/ $8,000	No
Select Care Network	EmblemHealth Silver	HMO	Yes	Yes	IN: $1,700/ $3,400	$30/ $50/ $250	No	Up to $7,500/ $15,000	No
Select Care Network	EmblemHealth Bronze	HMO	Yes	Yes	IN: $4,000/ $8,000	50%	No	Up to $7,600/ $15,200	Yes
Select Care Network	EmblemHealth Basic	HMO	Yes	Yes	IN: $7,900/ $15,800	0%	No	Up to $7,900/ $15,800	Yes

Select Care Network	EmblemHealth Gold Value	HMO	Yes	Yes/	IN: $3,000/ $6,000	$45**/ $65**/ $0 (3 free PCP visits)	No	Up to $3,000/ $6,000	No
Select Care Network	EmblemHealth Silver Value	HMO	Yes	Yes	IN: $3,000 /$6,000	$35**/ $70**/ $0 (3 free PCP visits)	No	Up to $6,100/ $12,200	No
Select Care Network	EmblemHealth Platinum D	HMO	Yes	Yes	IN:$0	$15/ $35/ $100	No	Up to $2,000/ $4,000	No
Select Care Network	EmblemHealth Gold D	HMO	Yes	Yes	IN: $600/ $1,200	$25/ $40/ $150	No	Up to $4,000/ $8,000	No
Select Care Network	EmblemHealth Silver D	HMO	Yes	Yes	IN: $1,700/ $4,000	$30/ $50/ $250	No	Up to $7,500/ $15,000	No
Select Care Network	EmblemHealth Bronze D	HMO	Yes	Yes	IN: $2,000/ $4,000	50%	No	Up to $7,6,00/ $15,200	Yes
Select Care Network	EmblemHealth Basic D	HMO	Yes	Yes	IN: $7,900/ $15,800	0%	No	Up to $7,900 / $15,800	Yes
Select Care Network	EmblemHealth Gold Value D	HMO	Yes	Yes	IN: $3,000/ $6,000	$45**/ $65**/ $0 (3 free PCP visits)	No	Up to $3,000/ $6,000	No
Select Care Network	EmblemHealth Silver Value D	HMO	Yes	Yes	IN: $6,100/ $12,200	$35**/ $70**/ $0 (3 free PCP visits)	No	Up to $6,100/ $12,200	No
Prime Network	EmblemHealth Platinum Premier	HMO	Yes	No	IN: $0 Rx deductible $0	$15/ $35/ $200	No	Up to $2,000/ $4,000	No

Prime Network	EmblemHealth Gold Premier	HMO	Yes	No	IN: $450/$900 Rx deductible $0	$30**/ $50**/ $300 (3 free PCP visits)	No	Up to $4,000/ $8,000	No
Prime Network	EmblemHealth Gold Premier[1]	HMO	Yes	No	IN: $2,000/ $4,000 Rx deductible $100/$200	$30**/ $60**/ $500	No	Up to $6,800/ $13,600	Yes
Prime Network	EmblemHealth Gold Plus	HMO	Yes	Yes	IN: $550/$1,100 Rx deductible $0	$40**/ $60**/ $300 (3 free PCP visits)	No	Up to $4,500/ $9,000	No
Prime Network	EmblemHealth Gold Plus[1]	HMO	Yes	Yes	IN: $1,000 /$2,000 Rx deductible $100/$200	$30**/ $60**/ $300	No	Up to $4,000/ $8,000	No
Prime Network	EmblemHealth Healthy NY Gold	HMO	Yes	Yes	IN: $600/ $1,200	$25/ $40/ $150	No	Up to $4,000/ $8,000	No
Prime Network	EmblemHealth Silver Premier	HMO	Yes	No	IN: $3,300/ $6,600 Rx deductible $0	$30**/ $55**/ $500 (3 free PCP visits)	No	Up to $7,000/ $14,000	No
Prime Network	EmblemHealth Silver Premier[1]	HMO	Yes	Yes	IN: $2,700/ $5,400 Rx deductible $200/$400	$40**/ $70**/ 30%	No	Up to $7,300/ $14,600	Yes
Prime Network	EmblemHealth Silver Plus	HMO	Yes	Yes	IN: $2,550/ $5,100 Rx deductible $0	$40/ $60/ $500 (3 free PCP visits)	No	Up to $7,300/ $14,600	No

Prime Network	EmblemHealth Silver Plus[1]	HMO	Yes	No	IN: $3,000/ $6,000 Rx deductible $200/$400	$35**/ $55**/ $700	No	Up to $7,000/ $14,000	Yes
Prime Network	EmblemHealth Bronze Plus H.S.A.	HMO	Yes	Yes	IN: $5,500/ $11,000	50%	No	Up to $6,550/ $13,100	Yes
Select Care Network	EmblemHealth Platinum Choice	HMO	Yes	No	IN: $200/ $400	$15**/ $35**/ $200	No	Up to $2,200/ $4,400	No
Select Care Network	EmblemHealth Gold Choice	HMO	Yes	No	IN: $750/ $1,500	$30**/ $50**/ $300 (3 free PCP visits)	No	Up to $5,000/ $10,000	No
Select Care Network	EmblemHealth Gold Value	HMO	Yes	Yes	IN: $3,000/ $6,000	$45**/ $65**/ $0 (3 free PCP visits)	No	Up to $3,000/ $6,000	No
Select Care Network	EmblemHealth Silver Choice	HMO	Yes	No	IN: $2,800/ $5,600	$30**/ $50/ $500 (3 free PCP visits)	No	Up to $7,100/ $14,200	No
Select Care Network	EmblemHealth Silver Value	HMO	Yes	Yes	IN: $6,300/ $12,600	$35**/ $70**/ $0 (3 free PCP visits)	No	Up to $6,100/ $12,600	No
Select Care Network	EmblemHealth Bronze Value	HMO	Yes	Yes	IN: $7,690/ $15,380	0% (3 free PCP visits)	No	Up to $7,690/ $15,380	Yes

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; Req'd = Required; Co-ins. = Co-insurance.

* Note: If your patient has the Access I, Access II, or other Direct Access benefit plan, with or without the HCP logo, the member does not need a referral to see a specialist. However, for plans that do require referrals and the member ID card has the HCP logo, please follow HCP's referral process.

** Benefit is not subject to deductible.

HIP Commercial Plan Descriptions

Child Health Plus

Child Health Plus (CHP) is a New York state-sponsored program that provides uninsured children under 19 years of age with a full

range of health care services for free or for a low monthly cost, depending on family income. In addition to immunizations and Well-Child care visits, CHP covers pharmaceutical drugs, vision, dental, and mental health services. There are no copays for CHP members for any covered services. CHP members may visit any one of our Prime Network providers that see children.

The service area for CHP includes the following New York state counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. CHP members are covered for emergency care in the U.S., Puerto Rico, the Virgin Islands, Mexico, Guam, Canada, American Samoa and the Northern Mariana Islands.

Enrollment period restrictions do not apply to CHP. Eligible individuals may enroll in CHP throughout the year via theNY State of Health Marketplace or through enrollment facilitators.

Continuity of Care for Our Members

We make every effort to assist new members whose current providers are not participating with one of our plans. We do the same when a health care professional or facility leaves the network. See the Continuity/Transition of Care - New Members and Continuity of Care - When Providers Leave the Network sections of the Care Managementchapter for information on transitions of care.

EmblemHealth

Medicaid and HARP Plan Summaries

The table below summarizes the network and benefit plans for our Medicaid and HARP members.

HIP Medicaid Network and Plan Summary for 2019
Enhanced Care Prime Network

Network	Plan Name	Plan Type	PCP Req'd	Referral Req'd	OON Coverage	In-Network Cost-Sharing	Service Area[1]	Comments
Enhanced Care Prime Network[1]	EmblemHealth Enhanced Care	HMO	Yes[2]	Yes[2]	Yes[3]	Rx Copays	8 county	Medicaid Managed Care plan for Medicaid-eligible individuals[4]including Medicaid children's health and behavioral health benefits
Enhanced Care Prime Network[1]	EmblemHealth Enhanced Care Plus	HMO	Yes[2]	Yes[2]	Yes[3]	Rx Copays	8 county	HARP for Medicaid-eligible individuals aged 21 and older[4]

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; FPL = federal poverty level; Req'd = Required

8 county = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Nassau, Suffolk, & Westchester counties. NYC = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, & Richmond (Staten Island) Counties.

[1]Medicaid and HARP members traveling outside of the continental United States can get coverage for urgent and emergency care only in the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Members needing any type of care while in any other country (including Canada and Mexico) will be responsible for payment.

[2]Except for self-referral services and services that Medicaid members can access from Medicaid FFS providers.

[3]Medicaid members can access certain services from county departments of health and academic dental centers. (See the Access to Care and Delivery Systems chapter for a list of applicable services where OON coverage applies.)

[4]See Medicaid Managed Care Model Contract for more details.

EmblemHealth

Essential Plan Summaries

The table below summarizes the network and benefit plans for our Essential Plan members.

HIP Commercial Network and Plan Summary for 2019
Enhanced Care Prime Network

Network	Plan Name	Plan Type	PCP Req'd	Referral Req'd	Deductibles (Ind/ Family)	PCP/ Special/ ER Copay	OON Coverage	MOOP (Ind/ Family)	Service Area	Co-ins.
Enhanced Care Prime Network[1]	Essential Plan 1	HMO	Yes	Yes	N/A	$15/$25/$75	No	$2,000	8 county	Yes, for certain services
Enhanced Care Prime Network[1]	Essential Plan 1 Plus	HMO	Yes	Yes	N/A	$15/$25/$75	No	$2,000	8 county	Yes, for certain services
Enhanced Care Prime Network[1]	Essential Plan 2	HMO	Yes	Yess	N/A	$0 copay	No	$200	8 county	No
Enhanced Care Prime Network[1]	Essential Plan 2 Plus	HMO	Yes	Yes	N/A	$0 copay	No	$200	8 county	No
Enhanced Care Prime Network[1]	Essential Plan 3	HMO	Yes	Yess	N/A	$0 copay	No	$200	8 county	No

Enhanced Care Prime Network[1]	Essential Plan 4	HMO	Yes	Yess	N/A	$0 copay	No	$0	8 county	No

ER = emergency room; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; Req'd = Required; Co-ins. = Co-insurance

8 county = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Nassau, Suffolk, & Westchester counties.

[1]Enhanced Care Prime Network members traveling outside of the United States can get coverage for urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Members needing any type of care while in any other country (including Canada and Mexico) will be held responsible for payment.

Essential Plan

The Essential Plan is a low-cost plan for adult individuals available on the NY State of Health Marketplace. As with Qualified Health Plans (QHPs), the Essential Plan includes all benefits under the 10 categories of the ACA-required Essential Health Benefits. Premiums for the Essential Plan are either $0 or $20.

The Essential Plan includes members from two already-existing member populations – a subset of the current QHP EmblemHealth Silver population and the current Medicaid Aliessa population. The Aliessa population is New York's legally residing immigrant population. Eligible individuals in the Aliessa population, who previously were only eligible for coverage through state-only-funded Medicaid, will transition into the Essential Plan. Essential Plan members are covered for emergency care in the U.S., Puerto Rico, the Virgin Islands, Mexico, Guam, Canada, and the Northern Mariana Islands.

Eligibility

The Essential Plan covers adult individuals only. If eligible, spouses and children must enroll into Essential Plan separately under an individual policy. To qualify for the Essential Plan, individuals must:

- Be a New York state resident.
- Be between the ages of 19 and 64 (U.S. citizens) or 21 to 64 (legally residing immigrants).
- Not be eligible for Medicare, Medicaid, Child Health Plus, affordable health care coverage from an employer, or another type of minimum essential health coverage.
- Be either:
  - A U.S. citizen (residing in New York) with an income between 138% and 200% of the federal poverty level (FPL).
    - These individuals were formerly eligible for a QHP Silver Plan, but will now transition to Essential Plan based on income status.
  - Legally residing immigrant with an income of less than 138% of FPL.
    - These individuals were formerly eligible for Medicaid, but have been transitioned to Essential Plan based on immigration status (also known as Aliessa population).
- Not be pregnant or eligible for long-term care. In both of these cases, members would be eligible for Medicaid instead of the Essential Plan.

Covered Services

Ten categories of essential health benefits are covered with no cost-sharing (no deductible, copay, or coinsurance) on preventive care services, such as screenings, tests, and shots. For more information, please see the Preventive Health Guidelines located on our Health and Wellness webpage. Information in our guidelines comes from medical expert organizations, such as the American Academy of Pediatrics, the U.S. Department of Health and Human Services, the Advisory Committee on Immunization Practices, and

the Centers for Disease Control and Prevention (CDC).

Unlike QHP Standard Plans, some Essential Plan members are also eligible for adult vision and dental benefits for a small additional monthly cost. The Aliessa population receives six additional benefits at no extra cost. These include: dental, vision, non-emergency transportation, non-prescription drugs, orthopedic footwear, and orthotic devices.

EmblemHealth

Medicare Network and Plan Summary

The table below summarizes our Medicare HMO/POS suite of products. Special Needs plans are located within the Medicare Special Needs Plans section of this chapter.

HIP Medicare HMO/POS Network and Plan Summary for 2019
(VIP Prime Network)

Network	Plan Name	Plan Type	PCP Req'd	Referral Req'd	OON Coverage	In-Network Cost-Sharing	Service Area	Comments
VIP Prime Network	EmblemHealth VIP Value	EmblemHealth Medicare HMO	Yes	Yes	No	Copays/ coinsurance	12 counties	$15 PCP copays Provider should confirm participation as PCP prior to accepting new patients.
VIP Prime Network	EmblemHealth VIP Essential	EmblemHealth Medicare HMO	Yes/	Yes	No	Copays/ coinsurance	14 counties	$0 PCP copays Provider should confirm participation as PCP prior to accepting new patients.
VIP Prime Network	EmblemHealth VIP Gold	EmblemHealth Medicare HMO	Yes	Yes	No	Copays/ coinsurance	14 counties	$10 Chiropractic copays
VIP Prime Network	EmblemHealth VIP Gold Plus	EmblemHealth Medicare HMO	Yes	Yes	No	Copays/ coinsurance	14 counties	$0 PCP copays $0 Specialist copays
VIP Prime Network	EmblemHealth VIP Premier	EmblemHealth Medicare HMO	Yes	Yes	No	Copays/ coinsurance	14 counties	Employer Group plan.
VIP Prime Network	EmblemHealth VIP Rx Carve-out	EmblemHealth Medicare HMO	Yes	Yes	No	Copays/ coinsurance	14 counties	Employer Group plan.

VIP Prime Network	EmblemHealth VIP Rx Saver	EmblemHealth Medicare HMO	Yes	Yes	No	Copays/ coinsurance	2 counties	$5 PCP copays and Comprehensive dental and fitness benefits with no maximums
VIP Prime Network	EmblemHealth VIP Part B Saver	EmblemHealth Medicare HMO	Yes	Yes	No	Copays/ coinsurance/ deductible applies to some services	14 counties	Optional dental and fitness benefit riders are available at a low cost
VIP Prime Network	EmblemHealth VIP Go	EmblemHealth Medicare HMO-POS	No	No	Yes	Copays/ coinsurance/ deductible applies to some services	14 counties	Out-of-network coverage allowed on many benefits
VIP Prime Network	EmblemHealth Affinity Passport Medicare Essentials	Affinity Medicare HMO	Yes	Yes	No	Copays/ coinsurance	4 counties	$5 PCP copays Dental, Vision and Hearing Coverage Acupuncture Fitness Program (Silver Sneakers)
VIP Prime Network	EmblemHealth Affinity Medicare Passport Essentials NYC	Affinity Medicare HMO	Yes	Yes	No	Copays/ coinsurance	5 counties	$10 PCP copays Dental, Vision and Hearing Coverage Acupuncture Fitness Program (Silver Sneakers)

OON = out-of-network; PCP = primary care provider.; Req'd = Required

14 county[1] = New York City (Bronx, Kings, New York, Queens, Richmond), Nassau, Suffolk, Orange, Rockland, Westchester , Dutchess, Sullivan, Ulster, and Putnam

12 county[2] = New York, Queens, Richmond, Nassau, Suffolk, Orange, Rockland, Westchester, Dutchess, Sullivan, Ulster, and Putnam

2 county[3]=Bronx, Westchester

4 county[4]= Orange, Rockland, Westchester and Nassau

5county[5]= New York, Bronx, Kings, Queens and Richmond

Members are covered for urgent and emergency care. HIP covers members in all 50 United States, Canada, Mexico, Puerto Rico, the U.S. Virgin Islands, Guam, and the Northern Mariana Islands. Medicare members have worldwide urgent and emergency coverage.

EmblemHealth Affinity Passport Medicare Essentials (HMO), EmblemHealth Affinity Medicare Passport Essentials NYC (HMO), EmblemHealth VIP Essential (HMO), EmblemHealth VIP Gold (HMO), and EmblemHealth VIP Gold Plus (HMO) members have access

to SilverSneakers® membership, an exercise program designed for older adults.

GHI Medicare Network and Plan Summary for 2019
Medicare Choice PPO Network

Network	Plan Name	Plan Type	PCP Req'd	Referral Req'd	OON Coverage	In-Network Cost-Sharing	Service Area	Comments
Medicare Choice PPO Network	EmblemHealth Group Access PPO	EmblemHealth Medicare PPO	No	No	Yes	Copays/ coinsurance	National	Employer Group MAPD plan. Each group contracts individually with the plan for benefit design. Pharmacy benefits excluded.
Medicare Choice PPO	GHI Retirees		No	No				
N/A	EmblemHealth National Drug Plan	EmblemHealth Medicare PDP	N/A	N/A	Yes	Copays/ coinsurance	National	Part D drug Coverage

EmblemHealth

Medicare Special Needs Plans Summary

The summary table below outlines the key components of the SNPs, such as Medicaid eligibility level, service area, and whether referrals are needed.

HIP Medicare Special Needs Network and Plan Summary for 2019 (VIP Prime Network)								
Network	Plan Name	Plan Type	PCP Req'd	Referral Req'd	OON Coverage	In-Network Cost-Sharing	Service Area	Comments
VIP Prime Network	EmblemHealth VIP Dual	EmblemHealth Medicare HMO	Yes	Yes	No	Copays/ Coinsurance	14 counties	Individual Medicare Plan. Special needs plan limited to individuals with both Medicare and full Medicaid coverage. Individuals with full Medicaid coverage are not required to pay cost-sharing.
VIP Prime Network	EmblemHealth VIP Dual Group	EmblemHealth Medicare HMO	Yes	Yes	No	Copays/ Coinsurance	14 counties	Employer Group Plan. Special needs plan limited to individuals with both Medicare and full Medicaid coverage. Individuals with full Medicaid coverage are not required to pay cost-sharing.

VIP Prime Network	EmblemHealth Affinity Medicare Ultimate	Affinity Medicare HMO SNP	Yes	Yes	No	Copays/ Coinsurance	10 counties	$0 PCP Copay, $0 Specialist Copay, Dental, Vision and Hearing Coverage, and OTC benefit at $60 Per Month/$720.
VIP Prime Network	EmblemHealth Affinity Medicare Solutions	Affinity Medicare HMO SNP	Yes	Yes	No	Copays/ Coinsurance	10 counties	$0 PCP Copay, Dental, Vision and Hearing Coverage, and Routine Transportation.

OON = out-of-network; PCP = primary care provider; OTC= over-the-counter; Req'd = Required.

14 county[1] = New York City (Bronx, Kings, New York, Queens, Richmond), Nassau, Suffolk, Orange, Rockland, Westchester, Dutchess, Sullivan, Ulster, and Putnam

10 county[2] = Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk and Westchester

EmblemHealth

Provider Manual

Chapter 6: 2019 Provider Networks and Member Benefit Plans

Overview

This chapter contains information about our Provider Networks and Member Benefit Plans. Providers may be required to sign multiple agreements in order to participate in all the benefit plans associated with our provider networks. EmblemHealth may amend the benefit programs and networks from time to time. If we do, we will send advance notice to affected providers.

In this chapter, plan information is presented in the following sections:

- Commercial and Child Health Plus
- Medicaid Managed Care/HARP/Essential Plan
- Medicare
- Medicare Special Needs Plans (SNPs)

Underwriting Companies

EmblemHealth's HIP HMO, GHI HMO, and Vytra HMO plans are underwritten by Health Insurance Plan of Greater New York. HIP POS plans are underwritten by both Health Insurance Plan of Greater New York and HIP Insurance Company of New York (HIPIC), and HIP EPO/PPO plans are underwritten by HIPIC. EmblemHealth's GHI EPO/PPO plans are underwritten by Group Health Incorporated (GHI).

Know Your Networks

You can help your patients keep their costs down by using in-network services and providers. To do this, you need to understand:

- Your own network participation.
  Knowing your network participation is critical. It will determine whether you are in-network for your patient and which facilities and health care professionals you may coordinate with in the care of your EmblemHealth patients.

- View video

- How to identify the network your patients can access.
  See our Access to Care chapter for instructions for keeping your information current.
  - View video
  - Look at the Member ID Cards.
  - Use provider portal – View Take a Tour.

- How to refer your patients for services and identify in-network facilities.
  - Help your members avoid surprise bills and avoidable costs by keeping care in-network even if no formal referral is needed for the benefit plan. Examples of plans that do not require referrals include:

    Commercial

    • Access I
    • Access II
    • EmblemHealth Platinum Choice
    • EmblemHealth Gold Choice
    • EmblemHealth Silver Choice
    • EmblemHealth Gold Premier 1
    • EmblemHealth Silver Plus 1
    • EmblemHealth Silver Premier
    • EmblemHealth Platinum Premier
    • EmblemHealth Gold Premier
    • EmblemHealth EPO Value
    • EmblemHealth EPO Value HDHP

    Medicare

    • EmblemHealth VIP GO
    • EmblemHealth Affinity Medicare Ultimate (HMO SNP)
    • EmblemHealth Affinity Medicare Solutions (HMO SNP)
    • EmblemHealth Affinity Medicare Passport Essentials (HMO)
    • EmblemHealth Affinity Medicare Passport Essentials NYC (HMO)

  - Use "Find-A-Doctor"
  - "Referral & Prior Approval" feature has doctor search feature that will return results that are limited to the member's network.
  - Use our hospital PEAR grid to see which hospitals are in-network and which have participating pathology, emergency, anesthesia, and radiology (PEAR) physician groups to help guide where you admit your patients.

- In addition to the networks described in this chapter, you are required to utilize and refer your patients to appropriate participating laboratories, and other ancillary services that make up the networks our members are entitled to access. Generic referrals should never be given.

Keep Your Information Current

Our mutual success is contingent on our having accurate information on file for all of our network providers. You are

required to tell us if your information changes. See our Access to Care chapter for instructions on how to keep your information current. Please make sure we have a valid email address so you can receive important updates and reminders.

Summary Table: Companies, Networks & Benefit Plans

The following table summarizes how our Provider Networks and Member Benefit Plans relate to our underwriting companies. You can print this page as a reference tool for the staff who schedule appointments for you. Check the boxes to show them which networks your contract covers. The blank spaces allow you to customize for each practice location.

Dr._____at _____can accept patients who have these networks:

Company	Provider Network	Member Benefit Plan
GHI	Commercial: CBP Network (Member ID cards may show: CBP, EPO, EPO1, EPO2, PPO, PPO1 or PPO4)	New York City Plans - GHI CBP plan - DC37 Med-Team
	Commercial: National Network Tristate Network	EmblemHealth EPO/PPO
	Commercial: Network Access Network	Network Access Plan
	Medicare: Medicare Choice PPO Network	EmblemHealth Group Access Rx (PPO) EmblemHealth Group Access Rx National (PPO) ArchCare Advantage HMO SNP

	Commercial: Select Care Network	Individual On/Off Exchange: - EmblemHealth Platinum/EmblemHealth Platinum D - EmblemHealth Gold/EmblemHealth Gold D - EmblemHealth Silver/EmblemHealth Silver D - EmblemHealth Bronze/EmblemHealth Bronze D - EmblemHealth Basic/EmblemHealth Basic D - EmblemHealth Gold Value/EmblemHealth Gold Value D - EmblemHealth Silver Value/EmblemHealth Silver Value D	Small Group: - EmblemHealth Platinum Choice - EmblemHealth Gold Choice - EmblemHealth Gold Value S - EmblemHealth Silver Choice - EmblemHealth Silver Value S - EmblemHealth Bronze Value S

HIP/HIPIC	Commercial: Prime Network	Prime Network – NYC, LI & Westchester - Child Health Plus Large Group – Prime Network with Tristate Access: - Prime HMO - HIP HMO Preferred (City of NY) - EmblemHealth HMO Plus - EmblemHealth HMO Preferred Plus - Prime POS - Access I - Access II - EmblemHealth EPO Value - GHI HMO - Vytra HMO Large Group – Prime Network: - Prime PPO - HIP Select PPO	Small Group - Prime Network with Tristate Access: - EmblemHealth Platinum Premier - EmblemHealth Gold Premier - EmblemHealth Gold Premier[1] - EmblemHealth Gold Plus - EmblemHealth Gold Plus[1] - EmblemHealth Healthy NY Gold - EmblemHealth Silver Premier - EmblemHealth Silver Premier[1] - EmblemHealth Silver Plus - EmblemHealth Silver Plus[1] - EmblemHealth Bronze Plus H.S.A.
	Medicaid/Commercial: Enhanced Care Prime Network	EmblemHealth Enhanced Care (Medicaid) EmblemHealth Enhanced Care Plus (HARP) Essential Plan (BHP)	
	Medicare: VIP Prime Network	EmblemHealth VIP Dual (HMO SNP) EmblemHealth VIP Gold (HMO) EmblemHealth VIP Gold Plus (HMO) EmblemHealth VIP Premier (HMO) EmblemHealth VIP Rx Carve-Out (HMO) EmblemHealth VIP Dual Group (HMO SNP) EmblemHealth VIP Rx Saver (HMO) EmblemHealth VIP Part B Saver (HMO)	EmblemHealth VIP Go (HMO-POS) EmblemHealth VIP Essential (HMO) EmblemHealth VIP Value (HMO) EmblemHealth Affinity Medicare Passport Essentials (HMO) EmblemHealth Affinity Medicare Passport Essentials NYC (HMO) EmblemHealth Affinity Medicare Ultimate (HMO SNP) EmblemHealth Affinity Medicare Solutions (HMO SNP)

ConnectiCare, Inc.	Commercial: Choice Network (includes full Prime Network) Passage Network (includes Prime Network except PCPs)	Choice HMO Choice POS Passage HMO Passage POS
ConnectiCare Insurance Company, Inc.	Commercial: Choice Network (includes full Prime Network) Flex Network (includes full Prime Network) Passage Network (includes Prime Network except PCPs)	Choice EPO Choice POS FlexPOS Passage EPO Passage POS
	Medicare: Passage Network	Medicare Advantage HMO-SNP Plans
ConnectiCare of Massachusetts	Commercial: Choice Network (includes full Prime Network)	Choice HMO Choice POS

Member Benefit Summaries

The benefits available to our members are provided in accordance with the terms of the members' benefit plans. Below, we provide links to sample benefit summaries for the following plans:

Note: These sample benefit summaries are provided for informational use only. They do not constitute an agreement, do not contain complete details of the plan benefits and cost-sharing, and the benefits may vary based on riders purchased. To view a member's actual benefits, sign in to our secure provider website at emblemhealth.com/Providers, and use the Eligibility/Benefits function.

- EmblemHealth Platinum Choice
- EmblemHealth Gold Choice
- EmblemHealth Gold Value
- EmblemHealth Silver Choice
- EmblemHealth Silver Value
- EmblemHealth Bronze Value
- EmblemHealth Basic
- EmblemHealth Essential

Commercial and Child Health Plus Networks

To review commercial networks covered by agreements please see here.

Medicaid Managed Care/HARP/Essential Plan

Medicaid Recertification

It's important that you and your staff remind Medicaid members to recertify with their local Department of Social Services or the health exchange about two months prior to their Eligibility End Date. If members do not recertify by the Eligibility End Date, they will lose eligibility for Medicaid, lose their health insurance coverage, and will have to reapply for Medicaid.

To help ensure that Medicaid members retain their coverage and don't lose access to valuable care, the Medicaid Recertification or Eligibility End Date is being added to the Health Care Eligibility Benefit Inquiry and Response (270/271) report for those that are close to their recertification dates.

Members requiring assistance with recertification should contact our Marketplace Facilitated Enrollers at 888-432-8026.

Mandatory Enrollment of the New York City Homeless Population

According to the New York State Department of Health (NYSDOH), all of New York City's homeless population must be enrolled into Medicaid Managed Care (MMC).

Primary Care Services Offered in Homeless Shelters

Homeless members can select any participating PCP. However, to improve access to care for our members with no place of usual residence, we've expanded our provider network to include practitioners who practice in homeless shelters. A PCP practicing at a homeless shelter is available only to members who reside in that shelter.

Identifying Members

Medicaid Managed Care (MMC): EmblemHealth Enhanced Care
EmblemHealth's Medicaid Managed Care Plan is called EmblemHealth Enhanced Care. The plan name "Enhanced Care" can be found in the upper right corner of the member's ID card. The letter "R" will appear after the plan name on the ID cards of members who are in the Restricted Recipient Program (RRP).

Health and Recovery Plan (HARP): EmblemHealth Enhanced Care Plus
EmblemHealth's Health and Recovery Plan (HARP) is called EmblemHealth Enhanced Care Plus. The plan name "Enhanced Care Plus" can be found in the upper right corner of the member's ID card. The letter "R" will appear after the plan name on the ID cards of members who are in the Restricted Recipient Program (RRP).

Homeless and HARP Members Enrolled with EmblemHealth
Since homeless and HARP members may present with unique health needs, we have identified which of your Medicaid Managed Care patients are homeless and/or HARP members. The following symbols are included within the secure provider website's panel report feature:

- "H" next to the name of homeless members.
- "R" next to the name of HARP members.

”P“ next to the name of homeless HARP members.

A homeless indicator is present on eligibility extracts. The homeless indicator ”H“ is included if the member is homeless, and blank if the member is not homeless.

Restricted Recipients
EmblemHealth is also required to identify members already enrolled that need to be restricted. All EmblemHealth RRP members are in an Employer Group that begins with “1RO.” Additionally, EmblemHealth RRP member ID cards have an “R” after the plan name on the front of the card so providers will know that they are restricted (i.e., Enhanced Care - R or Enhanced Care Plus - R).

Restricted Recipient Program
MMC and HARP members are placed in the Restricted Recipient Program (RRP) when a review of their service utilization and other information reveals that they are:

- Getting care from several doctors for the same problem.
- Getting medical care more often than needed.
- Using prescription medicine in a way that may be dangerous to their health.
- Allowing someone else to use their plan ID card.
- Using or accessing care in other inappropriate ways.

The Office of the Medicaid Inspector General (OMIG) is responsible for sending previous Managed Care Organization’s restriction notification for new enrollee to EmblemHealth within 30 days.

RRP members are restricted to certain provider types (dentists, hospitals, pharmacies, behavioral health professionals, etc.) based on a history of overuse or inappropriate use of specific services. Members are further restricted to using a specific provider of that type. EmblemHealth is required to continue the Medicaid Fee-for-Service (FFS) program restrictions for MMC and HARP members until their existing restriction period ends.

Neither the provider nor enrollee may be held liable for the cost of services when the provider could not have reasonably known that the enrollee was restricted to another provider. See above for instructions for identifying restricted recipients.

To report suspicious activity, please contact EmblemHealth’s Special Investigations Unit in one of the following ways:

E-mail: KOfraud@emblemhealth.com
Toll-free hotline: 888-4KO-FRAUD (888-456-3728)
Mail:
EmblemHealth
Attention: Special Investigations Unit
55 Water Street
New York, NY 10041

A trained investigator will address your concerns. The informant may remain anonymous. For more information, please see the Fraud and Abuse chapter.

NYSDOH Medicaid Provider Non-Interference

Medicaid providers and their employees or contractors are not permitted to interfere with the rights of Medicaid recipients in making decisions about their health care coverage. Medicaid providers and their employees or contractors are free to inform Medicaid recipients about their contractual relationships with Medicaid plans. However, they are prohibited from directing, assisting, or persuading Medicaid recipients on which plan to join or keep.

In addition, if a Medicaid recipient expresses interest in a Medicaid Managed Care program, providers and their employees or contractors must not dissuade or limit the recipient from seeking information about Medicaid Managed Care programs. Instead, they should direct the recipient to New York Medicaid Choice, New York state’s enrollment

broker responsible for providing Medicaid recipients with eligibility and enrollment information for all Medicaid Managed Care plans.

For assistance, please call New York Medicaid Choice: 800-505-5678, Monday to Friday, 8:30 a.m. to 8 pm, and Saturday from 10 a.m. to 6 p.m.

Any suspected violations will be turned over to the New York Office of the Medicaid Inspector General (OMIG) and potentially the Federal Office of Inspector General (OIG) for investigation.

Medicaid and HARP Benefits

Medicaid Benefits: Our Medicaid members are entitled to a standard set of benefits as set out in the Medicaid Managed Care Model Contract. They may directly access certain services. See the Direct Access (Self-Referral) Services section of the Access to Care and Delivery Systems chapter for a list of services that do not require a referral.

Below is a list of covered Home and Community Based Services (HCBS) for HARP members only. (See HCBS billing manual for full details.)

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Habilitation Services
- Family Support and Training
- Short-Term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Peer Supports
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment (ISE)
- Ongoing Supported Employment
- Care Coordination

Children's Health and Behavioral Health Benefits

Beginning January 1, 2019, EmblemHealth will manage the delivery of expanded behavioral and physical health services for Medicaid enrolled children and youth under 21 years of age. This will include medically fragile children, children with behavioral health diagnosis(es), and in 2019 children in foster care with developmental disabilities. Benefits will include Home and Community Based Services (HCBS) designed to provide children/youth access to a vast array of habilitative services (additional details can be found in the draft HCBS Manual). All HCBS are available to any child/youth determined eligible. Eligibility is based on Target Criteria, Risk Factors, and Functional Limitations. Health Homes will provide Care Management to children/youth eligible for HCBS.

Health Home Care Management for Children

Starting January 1, 2019, children eligible for HCBS will be enrolled in Health Home. The care coordination service of the children's HCBS will transition to Health Home unless the child opts out of Health Home. Health Homes will administer all HCBS assessments through the Uniform Assessment System, which will have algorithms (except for the foster care developmentally disabled (DD) and the OPWDD care at home medically fragile developmentally disabled (CAH MF) populations) to determine functional eligibility criteria. Health Homes will ensure that the child meets all

other eligibility criteria for HCBS (i.e., a child must live in a setting meeting HCBS settings criteria to be eligible for HCBS (i.e., Target and Risk criteria for LOC and LON populations). The Health Homes will develop one comprehensive plan of care that includes HCBS, as well as all the other services the member needs (e.g., health, behavioral health, specialtyservices, other community and social supports, etc.).

Health Homes is a care management service model for individuals enrolled in Medicaid with complex chronic medical and/or behavioral health needs. Health Home care managers provide person-centered, integrated physical health and behavioral health care management, transitional care management, and community and social supports to improve health outcomes of high-cost, high-need Medicaid members with chronic conditions.

EmblemHealth will collaborate with Beacon Health Options, Health Homes, and HCBS providers to gather information to support the evaluation the Enrollee's level of care; adequacy of service plans; provider qualifications; Enrollee health and safety; financial accountability and compliance, etc. EmblemHealth will utilize aggregated data from its care management and claims systems to identify trends and opportunities for improving member care.

Health Home care management not only provides comprehensive, integrated, child, and family-focused care management, but also ensures the efficient and effective implementation of the expanded array of State Plan services and HCBS. Please see the Health Homes Serving Children homepage for more information at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm Additiona strategies to promote behavioral health-medical integration for children, including at-risk populations, include:

- Provider access to rapid consultation from child and adolescent psychiatrists
- Provider access to education and training
- Provider access to referral and linkage support for child and adolescent patients

Required Training for Providers

All Enhanced Care Prime Network providers are required to complete an initial orientation and training on the expanded children's benefit and populations, including:

1. Training and technical assistance to the expanded array of providers on billing, coding, data interface, documentation requirements, provider profiling programs, and UM requirements.
2. Training on processes for assessment for HCBS eligibility (e.g., Targeting Criteria, Risk Factors, Functional Limitations) and Plan of Care development and review.
   For training opportunities, please visit our Learn Online webpage at https://www.emblemhealth.com/en/Providers/Provider-Resources/Learn-Online.

Adult Behavioral Health Covered Services

For more information on the Behavioral Health Services Program, please see the Behavioral Health Services chapter. On October 1, 2015, EmblemHealth replaced Medicaid FFS for the coverage of behavioral health services for its MMC members aged 21 and older who reside in the five boroughs of New York City. EmblemHealth covers the following additional behavioral health benefits:

- Medically supervised outpatient withdrawal services.
- Outpatient clinic and opioid treatment program services.
- Outpatient clinic services.
- Comprehensive psychiatric emergency program services.
- Continuing day treatment.
- Partial hospitalization.
- Personalized recovery-oriented services.
- Assertive community treatment.

- Intensive and supportive case management.
- Health home care coordination and management.
- Inpatient hospital detoxification.
- Inpatient medically supervised inpatient detoxification.
- Rehabilitation services for residential substance use disorder treatment.
- Inpatient psychiatric services.

Health Home Program

Under the Federal Patient Protection and Affordable Care Act (PPACA), New York state has developed a set of Health Home services for Medicaid members. In order to be eligible for Health Home services, the member must be enrolled in Medicaid and must have:

- Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*), or
- One single qualifying chronic condition: HIV/AIDS, or
- Serious Mental Illness (SMI) (Adults), or
- Serious Emotional Disturbance (SED) or Complex Trauma (Children)

If a Medicaid member has HIV or SMI, he or she does not have to be determined to be at risk of another condition to be eligible for Health Home services.

Substance use disorders (SUD) are considered chronic conditions, but the presence of SUD by itself does not qualify a member for Health Home services. Members with SUD must have another chronic condition to qualify.

The Health Home Program is offered at no cost to all eligible EmblemHealth Medicaid members. All HARP members are assigned a Medicaid Health Home Care Manager to provide care plan coordination; however, members may opt out of the program at any time. EmblemHealth will then notify the member, and his or her PCP, of the Health Home assignment by letter. The member's assigned Health Home Care Manager will contact the member's PCP to ensure the treatment plan is included in the member's comprehensive care plan.

The following services are available through the Medicaid Health Home program:

- Comprehensive case management with an assigned, personal care manager.
- Assistance with getting necessary tests and screenings.
- Help and follow-up when leaving the hospital and going to another setting.
- Personal support and support for their caregiver or family.
- Referrals and access to community and social support services.

Health Home Services and Information is also available in the Forms, Brochure & More chapter. More information on the NYS Medicaid Health Home Program can be found on the NYSDOH website.

See our guide for Health Homes that need assistance with submitting claims.

Medicaid Members who are not eligible to participate in the Medicaid Health Home Program may still meet our criteria for Case Management services. If you think a member would benefit from case management, please refer the patient to the program by calling 800-447-0768, Monday through Friday, from 9 a.m. to 5 p.m.

A listing of EmblemHealth network Health Homes that support our Medicaid and HARP benefit plans are listed in the Directory chapter.

Permanent Placement in Nursing Homes

The Medicaid Managed Care (MMC) nursing home benefit includes coverage of permanent stays in residential health care facilities for Medicaid recipients aged 21 and over who reside in the five boroughs of New York City, Westchester, Nassau, or Suffolk county. Covered nursing home services include:

- Medical supervision
- 24-hour nursing care
- Assistance with daily living
- Physical therapy
- Occupational therapy
- Speech-language pathology and other services

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.

Veterans' Nursing Homes

Eligible Veterans, Spouses of Eligible Veterans, and Gold Star Parents of Eligible Veterans may choose to stay in a Veterans' nursing home.

If EmblemHealth does not have a Veterans' home in their provider network and a member requests access to a Veterans' home, the member will be allowed to change enrollment into an MMC plan that has the Veterans' home in their network. While the member's request to change plans is pending, EmblemHealth will allow the member access to the Veterans' home and pay the home the benchmark Medicaid daily benchmark rate until the member has changed plans.

- To review Medicaid and HARP Plan Summaries please go here
- For Essential Plan Summaries please go here

How to Enroll

There are four ways to apply:

- Online. Visit NYSOH online and go to the Individuals & Families section. Once there, start an account and begin shopping for a plan.
- In person. Get help from a Navigator, certified application counselor (CAC), Marketplace Facilitated Enroller (MFE), or broker/agent.
- By phone. Call EmblemHealth at 866-274-0060, Monday through Sunday from 8 a.m. to 8 p.m., and the NYSOH at 855-355-5777, Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 9 a.m. to 1 p.m.
- By mail. Print an application at nystateofhealth.ny.gov and send it back to NYSOH, who will then confirm eligibility and enroll you in the chosen plan. Enrollment period restrictions do not apply to the Essential Plan. Eligible individuals may enroll in CHP throughout the year via the NY State of Health Marketplace or through enrollment facilitators.

Continuity of Care for Our Members

We make every effort to assist new members whose current providers are not participating with one of our plans. We do the same when a health care professional or facility leaves the network. See the Continuity/Transition of Care - New Members and Continuity of Care - When Providers Leave the Network sections of the Care Management chapter for information on transitions of care.

Medicare Networks

Medicare Plans

EmblemHealth companies HIP and GHI underwrite the Medicare plans associated with the VIP Prime Network (HIP Health Plan of Greater New York), and Medicare Choice PPO Network (Group Health Incorporated). Our Important Plan Documents section includes benefit summaries and copies of members' Evidences of Coverage for each of these Medicare plans.

As a reminder, providers are deemed participating in all benefit plans associated with their participating networks and may not terminate participation in an individual benefit plan.

Starting January 1, 2019, all Affinity plans have been transitioned to EmblemHealth. This includes four Affinity Medicare HMO plans: EmblemHealth Affinity Medicare Passport Essentials, EmblemHealth Affinity Medicare Passport Essentials NYC, EmblemHealth Affinity Medicare Ultimate (HMO SNP) and EmblemHealth Affinity Medicare Solutions (HMO SNP). Members will access the VIP Prime Network for these plans. Providers will follow the same medical management and claim protocols as for all other members managed by EmblemHealth, Montefiore CMO and HealthCare Partners. There is one exception – no referrals are required. To identify these new members, look for the plan names on the member ID cards.

Maximum Out-of-Pocket Threshold

The maximum out-of-pocket (MOOP) threshold for Medicare Parts A and B services covered under the EmblemHealth Medicare Advantage Plans has not changed for existing plans. This includes the in-network MOOP under the EmblemHealth Medicare HMO plans and both the in-network and combined (in- and out-of-network) MOOPs under the EmblemHealth Medicare PPO plans. The MOOP for each benefit plan is shown in the Medicare Network and Plan Summary section of this chapter. Sign in to the provider section of the EmblemHealth website at emblemhealth.com/providers to confirm MOOPs for you members.

How MOOP is Communicated to Members: A statement of members' out-of-pocket spending to date will appear on their Explanation of Benefits. Members will continue to be notified by mail upon reaching the MOOP for their plan. This notice will also list services with $0 cost-sharing available to the member for the remainder of the calendar year.

Transferability of Maximum Out-of-Pocket (MOOP): If a member makes a mid-year change from one EmblemHealth Medicare plan to another, the MOOP accumulated thus far in the contract year will follow the member and count toward the MOOP in the new EmblemHealth Medicare plan.

Coinsurance and Copay Changes for 2019

Members: Member cost-sharing for our HMO Special Needs Plan (SNP) benefits has not changed from the current amount of $0. The amount of cost-sharing providers may need to bill to Medicaid has changed on some benefits (inpatient hospital, skilled nursing facility, rehabilitation therapies have increased and podiatry has decreased to $0). Our HMO SNP plan members are qualified Medicare beneficiaries (QMB), which means they receive help from New York State Medicaid to pay their cost-sharing. As a result, the provider must bill Medicaid for the cost-sharing upon receipt of payment from EmblemHealth. The correct address to bill Medicaid is located on these members' Common Benefits Identification Card (CBIC).

Annual Physical Exam

Most EmblemHealth Medicare HMO Plans cover an Annual Physical exam at no cost to the member. This is a great opportunity for members and providers to review and discuss management of chronic health conditions such as diabetes and hypertension, and complete preventive steps such as flu shots, breast cancer screenings and others.

Wellness Exams

Medicare Part B services include an annual wellness exam in addition to the ”Welcome to Medicare“ physical exam.

"Welcome to Medicare" Physical Exam: Our Medicare plans cover a one-time ”Welcome to Medicare“ physical exam. This exam includes a health review, education, and counseling about preventive services (including screenings and vaccinations) and referrals for care, if necessary. Note: Members must have the ”Welcome to Medicare“ physical exam within 12 months of enrolling in Medicare Part B. When making their appointment, they should let you know they are scheduling their ”Welcome to Medicare“ physical exam.

Annual Wellness Visit: A Health Risk Assessment (HRA) is to be used as part of the Annual Wellness Visits (AWV). Members enrolled in Medicare Part B for over 12 months are eligible for an annual wellness visit to develop or update a personalized prevention plan based on their health needs and risk factors. This is covered once every 12 months. Note: Following their ”Welcome to Medicare“ physical exam, members must wait 12 months before having their first annual wellness visit. However, once members have been enrolled in Medicare Part B for at least 12 months, they do not need to have had a ”Welcome to Medicare“ physical exam to be covered for annual wellness visits. Providers may bill for this service using HCPCS codes G0438 and G0439 for initial and subsequent visits, respectively.

No Cost-Sharing for Preventive Care Services: CMS has released National Coverage Determinations for preventive services that are to be offered without cost-sharing. All of the services are listed in the chart referenced below. For HMO members, including Dual Eligible members, Medicare required covered services that are not available in-network and receive prior approval from our plan, or the member’s assigned managing entity, as applicable, will be allowed at $0 cost-sharing as well.

Medicare Preventive Services
The preventive care services listed on this chart are those CMS has determined should be provided to all Medicare recipients with no cost-sharing. This requirement applies to original Medicare, as well as to all of our Medicare plans, when provided on an in-network basis.

Review Medicare Network and Plan Summary here

Continuity of Care for Our Members

We make every effort to assist new members whose current providers are not participating with one of our plans. We do the same when a health care professional or facility leaves the network. See the Continuity/Transition of Care - New Members and Continuity of Care - When Providers Leave the Network sections of the Care Management chapter for information on transitions of care.

Medicare Special Needs Plans (SNPs)

SNPs Meet Our Members’ Special Needs

Medicare Special Needs Plans (SNPs) are specially designated Medicare Advantage Plans with custom-designed

benefits to meet the needs of a specific population. Enrollment in an SNP is limited to Medicare beneficiaries within the target SNP population. The target populations for the EmblemHealth SNPs are individuals who live within the plan service area, are eligible for Medicare Part A and Part B, and are eligible for Medicaid.

Starting January 1, 2019, all Affinity plans have been transitioned to EmblemHealth, including two Affinity SNPs: EmblemHealth Affinity Medicare Ultimate (HMO SNP) and EmblemHealth Affinity Medicare Solutions (HMO SNP). Members will access the VIP Prime Network for these plans. Providers will follow the same medical management and claim protocols, including our SNP Model of Care, as for all other members managed by EmblemHealth, Monte CMO and HCP. There is one exception – no referrals are required. To identify these new members, look for the plan names on the member ID cards.

EmblemHealth's SNPs consist of:

Medicare Choice PPO Network
ArchCare Advantage (HMO SNP)

VIP Prime Network
EmblemHealth VIP Dual Group (HMO SNP)
EmblemHealth VIP Dual (HMO SNP)

EmblemHealth Affinity Medicare Ultimate (HMO SNP)
EmblemHealth Affinity Medicare Solutions (HMO SNP)

The Medicare benefit for each of these plans is supplemented by a specific set of Medicaid benefits.

Provider Obligations/Responsibilities for Participation in Dual-Eligible Special Needs Plans

Members have no copayment for covered services other than for prescriptions drugs. The provider must verify Medicaid eligibility of every member enrolled in Dual SNP and may not collect a copayment for covered services from a Medicaid member eligible for Medicaid coverage of Medicare cost-sharing. EmblemHealth Affinity Medicare Solutions (HMO SNP) members may not be eligible for full Medicaid and may pay cost-sharing for covered services.

Provider Obligations/Responsibilities for Participation in Medicare-Medicaid Plans (MMPs)

Members have no copayment for covered services other than for prescriptions drugs. The provider may not collect a copayment for covered services from a Medicare-Medicaid Plan (MMP) member (including Affinity and ArchCare members).

HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information of your medical practice, including books, contracts, records, including medical records, and documentation related to CMS' contract with EmblemHealth for a period of 10 years from the final date of the contract period or the completion of any audit, whichever is later.

The provider may not hold members liable for payment of fees that are the legal obligation of EmblemHealth or a payor (including Affinity and ArchCare members).

For information about provider obligations and responsibilities, see Medicare/Advantage-Medicaid Required Provisions in the Required Provisions to Network Provider Agreements chapter.

The SNP Interdisciplinary Team

Our SNP goals are to:

- Improve access to medical, mental health, social services, affordable care, and preventive health services.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health care settings and providers.
- Assure appropriate utilization of services.
- Assure cost-effective service delivery.

Improve beneficiary health outcomes.

-

The SNP interdisciplinary team provides the framework to coordinate and deliver the plan of care and to provide appropriate staff and program oversight to achieve the SNP goals. The care management staff assumes an important role in developing and implementing the individualized care plan, coordinating care, and sharing information with the interdisciplinary care team, and with the member, their family, or caregiver.

Practitioners providing care to our SNP members are important members of the SNP interdisciplinary team. As such, they participate in one of our regularly scheduled care coordination or case rounds meetings to discuss their plan of care and the health status of the SNP-enrolled patient. These practitioners also share their progress with the team to ensure we are meeting our SNP program goals.

Required Training for EmblemHealth Practitioners, Providers, and Vendors

Each year, all Medicare providers are required to complete the Special Needs Plan (SNP) Model of Care Training for each of the Dual Eligible SNPs in which they participate, as mandated by Centers for Medicare & Medicaid Services (CMS). For training presentations and other learning opportunities, please visit our Learn Online webpage.

Review Medicare Special Needs Plans Summary here

Continuity of Care for Our Members

We make every effort to assist new members whose current providers are not participating with one of our plans. We do the same when a health care professional or facility leaves the network. See the Continuity/Transition of Care - New Members and Continuity of Care - When Providers Leave the Network sections of the Care Management chapter for information on transitions of care.

Medicaid Managed Care and HARP Prepaid Benefit Package Definitions of Covered and Non-Covered Services (Appendix K - K.1, K.2, K.3)

Please see the Appendix K table for a listing of all covered services under Medicaid Managed Care Supplemental Security Income (SSI), non-SSI related, Fee-for-Service, and HARP. Family Health Plus and HIV Special Needs Plan members are not applicable.

Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care Populations under 21 Included in the Children's System Transformation

Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care

Services	Current Delivery System	MMCO Benefit Package

Assertive Community Treatment (minimum age is 18 for medical necessity for this adult-oriented service)	FFS	10/1/2019
CFCO State Plan Services for children meeting eligibility criteria[8]	FFS	7/1/2019
Children's Crisis Intervention	FFS/1915(c) Children's Waiver service	1/1/2020
Children's Day Treatment	FFS	TBD
Comprehensive psychiatric emergency program (CPEP) including Extended Observation Bed	Current MMC Benefit for individuals age 21 and over	10/1/2019
Continuing day treatment (minimum age is 18 for medical necessity for this adult-oriented service)	FFS	10/1/2019
CPST[9]	N/A (new SPA service)	1/1/2019
Crisis Intervention Demonstration Service	MMC Demonstration Benefit for all ages	1/1/2020
Family Peer Support Services	FFS/1915(c) Children's waiver service	7/1/2019
Health Home Care Management	FFS	1/1/2019
Inpatient psychiatric services	Current Medicaid Managed Care Benefit	Current Benefit
Intensive Psychiatric Rehabilitation Treatment (IPRT)	FFS	7/1/2018
Licensed Behavioral Health Practitioner (NP-LBHP) Service	MMC Demonstration Benefit for all ages	Combined with OLP for 1/1/2019

Licensed outpatient clinic services	Current MMC Benefit	Current Benefit
Medically Managed detoxification (hospital based)	Current Medicaid Managed Care Benefit	Current Benefit
Medically supervised inpatient detoxification	Current Medicaid Managed Care Benefit	Current Benefit
Medically supervised outpatient withdrawal	Current Medicaid Managed Care Benefit	Current Benefit
OASAS Inpatient Rehabilitation Services	Current Medicaid Managed Care Benefit	Current Benefit
OASAS opioid treatment program (OTP) services	FFS	10/1/2019
OASAS Outpatient Rehabilitation Services	FFS	10/1/2019
OASAS Outpatient Services	FFS	10/1/2019
OMH State Operated Inpatient	FFS	TBD
Other Licensed Practitioner (OLP)	N/A (New SPA service)	1/1/2019
Partial hospitalization	FFS	10/1/2019
Personalized Recovery Oriented Services (minimum age is 18 for medical necessity for this adult-oriented service)	FFS	10/1/2019
Psychosocial Rehabilitation (PSR)	N/A (New SPA service)	1/1/2019

Rehabilitation Services for residents of community residences	FFS	TBD
Residential Addiction services	MMC Demonstration Benefit for all ages	10/1/2019
Residential Rehabilitation Services for Youth (RRSY)	FFS	TBD
Residential Supports and Services (VFCA) (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention effect 10/1/2019)	OCFS Foster Care	10/1/2019
Residential Treatment Facility (RTF)	FFS	TBD
Teaching Family Home	FFS	TBD
Youth Peer Support and Training	FFS/1915(c) Children's Waiver service	1/1/2020

[8] Beginning 7/1/18, eligibility for CFCO benefits will become available to children who are eligible for Medicaid solely because of receipt of HCBS (i.e., Family of One children who meet institutional admission criteria and receive HCBS). These children are not eligible for CFCO under the State Plan but will be eligible for identical benefits under the 1115 Demonstration Waiver Amendment.

[9] NYS is exploring the use of EBPs. Pending CMS approval, these services will be billed through CPST and/or OLP, depending upon provider qualifications. Additional guidance will be issued regarding provider designation as well as the rate structure.

EmblemHealth

Provider Manual

Chapter 7: Fully Integrated Dual Advantage (FIDA) - closed effective 12/31/18

This chapter outlines the plans designed for the Fully Integrated Dual Advantage (FIDA)-eligible population. Information includes an overview, covered items and services, participant rights and responsibilities, criteria for culturally-, linguistically- and disability-competent care, accessibility requirements, utilization management, grievances and appeals, claims, billing and reporting requirements, and provider training.

As part of the FIDA Demonstration, EmblemHealth provides network management services to our ASO client, GuildNet. The table below summarizes the key components of the plan and network. For more information on participant ID cards, please refer to the Member Identification Cards section in the Your Plan Members chapter.

FULLY INTEGRATED DUAL ADVANTAGE (FIDA) NETWORKS AND PLANS						
Network	Plan Name	Plan Type	Referral/ PCP Req'd	In-Network Cost-Sharing	Service Area	Comments
Associated Dual Assurance	GuildNet Gold Plus FIDA Plan POS	POS	No/No[1]	None[2]	6 county	Medicaid-related services should be billed directly to GuildNet c/o Relay Health (see Claims Contact table in the Contact Information section.

6 county = New York City (Bronx, Kings, New York, Queens, Richmond) & Nassau

[1]GuildNet Gold Plus FIDA Plan POS members are not required to have a PCP. However, EmblemHealth is required to populate PCP information on the member's ID card to comply with NYSDOH requirements. The provider listed on the member's ID card may be a participating or non-participating provider in accordance with GuildNet's policy and procedures. For more information, please contact the member's case manager.

[2] No in-network or out-of-network cost-sharing.

Overview and Contacts

The overall goal of the FIDA Demonstration is to create an aligned and integrated managed care model for the dually eligible who require home- and community-based long-term care services in which medical, behavioral health and long-term care needs are coordinated.

For information about provider obligations and responsibilities, see Standard Clauses for Managed Care Provider/IPA Contracts for the Fully-Integrated Duals Advantage Program in the Required Provisions to Network Provider Agreements chapter.

EmblemHealth's goals include:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services

EmblemHealth requires providers to use evidence-based practices for their patients in the FIDA Plan. In doing so, EmblemHealth:

- Develops and employs mechanisms to ensure that service delivery is evidence-based and that best practices are followed in care planning and service delivery
- Ensures that providers are following best-evidence clinical guidelines through decision support tools and other means to inform and prompt providers about treatment options
- Identifies and tracks patients to provide patient-specific and population-based support, reminders, data and analysis, and provider feedback
- Educates providers about evidence-based best practices and supports them through training or consultations in following evidence-based practices so that EmblemHealth can hold providers to the evidence-based practices specific to their practice areas

For more information about provider performance evaluations, please refer to the Health Care Provider Performance Evaluations section of the Care Management chapter.

FIDA Plans make resources (such as language lines) available to medical, behavioral, community-based and facility-based long-term services and support (LTSS), and pharmacy providers working with FIDA participants who require culturally, linguistically or disability-competent care.

Free multi-language interpreter service is available to answer any questions providers and their patients may have about the plan. Services are available in over 200 languages, including English, Spanish, Chinese Mandarin, Chinese Cantonese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi and Japanese. To get an interpreter, call customer care provider advocates at 1-866-447-9717. When calling, after entering your provider tax ID and selecting an option from the main menu, there are two main routes that will connect you with a customer care provider advocate who will assist you with our interpreter service:

- Following the main menu, if you do not enter the ID and date of birth of the participant you are calling about, you will hear a list of member plan types, press #7 when you hear "Are you inquiring about a FIDA Member? Press 7."
- Following the main menu, if you selected eligibility and benefits; check claim status; verify a referral; pre-certification/prior approval, behavioral health and substance abuse information and other services, you will have the option to hold and be transferred to a customer service advocate.

Participant Information - Target Population

FIDA-eligible participants must meet the following three criteria:

- Age 21 or older
- Entitled to benefits under Part A and enrolled under Parts B and D, and receiving full Medicaid benefits

- Reside in a FIDA Demonstration county

FIDA-eligible participants must also meet one of the following three criteria:

- Nursing facility clinically eligible (NFCE) and receiving facility-based LTSS
- Eligible for the nursing home transition and diversion (NHTD) waiver
- Require community-based LTSS for more than 120 days

Download contact information here

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Covered Items and Services

Participants are provided access to the following covered items and services:

- All items and services provided under New York State Plan services (including long-term services and supports [LTSS]), excluding ICF/MR services and those services otherwise excluded or limited in the three-way contract
- All home and community-based waiver services
- All items and services provided under Medicare Part A
- All items and services provided under Medicare Part B
- All items and services provided under Medicare Part D. The integrated formulary must include any Medicaid-covered prescription drugs and certain nonprescription drugs that are excluded by Medicare Part D. The Medicaid-covered prescription and certain nonprescription drugs required for inclusion in the integrated formulary are those listed in the Medicaid State Plan. In all respects, unless stated otherwise in the MOU or the Contract, Part D requirements will continue to apply.

Participant Rights and Responsibilities

The rights and responsibilities listed below indicate what participants can expect of FIDA plans and what responsibilities participants have to FIDA plans.

FIDA Plan participants have the right to:

- To receive medically necessary items and services as needed to meet the participant's needs, in a manner that is sensitive to the participant's language and culture and that is provided in an appropriate care setting, including the home and community.
- To receive timely access to care and services.
- To request and receive written and oral information about the FIDA Plan, its participating providers, its benefits and services and the participants' rights and responsibilities in a manner the participant understands.
- To receive materials and/or assistance in a foreign language and in alternative formats, if necessary.
- To be provided qualified interpreters free of charge if a participant needs interpreters during appointments with providers and when talking to the FIDA Plan.
- To be treated with consideration, respect and full recognition of his or her dignity, privacy, and individuality.

- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Not to be neglected, intimidated, physically or verbally abused, mistreated or exploited.
- To not be discriminated against on the basis of and to get care without regard to sex, race, health status, disability, color, age, national origin, sexual orientation, marital status or religion.
- To be told where, when and how to get the services the participant needs, including how to get covered benefits from out-of-network providers if they are not available in the FIDA Plan network.
- To complain to NYSDOH or the Local Department of Social Services, and the right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- To be advised in writing of the availability of the NYSDOH toll-free hotline, the telephone number, the hours of its operation and that the purpose of the hotline is to receive complaints or answer questions about home care agencies.
- To appoint someone to speak for him/her about the care he/she needs.
- To be informed of all rights, and the right to exercise such rights, in writing prior to the effective date of enrollment.
- To participate in his/her care planning and participate in any discussions around changes to the person-centered service plan, if/when they are warranted.
- To recommend changes in policies and services to agency personnel, NYSDOH or any outside representative of the participant's choice.
- To have telephone access to a nursing hotline and on-call participating providers 24/7 in order to obtain any needed emergency or urgent care or assistance.
- To access care without facing physical barriers. This includes the right to be able to get in and out of a provider’s office, including barrier-free access for participants with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act.
- To receive reasonable accommodations in accessing care, in interacting with the FIDA Plan and providers, and in receiving information about one’s care and coverage.
- To see a specialist and request to have a specialist serve as primary care provider.
- To talk with and receive information from providers on all conditions and all available treatment options and alternatives, regardless of cost, and to have these presented in a manner the participant understands. This includes the right to be told about any risks involved in treatment options and about whether any proposed medical care or treatment is part of a research experiment.
- To choose whether to accept or refuse care and treatment, after being fully informed of the options and the risks involved. This includes the right to say yes or no to the care recommended by providers, the right to leave a hospital or other medical facility, even if against medical advice, and to stop taking a prescribed medication.
- To receive a written explanation if covered items or services were denied, without having to request a written explanation.
- To have privacy in care, conversations with providers, and medical records such that:
  - Medical and other records and discussions with providers will be kept private and confidential.
  - Participant gets to approve or refuse to allow the release of identifiable medical or personal information, except when the release is required by law.
  - Participant may request that any communication that contains protected health information from the FIDA Plan be sent by alternative means or to an alternative address.
  - Participant is provided a copy of the FIDA Plan’s Privacy Practices, without having to request the same.
  - Participant may request and receive a copy of his or her medical records and request that they be amended or corrected, if the privacy rule applies.
  - Participant may request information on how his/her health and other personal information has been released by the FIDA Plan.

- To seek and receive information and assistance from the independent, conflict-free Participant Ombudsman.
- To make decisions about providers and coverage, which includes the right to choose and change providers within the FIDA Plan's network and to choose and change coverage (including how one receives his/her Medicare and/or Medicaid coverage – whether by changing to another FIDA Plan or making other changes in coverage).
- To be informed at the time of enrollment and at PCSP update or revision meetings of the explanation of what is an advance directive and the right to make an advance directive – giving instructions about what is to be done if the participant is not able to make medical decisions for him/herself - and to have the FIDA Plan and its participating providers honor it
- To access information about the FIDA Plan, its network of providers, and covered items and services.

IMPORTANT: State and federal laws give adults in New York State the right to accept or refuse medical treatment, including life-sustaining treatment, in the event of catastrophic illness or injury. FIDA Plans make available materials on advance directives with written instructions, such as a living will or health care proxy containing the members' wishes relating to health care should they become incapacitated. If members live in another state, they should check with their local state insurance department, if available, for information on additional rights they may have.

FIDA Plan participants have the responsibility to:

- To try to understand covered items and services and the rules around getting covered items and services.
- To tell providers that they are enrolled in a FIDA Plan and show their FIDA Plan ID card.
- To treat providers and employees of the FIDA Plan with respect.
- To communicate problems immediately to the FIDA Plan.
- To keep appointments or notify the interdisciplinary team if an appointment cannot be kept.
- To supply accurate and complete information to the FIDA Plan's employees.
- To actively participate in PCSP development and implementation.
- To notify the State and the FIDA Plan of any changes in income and assets. Assets include bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies and any other assets.
- To ask questions and request further information regarding anything not understood.
- To use the FIDA Plan's participating providers for services included in the FIDA Plan benefit package.
- To notify the FIDA Plan of any change in address or lengthy absence from the area.
- To comply with all policies of the FIDA Plan as noted in the Participant Handbook.
- If sick or injured, to call their doctors or care coordinators for direction right away.
- In case of emergency, to call 911.
- If emergency services are required out of the service area, to notify the FIDA Plan as soon as possible.

Cultural, Linguistic and Disability Competency

Medical, behavioral, and community-based and facility-based long-term services and supports providers are encouraged to take cultural, linguistic and disability competency trainings, required to comply with ADA guidelines, and be educated about their legal obligations under State and Federal law. Additional information about training can be found in the Training section of this chapter.

EmblemHealth policies ensure culturally, linguistically, and disability-competent and service delivery. Available resources, such as the multi-language interpreter service, give providers the capacity to communicate with

participants in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing, blind or visually impaired.

For information about cultural and linguistic competence, please refer to the Member Rights section of the Your Plan Members chapter.

Accessibility Requirements

EmblemHealth ensures that the hours of operation of all of its network providers, including medical, behavioral, and community-based and facility-based LTSS, are convenient to the population served and do not discriminate against FIDA Plan participants (e.g., hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals), and that FIDA Plan services are available 24 hours a day, 7 days a week, when medically necessary.

Provider locations where participants receive services must be ADA compliant. All providers must meet ADA requirements and have a signed ADA Accessibility Attestation form on file with EmblemHealth. Providers must notify EmblemHealth within ten business days of any change in its ability to meet the ADA Accessibility standards as outlined in the signed ADA Accessibility Attestation form. A copy of the ADA form is located at the end of this chapter.

For more information about accessibility requirements, please refer to the Access to Care and Delivery System chapter.

Utilization Management

Utilization Management Process and Role of the Interdisciplinary Team

The IDT is the primary source for approval of services and approval of the PCSP. The IDT is responsible for monitoring participant service plans, assuring that services are provided consistent with the plan, staying apprised of changes in status, assessing the continued appropriateness of the plan between reassessments, and identifying emerging needs. The care manager has overall responsibility for these tasks and works directly with community and network providers and community-based or facility-based LTSS providers, as well as members of the IDT, including rehab, nutrition, behavioral health specialists and the consulting pharmacist.

The IDT will assist participants in obtaining needed medical, behavioral health, prescription and nonprescription drugs, community-based and facility-based LTSS, and social, educational, psycho-social, financial and other services in support of the PCSP, regardless of whether the needed services are covered under the provider payment. Consumer direction is included in the covered services and in the service planning process.

The IDT is, at a minimum, comprised of the participant and/or his/her designee, and the assigned care manager. Other members, as agreed to by the participant, include the PCP (or a designee with clinical experience from the PCP's practice who has knowledge of the needs of the Participant), a behavioral health professional (when appropriate), the participant's home care aide (if indicated), and other providers either as requested by the participant or his/her designee or as recommended by other IDT members. The IDT makes coverage determinations that may not be modified by the FIDA Plan outside of this team and that can be appealed by the participant.

Practitioners who participate on an IDT are eligible for additional compensation for IDT meeting attendance. For more information about additional compensation, see the Billing section of this chapter.

For more information about IDT, see the Medicare Special Needs Plans section of the Provider Networks and Member Benefit Plans chapter.

Utilization Management - Clinical Practice Guidelines

EmblemHealth utilizes approved criteria, which are objective and based on medical evidence, as well as the plan's internal medical guidelines, when making determinations for clinical appropriateness. These criteria, which consider the needs of the participant and are applied to individual cases, are based on an assessment of the local delivery system. Along with the pre-established health care industry clinical review criteria used as guidelines, determinations are also based on a physician's general medical knowledge and judgment.

Other medical necessity criteria, such as InterQual/CMS, are also utilized by EmblemHealth to identify the medical necessity and appropriate level of care. These guidelines are reviewed and approved by the Medical Policy Subcommittee on a biennial basis. If evidence-based clinical practice guidelines from a recognized source are not used, EmblemHealth gives board-certified practitioners from the specialties that would use the guidelines an opportunity to provide input during guideline development. In those cases where criteria do not apply, a referral is made to the medical director for higher level determinations. An application of alternate criteria, when reasonable, can be applied to assist in the decision-making process.

The plan medical guidelines are internally created using evidence-based medical information. They are initially reviewed by practitioners with current knowledge in the appropriate areas. Afterwards, they are presented for review and approval to the Medical Policy Subcommittee, which is chaired by a medical director. This evaluation process is conducted biennially. This process applies throughout care management, including but not limited to pre-service review, concurrent review, case management and retrospective review.

In presenting the guidelines, EmblemHealth publishes a direct website link to the organization whose guidelines were adopted. Clinical practice guidelines are distributed to the appropriate practitioners via the Provider Manual, the EmblemHealth website and notices of updates in the provider newsletter. A paper copy of the posted Clinical Practice Guidelines is also available on request. For more information about clinical practice guidelines, refer to the Clinical Practice Guidelines chapter.

Utilization Management - Prior Approval and Referral Procedures

Referrals are not required for covered items and services under the FIDA Demonstration. The IDT makes all service and authorization decisions. Authorizations between IDT meetings and before the PCSP is developed may be made through EmblemHealth's Utilization Management process for Medicare-only GuildNet members. Prior approval is not required for FIDA participants for the following services:

- Emergency or urgently needed care
- Out-of-network dialysis when the participant is out of the service area
- Primary care doctor visits
- Physician specialty services, excluding psychiatric services
- Family planning and women's health specialists services
- Indian health care providers for any participant that is Indian eligible
- Public health agency facilities for tuberculosis screening, diagnosis and treatment
- Immunizations
- Palliative care
- Other preventive services
- Vision services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services
- Dental services through Article 28 clinics operated by academic dental centers
- Cardiac rehabilitation, first course of treatment (physician or RN approval for subsequent treatment)
- Supplemental education, wellness and health management services

- Prescription drugs:
  - which are on the formulary
  - which are not on the formulary, but where a refill request is made for an existing prescription within the 90-day transitional period

- Mental Health Specialty Services – Non-Physician
  - Authorization required after initial visit for visits 2-5
  - Additional authorization required thereafter

- Psychiatric services
  - Authorization required after initial visit for visits 2-5
  - Additional authorization required thereafter

- Outpatient diagnostic procedures, Tests and Lab Services
  - Genetic testing subject to prior authorization rules

- Outpatient Diagnostic and Therapeutic Radiological Services
  - Authorization required for MRI, MRA, CT, PET scans and nuclear imaging

- Outpatient Substance Abuse Services
  - Authorization required after initial visit for visits 2-5
  - Additional authorization required thereafter

The PCSP identifies all services authorized by the IDT and identifies and prioritizes the participant's need for medically necessary covered services and for LTSS necessary for maintaining or improving the participant's functional independence. Preserving the participant's ability to remain in the least restrictive environment is the goal.

At a minimum, participants are eligible for any covered service that is medically necessary to treat or manage a medical or behavioral condition. LTSS for independent living may be authorized strategically for the purpose of:

- Maintaining or improving a participant's level of functional independence
- Reducing a participant's risk for more restrictive care because of a loss of functional independence

Participants may obtain a second opinion from a qualified health care professional regarding the assessment of needs, statement of goals and services prescribed in their PCSP at no cost to the member. For more information about second opinions, refer to the Referral Procedures section of the Care Management chapter.

For information about accessibility requirements, please refer to the Access to Care and Delivery System chapter.

Utilization Management - Continuity of Care

Participants receiving any service other than nursing facility services at the time of enrollment may continue with their current providers and service levels until the later of the two scenarios:

- At least 90 days after enrollment
- Until a comprehensive assessment has been completed and a PCSP is put in place

The provider must agree to accept the plan rate, adhere to plan quality assurance and other policies, and provide medical information about the participant's care.

Grievance and Appeal

Grievance

FIDA Plan policies and procedures for participant grievances include the following:

- Participants are entitled to file grievances directly with EmblemHealth.
- EmblemHealth must send written acknowledgement of grievances to the participant within 15 days of receipt.
- If a decision is reached before the written acknowledgement is sent, EmblemHealth will not send the written acknowledgment.
- The grievance must be decided as fast as the participant's condition requires but not later than:
  - Expedited: Paper review – decision and notification within 24 hours (in certain circumstances outlined in the Memorandum of Understanding). For all other circumstances where a standard decision would significantly increase the risk to a participant's health, decision and notification within 48 hours after receipt of all necessary information and no more than 7 calendar days from the receipt of the grievance.
  - Standard: Notification of decision within 30 calendar days of EmblemHealth receiving the written or oral grievance.
- EmblemHealth must notify the participant of the decision by phone for expedited grievances and provide written notice of the decision within 3 business days of decision (expedited).
- EmblemHealth tracks and resolves all grievances or reroutes grievances to the coverage decision or appeals process as appropriate
- EmblemHealth has internal controls in place to identify incoming requests as grievances, initial requests for coverage, or appeals, and has processes to ensure that such requests are processed through the appropriate avenues in a timely manner.

Appeal

EmblemHealth notifies FIDA participants of all Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question.

EmblemHealth maintains policies and procedures for participant appeals, in accordance with the requirements specified in the CMS-State Memorandum of Understanding. These policies and procedures include the following:

- Participants are entitled to file appeals directly with EmblemHealth. The appeal must be requested within 60 days of postmark date of notice of action if there is no request to continue benefits while the appeal decision is pending. If there is a request to continue benefits while the appeal decision is pending and the appeal involves the termination or modification of a previously authorized service, the appeal must be requested within 10 days of the notice's postmark date or by the intended effective date of the action, whichever is later.
- Upon receipt of an appeal, EmblemHealth sends written acknowledgement of appeal to the participant and their providers or representatives (if the participant did not file the appeal) within 15 calendar days of receipt. If a decision is reached before written acknowledgement is sent, EmblemHealth will not send the written acknowledgement.
- EmblemHealth decides and notifies the participant (and provider, as appropriate) of its decision as fast as the participant's condition requires but:
  - Expedited: Paper review unless a participant requests in-person review - as fast as the participant's condition requires, but no later than within 72 hours of the receipt of the appeal.
  - Standard: Paper review unless a participant requests in-person review - as fast as the participant's condition requires, but no later than 7 calendar days from the date of the receipt of the appeal on Medicaid prescription drug appeals and no later than 30 calendar days from the date of the receipt of the appeal.
  - Extension: An extension may be requested by a participant or provider on a participant's behalf (written or oral). EmblemHealth may also initiate an extension if it can justify need for additional information and if the extension is in the participant's interest. In all cases, the extension reason must be well-documented, and when EmblemHealth requests the extension it notifies the participant in writing of the reasons for delay and

informs the participant of the right to file an expedited grievance if he or she disagrees with EmblemHealth's decision to grant an extension.

- EmblemHealth makes a reasonable effort to provide prompt oral notice to the participant for expedited appeals and document those efforts. EmblemHealth sends written notice within 2 calendar days of providing oral notice of its decision for appeals.

For filing instructions, see the Overview and Contracts section of this chapter.

Claims

For instructions on submitting your claims, see the Overview and Contracts section of this chapter. For information about EmblemHealth's policies and procedures for submitting your claims, please refer to the Claims chapter.

Billing

Providers may not balance bill participants in the FIDA Plans for the cost of any covered service, which includes any coinsurance, deductibles or financial penalties, or any other amount in full or in part.

The FIDA Plans will not charge Medicare Part C or D premiums, nor assess any cost-sharing for Medicare Parts A and B services. All participants are currently eligible for $0 Part D copays in accordance with Section 1860D 14(a)(1)(D)(i) of the Social Security Act and 42 CFR Part 423.782(a)(ii). The FIDA Plans will not assess any cost-sharing for Medicare Part D or NYS Department of Health services.

Practitioners who participate on an IDT may be eligible for additional compensation for IDT meeting attendance billed under the following CPT codes:

IDT Meetings

CPT CODE	PROCEDURE DESCRIPTION
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99487	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month
99488	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

99489	Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Required Use of Codes in Screening for Clinical Depression

Effective January 2015, the Associated Dual Assurance Network primary care and behavioral health providers must include the G codes noted below in claims and encounter submissions as applicable to Screening for Clinical Depression and Follow-up Plan. CMS and DOH have developed data reporting requirements for all FIDA plans to measure the percentage of patients screened for clinical depression using an age appropriate standardized tool with appropriate follow-up plan documented in the medical record. Please see page 31 of the Medicaid Adult Core Set for a list of acceptable depression screening tools.

Standardized screening tools help predict the likelihood of someone developing or having clinical depression. The purpose of using a standardized screening tool is to determine if the patient screens positive or negative for depression. If the patient has a negative screen for depression, no follow-up plan is required. If the patient has a positive screen for depression using a standardized screening tool, the provider must have a follow-up plan as outlined below.

Follow-up for a positive depression screening must include one (1) or more of the following:

- Additional evaluation
- Suicide risk assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions - if you decide to prescribe an anti-depressant for the patient, please make sure to schedule follow-up appointments as appropriate and provide the care and education necessary to support medication adherence
- Other interventions or follow-up for the diagnosis or treatment of depression

A patient is not eligible for depression screening if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
- Patient was referred with a diagnosis of depression
- Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

Codes to Identify Outpatient Visits

CPT Code	HCPCS
90791, 90792, 90832, 90834, 90837, 90839, 92557, 92567, 92568, 92625, 92626, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	G0101, G0402, G0438, G0439, G0444

Codes to Identify Outpatient Visits

CPT CODE	Description
G8431	Screening for clinical depression is documented as being positive and a follow-up plan is documented
G8510	Screening for clinical depression is documented as negative, a follow-up plan is not required

Codes to Identify Exclusions

CPT CODE	Description
G8433	Screening for clinical depression not documented, documentation stating the patient is not eligible
G8940	Screening for clinical depression is documented as negative, a follow-up plan is not required

Reporting

For information about reporting requirements, please refer to the Regulatory Mandatory Reporting chapter.

Training

To help you care for your FIDA participants, all providers participating in a FIDA network are encouraged to complete web-based training modules on the following topics.

- FIDA Provider Overview
- Behavioral Health
- Cultural Competency
- Disability Awareness
- Recovery & Wellness

To access the FIDA provider training site visit: https://fida.resourcesforintegratedcare.com. Downloadable versions of the training are also available.

In addition, all members of an IDT, including FIDA providers, are encouraged to complete the above trainings to gain experience in the person-centered planning process, cultural competency, disability, accessibility and accommodations, independent living and recovery, and wellness principles. Training is voluntary.

EmblemHealth ADA Attestation

A copy of the EmblemHealth Americans With Disabilities Act (ADA) Attestation form is located at the end of this

chapter.

EmblemHealth

Provider Manual

Chapter 8: Access to Care and Delivery System

This chapter outlines EmblemHealth policies and procedures for the provision of medical care to our members, including participation requirements, role of primary care providers and provider termination procedures.

Accessibility and Timeliness of Care

All EmblemHealth plan members are entitled to:

- An initial assessment of their health care status performed within 90 days of enrollment (For Medicaid members over age 21, within 12 weeks [84 days])
- Information regarding health care needs that require follow up
- Self-care training (as necessary)

Office Hours

Health care professionals must notify EmblemHealth (and the HIP Network Services IPA, Inc., if applicable) within five business days after any change in office address, telephone number and/or office hours.

From time to time, regulatory agencies will audit Plans' directories for accuracy and may impose fines and/or penalties when information is found to be inaccurate. Any fines/penalties received by the Plan or negative financial impact experienced by the Plan due to a Practitioner's failure to notify the Plan of any required change listed above will be levied to the Practitioner in the amount equal to the fine/penalty.

Health care professionals doing business as primary care physicians must maintain office hours not less than two (2)

days per week, eight hours per day, at each primary care office.

Telephone Response

Telephone response to member calls to the office should be handled by the physician or designated office staff (as appropriate to the situation) while adhering to the following guidelines:

- Emergency conditions should receive immediate response
- Urgent conditions should be responded to within four hours
- Semi-urgent conditions should be responded to during the current day
- Routine conditions should be responded to within two working days
- After hours calls where the nature is unclear should receive response within 30 minutes

Update Your Practice Records

Your practice information appears in our network directories (including our online Find a Doctor tool) and is used in claims processing. Keeping your information up to date helps ensure that patients can locate your practice and we process your claims accurately. You must report updates to your practice information whenever change occurs in the following:

- Ability to accept new members
- Age-range limitations applicable to the health care professional
- Add or delete a provider from your practice
- Email address
- Fax number
- Hospital affiliations
- IRS taxpayer identification number (TIN)
- Languages spoken in your office
- Medicaid Number is assigned
- Medicare Number is assigned
- National Provider Identifier (NPI) number is assigned
- Office hours
- Opening or closing a primary care panel
- Practice address
- Practice phone number used for scheduling patient appointments

- Billing information
- Specialties
- Wheelchair accessibility has been added to a practice location
- When an OB/GYN opts to see GYN-only patients

Unless you're part of a group that has arranged to submit changes via a spreadsheet/ dataset process, providers, and their staff, can access and update their practice records on our secure provider website. For changes that cannot be processed online, mail or fax your changes to our Provider Modifications team:

Provider Modifications Team
EmblemHealth
55 Water Street, 6th Floor
New York, New York, 10041-8190

Fax: 1-877-889-9061

Providers must inform EmblemHealth as soon as possible or within five (5) business days after any change to office address, telephone number, office hours, specialty, languages spoken, hospital affiliation, addition or termination of an individual provider in a medical group. Updates to your practice information will be posted to the EmblemHealth website within 15 days. In general, some updates, such as to your license number, specialty or school, will be verified by our Credentialing department and may take longer to appear.

Note: Removing an individual provider from a service location will not affect previously submitted claims. EmblemHealth will continue to process claims with a Date of Service on or before the provider's termination date for that location.

EmblemHealth may terminate a provider if he/she fails to notify EmblemHealth of any required changes in a timely manner (subject to any applicable reconsideration or hearing rights required by state or federal law).

From time to time, regulatory agencies will audit the Plans' directories for accuracy and may impose fines and/or penalties when information is determined to be inaccurate. Any fines/penalties received by the Plan due to a Practitioner's failure to notify the Plan of any required change listed above will be levied to the Practitioner in the amount equal to the fine/penalty.

Change of Ownership

A change of ownership (CHOW) cannot be performed online; a CHOW is treated like a new enrollment. When a change of ownership occurs, providers must contact EmblemHealth. The appropriate contact information can be located in the EmblemHealth Contact Information section of the Directory chapter.

Know Your Network Participation

The provider profile also lists your network affiliations. If the network information on the member's ID card matches your network affiliations, then you are in-network for that member's benefit plan. See the Provider Networks and Member Benefit Plans chapter for a listing of all networks and plans.

Note: Some government program cards don't have network names; however, they are easily identified by the plan name. Digital representations of our most common member ID cards are located in the Member Identification Cards section of the Your Plan Members chapter.

Ask to see a member's ID card at each appointment, emergency visit or inpatient stay. However, the provision of service should not be conditioned solely on the presentation of a member ID card because a member's enrollment status can change due to various reasons. Sign in to our secure provider website to check your patients' eligibility status.

Keeping your information current ensures we send your claims payments and other important correspondence to the correct address. It also helps our members contact you at your current location. We recommend that you

periodically review the information we have on file for you and encourage you to share your network participation and any changes with your staff on a regular basis.

EmblemHealth Access Standards

Revised June 6, 2018

Practitioners are expected to adhere to EmblemHealth's appointment availability and 24-hour access standards for primary care physicians, OB/GYNs, Oncologists, specialists and mental health and substance abuse practitioners (as appropriate). These standards are based on industry, Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) access standards.

Appointment Availability Standards

Practitioner offices will schedule appointments in a timely and efficient manner. Member visits to see a practitioner shall be scheduled based on EmblemHealth's Appointment Availability Standards During Office Hours & After Office Hours Access Standards, which is available at the end of this chapter.

Starting January 1, 2019, new access to care standards will be introduced to meet the needs of Medicaid children. See Appointment Availability Standard by Service Type for Medicaid Children’s Health and Behavioral Health Benefits.

Customer Service will maintain and monitor standards for customer telephone access.

EmblemHealth conducts semi-annual appointment availability surveys by calling practitioner offices to determine the next available appointment for a given type of service. This determines both individual practitioner and overall network compliance with these standards as part of our Quality Management program. Noncompliant practitioners are notified and resurveyed approximately six months after the initial survey. Practitioners that are not compliant with these standards upon resurvey will be forwarded to our Recredentialing Committee for review and action.

24-hour Access Standards

All network practitioners must be available, either directly or through coverage arrangements, 24 hours a day, 7 days a week, 365 days a year. Availability must be by live voice direct to the practitioner or covering practitioner, or via an answering service that can reach the practitioner or covering practitioner. If an answering machine is used, it must provide an option for the member to directly contact the practitioner or covering practitioner in case of emergencies. An answering machine cannot simply refer the member to an emergency room unless it is a life-threatening issue.

Annual Practitioner Surveys for Appointment Availability and 24-hour Access

EmblemHealth conducts annual surveysfor appointment availability, by calling practitioner offices during office hours to determine the next available appointment for a given type of service, and 24-hour access by calling after-hours telephone numbers These surveys determine both individual practitioner and overall network compliance with these standards as part of our Quality Management program.

Noncompliant practitioners are notified by letter that they failed one or more components of the survey. Practitioners that fail the survey are automatically included in the next survey administration. Practitioners who are not compliant with the standards and fail when they are re-surveyed will be forwarded to our Credentialing/Recredentialing Committee (CRC) for review and action.

The NYSDOH may also conduct surveys of your appointment availability and after-hours access.

Covering Practitioners

Covering practitioners should be contracted and credentialed by EmblemHealth's companies. Practitioners must provide EmblemHealth with a list of the covering physicians and notify us of any changes. If the covering practitioner in the coverage group does not participate with the EmblemHealth plan, the network practice must inform that practitioner of our policies and procedures. Out-of-network practitioners are prohibited from balance billing and they must clearly identify the name of the practice/practitioner for whom they are covering. Patients should be instructed by the covering physician to follow up with their PCP. Only one visit will be approved for the covering practitioner's services, unless the office is closed for more than 24 hours. If a practice is closed for an extended period of time, the practice must notify the Provider Relations department and any members that may be affected by the closure.

Urgent Care Access

For urgent conditions that do not meet the layperson's definition of an emergency, EmblemHealth maintains a network Urgent Care Centers for all plan members. To access a list of participating urgent care centers, use the Find a Doctor tool on our website.

Customer Service

EmblemHealth provides member services through our Customer Service. Customer Service Advocates assist members with questions about services, benefits, enrollment and other issues. Our computerized Member Contact System enables same-day responses to most member requests. If a member's inquiry cannot be resolved during the initial call on the same day, then a Customer Service Advocate strives to call the member back within 48 hours.

Provider Customer Care Advocates are dedicated on a full-time basis to assist providers with questions about EmblemHealth, participation status, contract questions and to provide education and educational material.

We are committed to encouraging and rewarding superior service and recognize that cooperation is an essential component of the provision of quality medical care.

Customer Service will maintain and monitor standards for customer telephone access.

Medical Care Delivery System

Medical care for EmblemHealth plan members is provided by a network of thousands of contracted practitioners (including multi-specialty practices) that provide care both in medical centers and in their own offices within the community.

We have contracted with an extensive and comprehensive array of facilities and ancillary clinicians to ensure a full continuum of care including an extensive network of prestigious teaching and community hospitals, skilled nursing facilities and freestanding ambulatory care centers.

EmblemHealth will maintain a network of practitioners adequate to meet the comprehensive and diverse health needs of its enrollees. Practitioner selection is based on meeting our minimum criteria for credentialing, geographic

standards for accessibility, compliance with the Americans with Disability Act and cultural and linguistic competency.

In the event that a participating practitioner is not available with the skills required to meet a member's needs or is not available within a reasonable distance from the member's place of residence, EmblemHealth, when appropriate, will arrange and authorize the use of a nonparticipating practitioner at no additional out-of-pocket expense to the member.

Behavioral Health Services

EmblemHealth has engaged Beacon Health Options to administer behavioral health services for most of its members under two programs. Members of plans underwritten by HIP or HIPIC and ASO plans administered by VHMS have their behavioral health services administered by Beacon Health Options under the Emblem Behavioral Health Services Program (EBHSP). GHI-underwritten plan members by have their behavioral health services administered by Beacon Health Options under the EmblemHealth Behavioral Management Program (BMP). For more information, please see the Behavioral Health Services chapter.

The Primary Care Practitioner / Primary Caregiver

EmblemHealth-contracted Primary Care Practitioners (PCPs) are responsible for supervising and coordinating medically necessary health care of their patients including, but not limited to:

- Providing health counseling and advice
- Baseline and periodic health examinations
- Diagnosing and treating conditions not requiring the services of a specialist
- Arranging inpatient care, specialist consults and laboratory/radiological services when medically necessary and in a timely manner
- Coordinating the findings of consultants and laboratories and interpreting such findings to the member and the member's family (subject to HIPAA Privacy Rules)
- Maintaining a current medical record for each patient

PCPs are required to follow the standards of care contained in this manual and the administrative guidelines posted to our website, which are reflective of professional and generally accepted standards of medical practice. One of the first and most important decisions any member makes is the selection of a PCP. It is equally important for PCPs to establish a meaningful professional and lasting relationship with their patients. A PCP cannot be his/her own or his/her family's primary care physician.

If a member is using a behavioral health clinic that also provides primary care services, the member may select the lead provider to be their PCP.

Credentialed advanced nurse practitioners (ANPs) may act as primary caregivers, maintaining their own panel of EmblemHealth members and issuing referrals for specialty care. All ANPs functioning as primary caregivers must maintain a current collaborative relationship with an EmblemHealth physician who is participating in the same networks and coverage arrangement for hospital admissions at an EmblemHealth contracted hospital. ANPs may submit to EmblemHealth either a written collaborative agreement or the NYS Education Department Collaborative Relationships Attestation Form(NP-CR). See the Credentialing Chapter for more information. In general, NPs and PAs are paid for covered services at 85 percent of what a physician is paid.

For more information on how to become credentialed with EmblemHealth as a primary caregiver, please sign in to our secure provider website at www.emblemhealth.com/providers and send us an email via our Message Center.

EmblemHealth encourages new members to contact their PCP within 90 days of enrollment for an initial evaluation. If the initial contact with the practitioner is for an acute visit, the practitioner should recommend that the member return for a general health assessment based on age, state of health and the member's last health assessment.

Each time a member needs to see a specialist, it is the PCP's/primary caregiver's responsibility to identify and refer the member to a participating practitioner and to give the member an appropriate referral, either for a consult only or for specific medical services. If the PCP or primary caregiver anticipates the need to refer a member for services that require a referral, prior approval, or the use of a non-participating provider, the request must be approved by EmblemHealth in advance.

All members have direct access to OB/GYN care without a referral or prior approval, as required by New York State law.

Primary Care Practitioner Responsibilities

Primary care practitioners (PCPs) are responsible for providing primary care services and managing all necessary health care services for the members assigned to them. Coordinating all care and maintaining an overall picture of member health is key to helping members stay healthy while effectively managing appropriate use of health care resources.

When providing primary health care services and coordination of care, the PCP must:

- Provide for all primary health care services that do not require specialized care. These include, but are not limited to:
  - Routine preventive health screenings.
  - Physical examinations.
  - Routine immunizations.
  - Child/Teen Health Plan Services (C/THP) screenings for children and adolescents (required for Medicaid members; as appropriate for other members).
  - Reporting communicable and other diseases as required by Public Health Law.
  - Behavioral health screening (as appropriate).
  - Routine/urgent/emergent office visits for illnesses or injuries.
  - Clinical management of chronic conditions not requiring a specialist.
  - Hospital medical visits (when applicable).
  - Maintain appropriate coverage for members 24 hours a day, seven days a week, three hundred and sixty-five days a year as noted in the above section on 24-hour access.
- Refer all members for services in accordance with EmblemHealth's referral policies and procedures. See the Care Management chapter of this manual for more details.
- Provide services of available allied health professionals and support staff in your office.
- Provide supplies, laboratory services and specialized or diagnostic tests that can be performed in the office.
- Assure members understand the scope of referred specialty or ancillary services and how/where the member should access the care.
- Communicate conditions, treatment plans and approved authorizations for services to member and appropriate specialists.
- Consult and coordinate with members regarding specialist recommendations.
- Comply with the New York State "Vaccine for Children Program," as appropriate, and with New York State and New York City requirements for reporting communicable diseases.

EmblemHealth Medicaid and Child Health Plus Participating Practitioners

Practitioners treating members enrolled in Medicaid or Child Health Plus shall have no more than 1,500 members on their panel or 2,400 for a physician practicing in combination with a registered physician assistant or certified nurse practitioner. Advanced nurse practitioners credentialed as primary caregivers shall have no more than 1,000 members on their panel.

These member-to-practitioner ratios are based on the assumption that the practitioner works 40 hours per week and therefore must be prorated for practitioners working less than 40 hours per week. The ratios apply to practitioners, not to each of their practice locations.

Primary Care Physician Selection, Assignment and Change Policy for Members Whose Benefit Design Requires the Selection of a PCP

When EmblemHealth members first enroll, they choose where they want to receive medical care. Members can choose any participating primary care physician (PCP) with an open panel. Members who fail to select a PCP within a given period of time are assigned to a PCP and notified of the assignment in writing.

Members who subsequently wish to transfer to another network PCP may do so at any time for any reason by calling our Customer Service departments or by logging on to our Web site, www.emblemhealth.com. PCP changes take effect immediately upon request.

When members transfer from one network PCP practice to another, the PCP who previously treated the member is required to forward a copy of the member's medical record to the new PCP, allowing for continuity of care. The original record should be retained and treated as a terminated record.

Note that Medicaid members that are in the Restricted Recipient Program have restrictions on when they can change PCPs out of good cause reasons such as:

- Provider no longer wishes to be the RRP member's provider;
- Provider closed/moved servicing location or moved to a location that is beyond 30 minutes or 30 miles from RRP member's home;
- Provider no longer participates in HIP's network;
- Member moved beyond 30 minutes or 30 miles from RRP provider;
- Other circumstances exist that make it necessary to change providers, including but not limited to good cause reasons for changing PCPs as provided by applicable statute and regulations.

Removal of a Member From a PCP Panel / Discontinuation of Specialty Care Services

A PCP or Primary Caregiver may request removal of a member from his/her panel or a specialty care practitioner may request to discontinue treating a member if:

- The member repeatedly fails to keep appointments
- The member repeatedly disregards the practitioner's medical advice
- The member exhibits continual abusive behavior toward the practitioner or his/her office staff
- The practitioner is unable to establish a mutually beneficial relationship with the member

The practitioner should provide at least 90 days prior written notice to Provider Relations that he/she will not continue as the member's physician. Provider Relations will coordinate with the Customer Service department to notify the member.

Medical Records Transfer

The medical records transfer procedure ensures that the new PCP will have a continuous medical record of the member. See the Medical Records Guidelines chapter of this manual for more details.

Medical Specialists

EmblemHealth contracted specialist physicians agree to see members referred by a participating primary care physician except when members are seeking services to which they are permitted to self-refer (see the Direct Access section of this chapter for these services), when a member's benefit plan does not require the selection of a PCP, or when the plan's design does not require referrals. Refer to the 2020 Summary of Companies, Networks & Benefit Plans to see which plans do not require PCPs and/or referrals.

Specialists should make note of the scope of the referral and refer the member back to the referring PCP for continuation of care.

In order to ensure continuity of care, the specialist must communicate with the PCP, if applicable, regarding the consultation, findings and recommended treatment plan.

When a member has been referred to a specialist, the specialist is responsible for diagnosing the member's clinical condition and/or managing treatment of t he condition, up to the number of visits identified on the referral authorization. The scope of the services rendered is limited to those related to the clinical condition for which the primary care practitioner referred the member.

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

When providing specialty care, the practitioner must:

- Keep the PCP informed of the member's general condition with prompt verbal or written consult reports
- Obtain PCP authorization for subsequent referrals for tests, hospitalization or additional covered services
- Provide only those services authorized by a PCP and/or the medical director (or his or her designee) and emergency care
- Deliver all medical health care services available to members with self-referral benefits

Note: OB/GYN specialists may see members without referral from a PCP consistent with § 4406-b of the New York State Public Health Law. OB/GYN specialists must be available after hours for emergency care of pregnant enrollees.

For information on specialists functioning as PCPs, see the Specialists as PCPs subsection in the Care Management chapter.

Note: Qualified providers of OB/GYN care are required to provide HIV pre-testing counseling with clinical recommendation of testing for all pregnant women. Those women and their newborns must have access to services

for positive management of HIV disease, psychological support and case management for medical, social and addictive services. See Direct Access (Self-Referral) Services.

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

Routine Voluntary HIV Testing

In New York State, voluntary HIV testing is part of routine medical care. Additionally, New York State public health law requires most medical facilities to offer voluntary HIV testing to patients of all ages. With limited exceptions, the law applies to anyone receiving treatment for a condition that is not life-threatening, whether in a hospital, emergency room or primary care setting such as a doctor's office or outpatient clinic.

For a summary of changes to simplify HIV testing consent and improve linkage to care, please see New York State HIV Testing Law Update: May 2014.

Consent Still Required

The amended law allows patients to give verbal consent for a rapid HIV test, which produces results within an hour. Consent must be documented in the patient's medical record, and the practitioner must counsel the patient on the following seven points about HIV:

1. HIV is the virus that causes AIDS. HIV can be passed through:
   - Unprotected sex (vaginal, anal or oral sex without a condom) with a person who has HIV.
   - Shooting drugs with needles, or "works," of a person who has HIV.
   - Pregnancy, birth or breastfeeding.
2. Treatments are available to help people living with HIV stay healthy. Getting tested early can help patients get the most from their health care benefits.
3. HIV testing is important for women before or during pregnancy. Treatment can reduce the chance that a woman with HIV will pass the virus to her infant.
4. Many resources are available in New York to help people living with HIV meet their medical, social and legal needs.
5. HIV testing is confidential. A doctor can share HIV test results with other practitioners only when the information is needed for the patient's health care. The names of people who have HIV or other STDs, such as syphilis and gonorrhea, are confidentially sent to the State Health Department. This helps the State Health Department plan services for people with HIV.
6. If test results show that a patient has HIV, the doctor will talk with the patient about urging sex and needle-sharing partners to get tested for HIV. Counselors from the Health Department's Partner Assistance Program (PNAP) or Contact Notification Assistance Program (CNAP in New York City) can help notify partners without revealing the patient's name.
7. HIV testing is voluntary. The practitioner must ask the patient to sign a consent form for HIV testing, and the patient should read this form carefully. The practitioner will answer any questions the patient has about HIV testing.

Patients must still provide written consent for HIV tests that require more time, but the process has been simplified. Consent for HIV testing can now be included in a patient's general consent for routine medical care as long as the

consent form permits patients to opt out of HIV testing.

Treating HIV/AIDS

We post clinical practice guidelines for the treatment of HIV/AIDS on our Web site. To review these guidelines, visit Clinical Corner at www.emblemhealth.com . In addition, New York State Quality Assurance Reporting Requirements (QARR) include four quality measures for HIV/AIDS Comprehensive Care. Recommended treatment and preventive criteria for people living with HIV/AIDS are:

- Two outpatient visits occurring at least 182 days apart (every six months) for each patient age 2 and older.
- Two annual viral load tests conducted at least 182 days apart for each patient age 2 and older.
- One annual screening for syphilis for each patient age 19 and older.
- One annual screening for cervical cancer for each female patient age 19 to 64.

Documentation of these measures must be included in the patient's medical records and will be reviewed as necessary.

Hepatitis C Testing

Effective January 1, 2014, a hepatitis C screening test must be offered to every individual born between 1945 and 1965 when one of the following criteria is met:

- Inpatient of a hospital
- Receiving primary care services in the outpatient department of a hospital
- In a freestanding diagnostic and treatment center
- From a physician, physician assistant or nurse practitioner providing primary care regardless of setting type

If the test is reactive, follow-up health care including an HCV RNA test must be offered onsite or by referral.

For more information on hepatitis C, please visit the New York State Department of Health website at https://www.health.ny.gov/diseases/communicable/hepatitis/hepatitis_c/provider.htm.

Requesting Information for Continuity of Care

The PCP will request all pertinent medical records from any other health practitioner from whom the member is receiving care. The following information will be requested:

- Patient's name, EmblemHealth ID number and birth date
- The problem or reason for visit, as stated by the patient
- The duration of the problem
- Findings on physical examination
- Diagnosis or assessment of the patient's condition
- Therapeutic or preventive services recommended or prescribed, if any, or that none were indicated

- Dosage and duration information regarding any prescription given
- Follow-up plan, or that no follow up was planned
- Childhood immunization records

Transitional Care for New Members

We make every effort to assist new members whose current providers are not participating with one of our plans. See the Continuity/Transition of Care - New Members section of the Care Management chapter for information on transition of care.

Transitional Care When Practitioners Leave the EmblemHealth Network

Upon a practitioner's termination from EmblemHealth, EmblemHealth shall:

- Make a good faith effort to notify affected enrollees of a practitioner's termination 30 days prior to the effective date
- Provide the affected practitioner with a written notice explaining the reasons for the termination or suspension as well as the right to a notice and hearing (See the Termination and Appeal section of the Credentialing chapter.)

We make every effort to assist members whose physicians end their participation with one of our plans. Members who wish to continue seeing their current health care provider for a limited time must contact or have their provider contact their plan/managing entity. See the Continuity of Care - When Providers Leave the Network subsection of the Care Management chapter on transitional care.

If the physician is a PCP and the member opts to stay with the PCP, the member must notify Customer Service of the new PCP who will manage their care following the 90-day transition period. If the physician leaving the network is a specialist and the member opts to stay with the specialist for the 90-day transition period, the member should obtain a referral to a new specialist for care following the 90-day transition period.

Newborn Access to Care

EmblemHealth Medicaid Newborns

Newborn children of mothers enrolled in EmblemHealth's Medicaid plans will be automatically enrolled in the Medicaid program of the mother's plan, and shall receive all benefits and services of that plan beginning on the newborn's date of birth, even if the newborn has not yet been enrolled.

All members should call our Customer Service department to provide their newborn's name, sex, date of birth, birth weight and birth hospital so that we can complete the enrollment process. Once enrolled, the newborn is issued a member ID card.

Note that enrollment could be delayed for a number of reasons. Therefore, if a newborn presents for care without an ID card, but the mother was an active Medicaid member on the date of the baby's birth, care must be rendered. Practitioners should call EmblemHealth's Customer Service Department to verify eligibility.

EmblemHealth Child Health Plus

Note: If a Child Health Plus member gives birth, the parent must complete an application for the newborn. There is no automatic enrollment in Child Health Plus. The parent can contact Customer Service for information on how to apply.

Medically Fragile Children Access to Care

EmblemHealth contracts with health care professionals and facilities that have expertise in caring for medically fragile children, to ensure that they, including children with co-occurring developmental disabilities, receive services from appropriate providers. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child, or seek authorization care for out-of-network providers when participating providers cannot meet the child's needs.

EmblemHealth will authorize services in accordance with established time frames in the Medicaid Managed Care Model Contract;OHIP Principles for Medically Fragile Children (Attachment G); under EPSDT, HCBS, and CFCO rules; and with consideration for extended discharge planning.

Direct Access (Self-Referral) Services

EmblemHealth Members

EmblemHealth members can self-refer for the following services to network practitioners when covered by their benefit plan:

- Chiropractic services*
- Preventive and primary care services from the member's PCP
- Preventive obstetric and gynecological care including mammography screenings and cervical cytology screenings
- Ob-gyn Care: Prenatal care, two routine visits per year and any follow-up care, acute gynecological condition
- One mental health visit and one substance abuse visit with a participating provider per year for evaluation.
- Vision Care
  - Refractive eye exams from an optometrist or ophthalmologist
  - Eyeglasses (within benefit limits)
  - Diabetic eye exams from an ophthalmologist
- HIV pre-test counseling with clinical recommendation of testing required for all pregnant women. Those women and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services. (This requirement is applicable to all qualified providers of OB/GYN care whether the member directly accesses care or is referred by another provider. See the section titled Medical Specialists for more information.)
- Emergency Care: Members should call 911.

*EmblemHealth Medicaid and Child Health Plus members do not have chiropractic coverage. See below for more details.

Medicare Members

Medicare members may self-refer to a participating clinician for certain EmblemHealth-covered services and certain Medicare-covered services at designated frequencies and ages:

- Annual mammography screening
- Annual routine eye exam
- Colorectal screening
- Four routine podiatry visits (VIP HMO, VIP Essential HMO, and VIP High Option HMO only)
- Glaucoma screening, if at high risk
- HIV screening
- Influenza and pneumococcal vaccine
- Initial chiropractic assessment
- Initial mental health consultation
- Nutritionist and social worker visit
- Prostate cancer screening

Female members may self-refer to a participating women's health care specialist for the following routine and preventive health care services:

- Pelvic exam
- Screening Pap test
- Bone mass measurement, if at risk

Members may also self-refer to a Medicare-certified hospice program.

EmblemHealth Medicaid and Child Health Plus Members

In addition to the above services to which all members have direct access, there are some services to which members in state sponsored programs (Medicaid and Child Health Plus) may also self-refer. Unless otherwise indicated, members in all state sponsored programs may self-refer to the following services:

- Unlimited behavioral health and substance use assessments (except for ACT, inpatient psychiatric hospitalization, partial hospitalization, HCBS services)
- Dental Services - Primary and preventive services from the member's assigned network dentist or to a dental clinic operated by an academic dental center.
- Orthodontic services (Medicaid only) - For orthodontic services, Medicaid members may also self-refer to Academic Dental Clinics affiliated with Article 28 Academic Centers, Medicaid fee-for-service dentists.
- Nonemergency transportation services (Medicaid members) - See the Transportation Services section of this chapter for more details.
- Family planning and reproductive health services include:
- Access to birth control
- Sterilization procedures
- Medically necessary abortions
- Screening for anemia, cervical cancer, sexually transmitted diseases, breast disease, pelvic abnormality and pregnancy

Medicaid members can obtain these services from a participating practitioner or any Medicaid fee-for-service

provider. Participating practitioners must bill EmblemHealth and not Medicaid FFS for family planning services. If the member is assigned to a Managing Entity, the participating practitioner must bill the Managing Entity at the address on the back of the member's ID card. However, all Child Health Plus members must self-refer to a participating clinician for family planning/reproductive health services.

All members must use network physicians for all other gynecologic and obstetric care, including hysterectomies, routine Gynecological exams, prenatal and postpartum care.

Federal regulations require patient notification for hysterectomy and sterilization procedures. The patient or their representative must sign the required consent form for the service to be deemed a covered service under the Medicaid plan. This form must also accompany manual claim submissions as proof of consent. If the required form is not received, then the claim will be returned requesting the required form. Once the form is received, then the claim will be considered eligible and processed.

Claims for hysterectomy procedures must be submitted along with a copy of the completed and signed Acknowledgment of Receipt of Hysterectomy Information Form, LDSS-3113. When billing for procedures performed for the purpose of sterilization (Code F), a completed Sterilization Consent Form, LDSS-3134, is required and must be attached to the claim. Both forms can be obtained from the New York State Department of Health's website at Local Districts Social Service Forms.

- Assessments for Foster Care Children (Medicaid) - EmblemHealth requires a 30-day obligation to complete a comprehensive physical that includes a behavioral health assessment and an assessment of exposure to any infectious disease. Foster Care children are not eligible for CHPlus.

  Starting in 2019, EmblemHealth will manage the delivery of expanded behavioral and physical health services for this population. Please see the end of this chapter for a copy of Foster Care Initial Health Services. This table outlines the time frames for initial health activities, to be completed within 60 days of placement. These assessments are a critical component to the development of a comprehensive plan of care.

- Child Protective Services (Medicaid) - EmblemHealth physicians shall comply with agencies such as Child Protective Services (CPS) or any other court-ordered services. This compliance includes, but is not be limited to, the provision of medical information to the CPS agency's investigation and any subsequent amendments thereto. If the child is referred by a court order for covered medical services, these services must be provided whether or not they are covered by the plan. Clinicians that are not currently participating with EmblemHealth will be reimbursed at the Medicaid fee schedule. For CHPlus, court-ordered services are only covered if they are medically necessary and covered by the plan.

- Immunizations - Members can obtain immunization services from an EmblemHealth network practitioner. However, immunizations provided to all Child Health Plus members and to Medicaid children under 19 years of age must be given with vaccines obtained through the Vaccines for Children Program. See the Pharmacy chapter of this manual for more details.
  In addition, Medicaid members can obtain immunization services from a public health agency clinic. Public health agencies are required to make reasonable efforts to contact the member's PCP to ascertain the member's immunization status prior to service delivery. If the public health agency clinic is unable to verify the immunization status from the PCP or learns that immunization is needed, it is authorized to render the service as appropriate and bill EmblemHealth or the responsible full risk provider.

- Tribal Health Center Services - Native Americans enrolled in EmblemHealth's Medicaid plan are free to access primary care services through their tribal health center without a referral or prior approval. EmblemHealth network PCPs must develop a relationship with tribal health center PCPs to ensure coordination of patient care.

- Tuberculosis (TB) screening, diagnosis and treatment, administered by EmblemHealth participating practitioners or from public health agency facilities. Public health agencies are required to notify EmblemHealth or the member's PCP of the presentation of TB in order to verify previous TB treatments and bill for the services rendered.
  EmblemHealth does not cover, and Medicaid FFS should be billed for, the following TB-related services:
  - Direct observed therapy (DOT) due to noncompliance with TB care regiments
  - HIV counseling and testing during a TB-related visit at a public health clinic
  - Testing for chlamydia

EmblemHealth participating practitioners and laboratories must report TB and STD cases to the local public health

agency. State and local departments of health will be available to offer technical assistance in establishing TB reporting policies.

- HIV counseling and testing services administered by:
  - EmblemHealth network practitioners
  - Anonymous HIV counseling and testing centers
  - For Medicaid members, any Medicaid fee-for-service practitioner as part of a family planning encounter
  - For New York City Medicaid members, any New York City Department of Health and Mental Hygiene clinic
- HIV / AIDS treatment services administered by EmblemHealth network practitioners
- Emergency care - EmblemHealth covers emergency care for Medicaid and Child Health Plus members in all 50 United States, Washington D.C, Canada, the United States Territories of the Virgin Islands, Puerto Rico, Guam, American Samoa, the Northern Mariana Islands and American territorial waters. Members that have a condition meeting the definition of emergency while in one of these areas can go to the nearest emergency room or call 911. Emergency care services are covered in Mexico for Child Health Plus members.

Medicaid Pregnant Members Only

- HIV pre-test counseling services with a clinical recommendation of testing
  Those women and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services.

EmblemHealth Neighborhood Care

The mission of EmblemHealth Neighborhood Care is to reinforce a holistic approach to health and wellness and help health plan and community members take a more active role in their mental and physical well-being. EmblemHealth Neighborhood Care offers our plan members and other community members a place to go to get the personalized, one-on-one support of experts in clinical, benefits and health management solutions. Neighborhood Care does not provide medical services. Instead, our role is to help practitioners manage patient care by supporting the primary practitioner-patient relationship.

Using the EmblemHealth Neighborhood Care Provider Recommendation Form, providers can recommend that a plan member visit a local Neighborhood Care site for the services listed below (see the forms at the end of this chapter and at emblemhealth.com):

- In-person EmblemHealth customer service (billing, claims)
- Health plan navigation
- Care management and coordination (for EmblemHealth plan members)
- Assistance with DME fulfillment
- Health and wellness resources
- Fitness and wellness classes
- Health care education
- Behavioral health care
- Medication support
- Disease and condition self-management

The Neighborhood Care team of professionals consists of:

- Site Managers: Site managers oversee the staff and operations of the site and also function as customer care navigators to help make appropriate connections for customers. They also work with community partners and care providers to develop health and educational programming relevant to the site to address the needs specific to the community.
- Customer Care Navigators: Customer Care Navigators help connect EmblemHealth members to health and wellness services, care coordination and customer service, and community resources. They also make warm connections to sales partners to help visitors determine their eligibility for health care, choose a health plan and complete health plan enrollment.
- Social Workers: Certified Social Workers assist members with matters such as housing, financial assistance, education and career guidance and specialized health services. They also help make connections to community resources.

Neighborhood Care locations:

Manhattan

EmblemHealth Neighborhood Care — Harlem (AdvantageCare Physicians next door)

215 W 125 Street | 866-469-0999

EmblemHealth Neighborhood Care — Chinatown

87 Bowery | 855-283-2151

EmblemHealth Neighborhood Care at AdvantageCare Physicians Express

52 Duane Street 212-423-3901

Queens

EmblemHealth Neighborhood Care — Cambria Heights (AdvantageCare Physicians next door)

206-20 Linden Blvd | 866-539-0999

EmblemHealth Neighborhood Care at AdvantageCare Physicians Flushing Medical Office

140-15 Sanford Ave Suite A, Area G | 800-447-0752

Brooklyn

EmblemHealth Neighborhood Care — Crown Heights (AdvantageCare Physicians next door)

546 Eastern Parkway | 855-283-2156

EmblemHealth Neighborhood Care at AdvantageCare Physicians Brooklyn Heights Medical Office

195 Montague Street, Floor 2 | 212-423-3901

EmblemHealth Neighborhood Care — Bensonhurst at EmblemHealth sales office

2482 86th Street | 800-447-0856

Visit the EmblemHealth Neighborhood Care website at emblemhealth.com/community for more details.

Transportation Services

Emergency transportation services for EmblemHealth members with conditions that meet the definition of emergency can call 911 for emergency transportation. Non-emergency transportation for EmblemHealth Medicaid and Medicaid Advantage members should be arranged according to the instructions in the Transportation chapter.

TeleHealth Services

EmblemHealth members enrolled in either a Medicaid or Medicare-Medicaid plan are able to access telehealth services from approved home health care agencies as a covered benefit if the members are assessed by the home health care agency on an individual basis and the members meet specific criteria.

To be eligible, the member must have conditions needing frequent monitoring and be at-risk of acute or long-term care facility admission. (Congestive heart failure, asthma, cardiac conditions, chronic obstructive pulmonary disease (COPD), HIV and diabetes are the most frequent diagnoses for those currently receiving telehealth services. However, this is not an exhaustive list of conditions for which telehealth may be indicated. Each case is assessed individually to determine the appropriateness of telehealth monitoring.) Telehealth services may only be provided during an episode of home care. They must be an adjunct to nursing care and they do not replace physician-ordered nursing visits.

The home health care agency must submit a doctor's order to EmblemHealth along with the member's assessment in order to obtain prior approval to provide telehealth services to the member as a covered benefit.

EmblemHealth will cover telehealth services if they are deemed medically necessary. If a member enrolls in EmblemHealth while in receipt of telehealth services through Medicaid fee-for-service, we provide transitional care while we conduct our own assessment of the individual's care needs. Our review may include review of the original assessment or we may request a new assessment.

Only home care agencies approved by Medicaid as providers of telehealth are authorized to provide telehealth monitoring.

The home health care agency may then bill using HCPCS code T1014 for either the nursing visit or the installation, but not both. Authorization is given for 30 days. On day 30, another 30 days may be requested. If longer than 60 days are needed, the member must be reassessed.

The risk assessment tool completed by the home care agency incorporates the following information. The member:

- Is at risk for hospitalization or emergency care visits
- Lives alone
- Has a documented history of, or is at risk of, requiring unscheduled nursing visits or interventions
- Has a history of non-compliance in adhering to disease management recommendations
- Requires ongoing symptom management related to dyspnea, fatigue, pain, edema, or medication side effect or adverse effects
- Resides in a medically under-served, rural or geographically inaccessible area
- Requires frequent physician office visits
- Has difficulty traveling to and from home for medical appointments
- Has the functional ability to work with the telehealth monitoring equipment in terms of sight, hearing, manual dexterity, comprehension and ability to communicate

Disclosure and Reporting Responsibilities

EmblemHealth shall not prohibit or restrict any practitioner from disclosing to any member, patient or designated representative any information that the practitioner deems appropriate regarding a condition or course of treatment with a member including the availability of other therapies, tests, medications, etc., regardless of benefit coverage limitations. EmblemHealth shall not prohibit or restrict a health care professional, acting within the lawful scope of practice, from advocating on behalf of an individual who is a patient and enrolled under EmblemHealth. Practitioners shall not be prohibited from discussing the risks, benefits and consequences of treatment (or absence of treatment) with the member, patient or designated representative. Patients shall have the opportunity to refuse treatment and to express preferences about future treatment decisions.

EmblemHealth Medicaid and Child Health Plus Responsibilities to Government Agencies

Any activities and reporting responsibilities delegated to a subcontractor, including a practitioner, shall be performed pursuant to standards set forth by the SDOH. In the event such policies and procedures are not complied with and the practitioner does not meet the SDOH requirements, EmblemHealth and/or SDOH may revoke the delegation in whole or in part. SDOH may also impose other sanctions if the practitioner's performance does not satisfy standards set forth in the agreement between EmblemHealth and SDOH for the Medicaid program. As required, the practitioner shall take any necessary corrective action(s) with respect to any delegated activities and responsibilities.

Subcontractors, including practitioners, shall perform all work and render all services in accordance with the terms of the agreement between EmblemHealth and SDOH for Medicaid. Practitioners agree to comply with and be bound by the confidentiality provisions set forth in the above referenced agreement. Any obligations and duties imposed on sub-contactors, including participating practitioners, do not impair any rights accorded to LDSSs, SDOH, the New York City Department of Health and Mental Hygiene (NYCDOHMH) or DHHS.

Contracted Vendors

EmblemHealth contracts with vendors to provide services to EmblemHealth plan members. These vendors are considered network providers. Prior approval, if required, must be obtained directly from these vendors. For a listing of EmblemHealth network vendors, please go to the Directory in this manual. More information about each vendor is organized by subject or specialty in the various chapters of this manual.

Physician Incentive Program

In the event EmblemHealth elects to operate a physician incentive plan, no specific payment will be made directly or indirectly to a network practitioner or group as an inducement to reduce or limit medically necessary services furnished to a member. All practitioner agreements will include language requiring that the practitioner submit incentive plan information to EmblemHealth in an accurate and timely manner and in the format requested by the NYSDOH.

Appointment Availability Standards During Office Hours & After Office Hours Access Standards

Please see the end of this chapter for a copy of our Appointment Availability Standards During Office Hours & After

Office Hours Access Standards.

Dental Service - DentaQuest

As of January 1, 2017, DentaQuest manages the dental benefits for members in the VIP Prime; Medicare Essential; Enhanced Care Prime; Prime; Premium (aka Vytra Premium); and Select Care Networks. This also includes those using the out of area benefits (via Careington) through our Preferred/Plus Dental Network. Go to dentaquest.com for more details, or call DentaQuest at 1-844-822-8108, Monday to Friday from 8 am to 5 pm.

Forms

See the following pages for the EmblemHealth Neighborhood Care Provider Recommendation Forms for the Cambria Heights and Harlem locations

EmblemHealth

Provider Manual

Chapter 9: Health Promotion and Care Management

In this chapter you will find quality improvement programs available to help members with identified conditions and diseases.

Health Promotion

EmblemHealth has health and wellness programs, tools and resources to help members stay fit and enhance their quality of life. EmblemHealth members have access to Healthy Discounts programs at no additional cost. Participating vendors offer discounts off their usual and customary fees for health club memberships, acupuncture, massage therapy and nutrition counseling, weight loss services, hearing and vision care, vitamins and supplements, and other comprehensive health care services and products.

Some member benefit plans include the ExerciseRewards™ Program, a gym membership reimbursement program where members can get back up to $200 of their membership dues.

EmblemHealth promotes the following quality improvement initiatives for EmblemHealth, GHI and HIP plan members through member and provider newsletters, and other educational materials:

Women's Wellness

- Breast health and mammography
- Cervical cancer screening
- Chlamydia screening
- Osteoporosis and musculoskeletal health
- Timely prenatal and postpartum care

Adult Health

- Cardiac care
- Cholesterol management
- Colorectal cancer screening

- Depression screening
- High blood pressure management
- Influenza and pneumonia vaccinations
- Stress management
- Weight management
- Appropriate use of antibiotics
- Respiratory management (COPD and asthma)
- Medication management and safety

Childhood and Adolescent Care

- Well-care visits
- Vaccinations
- Lead screening
- Dental screening
- Depression screening
- Adolescent immunizations
- Adolescent screening and counseling for:
  - Exercise
  - Nutrition
  - BMI and weight management
  - Sexual activity
  - Tobacco and substance abuse
  - Appropriate use of antibiotics

Counseling

- Smoking
- Alcohol
- Substance abuse

Clinical practice guidelines are updated regularly on emblemhealth.com. Please check updates on a monthly basis.

Care Management Programs

Overview

EmblemHealth has set up a Population Health Management model. It identifies members who require help to meet their care needs.

EmblemHealth's strategy is focused on keeping members healthy, managing those members with emerging risk, assessing social determinants of health, patient safety, and supporting members who have multiple complex health conditions.

Using sophisticated predictive modeling tools, we can identify members with developing risk to engage them earlier,

as well as identify members who would most benefit from field-based care management.

Members' needs are addressed through various initiatives. In the past, members with chronic conditions would have been managed through a standalone disease management program. Now, they are identified through our predictive modeling data, so we can provide them with the appropriate care.

Focus on care management programs assists with the overall care management of members. Our programs are designed to complement the care our members receive.

Activities include, but are not limited to:

- Collaborating with community-based organizations and hospitals to improve transitions of care from one setting to another and different levels of care.
- Coordinating care between practitioners and specialists, and behavioral health and medical practitioners.
- Providing information to you (the physician) regarding progress, member educational materials, member calls as appropriate, and other services as noted on the EmblemHealth website.
- We offer:
  - Scheduled outbound calls.
  - Field-based care managers' face-to-face interactions.
  - Ongoing education, as appropriate to each program.

Referrals for these programs are received through health risk surveys, claims data, self-referrals, caregiver referrals, discharge planner referrals, or directly from you, as the practitioner.

Program goals include:

- Higher compliance with physician instructions.
- Coordinating member continuum of care across potential settings, providers, and levels of care.
- Increased patient condition knowledge.
- Symptom improvement and/or stabilization.
- Reduction in inappropriate utilization.
- Positive behavioral health changes.

Practitioners may refer members to our care management programs, or the member may contact us directly at 800-447-0768 (TTY: 711). Our hours are 9 a.m. to 5 p.m., Monday to Friday. Enrollment is voluntary and, if applicable, allows members to receive:

- Educational tools to assist with understanding their diseases, symptom management, diet and nutrition needs, treatment options, and planning for doctor visits.
- An opportunity to work one on one with a nurse, social worker, or behavioral health care manager by telephone or face-to-face interaction.
- Access to community-based support services.
- Access to additional care through our other care management programs.

Care Management Program Components

The care management programs support practitioner care plans by using evidence-based clinical practice guidelines (CPGs) to emphasize ways to prevent complications and flare-ups of chronic conditions.

Key components include the following, as applicable:

- Matching members with disease-specific programs that meet their individual needs.
- Prompting practitioners and members to follow evidence-based clinical practice guidelines in treating chronic illness.
- Coordinating care amongst practitioners, support services providers, the health plan, the member, and caregivers.
- Educating and empowering members to make lifestyle choices that may prevent or control their conditions (including behavioral modification and compliance/surveillance).
- Providing health coaching and monitoring centered around a care plan created by a registered nurse and/or other clinically trained or licensed health professional.
- Making appropriate use of information technology. This may include specialized software, data registries, automated decision support tools, and tickler systems for materials and/or calls.
- Measuring progress and outcomes of care for quality improvement, reporting, and performance-based payment purposes.

Healthy Beginnings Pregnancy Program

The Healthy Beginnings pregnancy program helps eligible members better understand and manage their pregnancies and gives them support and education throughout their pregnancy. Program services include:

- A series of health-risk surveys that identify potential high-risk factors.
- Specialized care management services for members identified with risk factors.
- Comprehensive educational materials.
- Access to a 24-hour toll-free Nurse Line staffed by experienced nurses able to answer questions on pregnancy-related topics (note, no medical advice is given).
- Depression screening.
- Reminder mailings encouraging postpartum visits.

EmblemHealth follows New York State Prenatal Care Assistance Program (PCAP) guidelines to provide comprehensive care and information to women during and after pregnancy.

Healthy Beginnings pregnancy program provides screenings for high-risk behaviors, depression, tobacco, and drug and alcohol use, as well as education to expectant mothers about community services available in their area. Medicaid members also receive child birth/parenting education and receive Women, Infants and Children (WIC) Food Nutrition Service Program referrals free of charge.

More information, clinical guidelines, and resources can be found online at the PCAP website at health.state.ny.us/nysdoh/perinatal/en/pcap.htm.

For more information about the Healthy Beginnings pregnancy program, or to refer a member, please call 888-447-0337 (TTY: 711). Our hours are 9 a.m. to 5 p.m., Monday through Friday.

Tobacco-Free Quit-Smoking Program

EmblemHealth has partnered with the New York State Smokers Quitline to provide comprehensive smoking cessation services. New York State Smokers Quitline is a state program based at the Roswell Park Cancer Institute in Buffalo, NY. The program is available at no cost to all individuals residing in New York State.

Services available through the New York State Smokers Quitline include:

- Help developing a quit plan by phone from trained quit-smoking experts.
- Recorded phone messages and tips available 24 hours a day, seven days a week.
- Receipt of educational guides and materials by mail.
- A two-week supply of nicotine replacement therapy (nicotine patch or gum) for those who qualify.
- Access to information and services through the New York State Quitline website.
- Full coverage for smoking cessation medication (nicotine patch, gum, lozenge, bupropion [generic Zyban ®], and Chantix®) for members with EmblemHealth pharmacy benefit coverage enrolled in the Tobacco-Free quit-smoking program. Medicare members will be responsible for a copay for the smoking-cessation prescription products.

Practitioners are encouraged to refer members directly to the New York State Smokers Quitline at 866-NY-QUITS (866-697-8487), or 311 in New York City. Referral forms can be found online at nysmokefree.com. For out-of-state members, referrals can be made directly to the program by calling 877-500-2393.

Studies show that a follow-up visit or phone call within one week of the patient's quit date can double the effectiveness of any intervention. EmblemHealth provides reimbursement for smoking-cessation counseling based on current Centers for Medicare & Medicaid Services guidelines. We will reimburse for CPT codes 99406 and 99407.

We also offer a Tobacco-Free quit-smoking program.

For clinical practice guidelines, go to the Clinical Corner on our website.

Healthy Living Program

EmblemHealth provides many tools to help members manage their weight.

For more information about body mass index (BMI), clinical practice guidelines, recommendations, coding and tools, and the Childhood Obesity Action Network's implementation guide to prevention and treatment of childhood obesity, visit the Provider Weight Management Resources section of our website.

Serious and Persistent Mental Illness Disease Management Services

Our Serious and Persistent Mental Illness Disease Management Services is designed to help members with serious mental illness and high risk of hospitalization remain engaged in treatment in the most appropriate and least restrictive settings possible.

This program, delivered by master's-level clinicians, emphasizes communication with practitioners and family members, proper medication and treatment adherence, education for members and their families, access to community resources, and coordination of care.

HIP members may be enrolled by calling 888-447-2526 (TTY: 711)/GHI members 800-692-2489 (TTY: 711). If your patient’s ID card has a Montefiore logo in the lower left corner, please call 800-401-4822 (TTY: 711) for help finding a mental health or substance abuse practitioner.

Contract Management Organization Programs

The Contract Management Organization (CMO) programs are delegated for EmblemHealth plan members who receive treatment under the care of a CMO (i.e., Montefiore Medical Center) provider. They offer care management programs for members with chronic medical and behavioral health conditions.

For questions or more information about CMO Programs, please call 844-209-4932 (TTY: 711). Our hours are 9 a.m. to 5 p.m., Monday to Friday.

Note: For members with multiple chronic illnesses, or with severe or end-stage illness, this guidelines-based care should not take precedence over the provision of care that corresponds to patient preferences and needs. Such members require highly individualized care plans and are therefore typically not suited for participation in some of the care management programs.

Care for the Family Caregiver

EmblemHealth serves our members across all health plans, as well as the communities where our members live, with innovative, evidence-based programs that promote healthy living and advance better health outcomes.

Care for the Family Caregiver provides information, resources and support to promote awareness and understanding of the key role of the family caregiver within the health care system. Through its programs for members and employees, community outreach and partnerships, Care for the Family Caregiver provides support and encouragement to family caregivers to keep them from becoming care recipients. Programs such as Seniorlink are of particular interest to family caregivers with long distance caregiving needs. Seniorlink's national network provides expert assistance in developing senior care planning, regardless of where the care recipient lives, and helps reduce the stress of navigating a complex eldercare system. EmblemHealth continues to host and sponsor the NYC Family Caregiver Coalition. More information, resources and support may be found in the Care for the Family Caregiver webpage.

CME Events and Other Educational Opportunities

Educational opportunities in the arenas of mind and body medicine, self-care and spirituality and belief are available to the EmblemHealth provider community.

Currently, we support this commitment with our continuing medical education (CME) event: the Carl E. Flemister Symposium on Mind/Body Medicine, Spirituality and Health. This symposium makes available to our practitioners the most recent scientific research on the biology and physiology of belief and helps them to consider ways to make this research relevant in their practices. Leading experts on spirituality and health are invited to speak at the symposium.

We have also published a first-of-its-kind training and resource manual called The Medical Manual for Religio-Cultural Competency: A Comprehensive Resource for Providing Quality Care in a Diverse Health Care Setting, written by the Tanenbaum Center for Interreligious Understanding. Practitioners can now look to one resource to provide practical information on how the beliefs and practices of 10 of the world's major religious traditions intersect with medical science. This manual is packed with readily-accessible information for the busy health care practitioner who wants to be religio-culturally competent. Its wide-ranging chapters include practical information on different religions, spiritual assessment forms and tools, and tips for working effectively with people of diverse religious backgrounds and points of view. You may access The Medical Manual in its entirety by signing in to emblemhealth.com.

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Chapter 10: Pharmacy Services

This chapter contains information regarding pharmacy benefit services and prescription drug coverage, including pharmacy benefit designs, our Specialty Pharmacy Program, Medication Therapy Management program and home delivery.

Pharmacy Benefit Services Telephone Contacts

Clinical Pharmacy Services (Providers)

EmblemHealth:
(877) 362-5670, Monday through Friday, 8 a.m. to 6 p.m.

Express Scripts, Inc. (ESI):
(home delivery for all plan members except for state and federal employees and retirees with GHI coverage)
Physicians may call in new prescriptions to Express Scripts at (888) 327-9791.

Specialty Pharmacy Program:
(888) 447-0295, Monday through Friday, 8:30 a.m. to 5 p.m.

Accredo:
855-216-2166, Monday to Friday, 8 a.m. to 11 p.m.; Saturdays, 8 a.m. to 5 p.m.

Go to the Pharmacy Services section of the Directory chapter for additional contact information.

Pharmacy Benefit Services

Although prescriptions can be filled at one of our participating pharmacies, we encourage members to use our home delivery drug program as a more cost-effective method of medication management. Covered drugs are subject to the patients' applicable copay(s) as defined by their pharmacy coverage.

Pharmacy contact numbers are listed in the Pharmacy Benefit Services Telephone Contacts section of this chapter and in the Directory chapter.

The EmblemHealth Drug Formularies

The EmblemHealth formularies are compilations of brand name and generic pharmaceuticals covered under our benefit plans.

Experimental or investigational drugs (i.e., non-FDA approved) are excluded from coverage. The medications listed in EmblemHealth's formularies are covered for members who have prescription drug coverage, as defined by their benefit plan. EmblemHealth Child Health Plus members are covered for both formulary prescription drugs and a select list of nonprescription drugs (that are not listed on the Commercial formulary) when prescribed by a licensed healthcare professional.

EmblemHealth contracts with the Centers for Medicare & Medicaid Services (CMS) to provide drug coverage for Medicare Part D members using the Medicare Part D Drug Formulary, utilization management programs and pricing structure.

Effective October 1, 2011, EmblemHealth Medicaid members can receive pharmacy benefits directly from EmblemHealth rather than from New York State Medicaid.

Medications selected for inclusion in our formularies are chosen by specialty subcommittees whose recommendations are reviewed and finalized by the Pharmacy and Therapeutics (P&T) Committee. Members of the P&T and specialty committees include participating specialists, pharmacists and administrators. Together, these committees identify the pharmaceuticals that will provide optimal results for our members while controlling the cost of drug therapy. The committees meet regularly to keep the drug formularies current.

Visit the webpages listed in the following table to determine whether a drug is covered by a member's benefit plan.

Formulary Searches

Title	Description	Location

Commercial Drug Formularies	EmblemHealth, GHI, HIP and Vytra commercial benefit plans and EmblemHealth Child Health Plus	Pharmacy
Medicare Part D Formulary	E mblemHealth Medicare HMO, EmblemHealth Medicare PPO and EmblemHealth Medicare PDP	Request a Formulary
Medicaid Formulary	EmblemHealth Medicaid	http://www.emblemhealth.com/~/media/Files/PDF/Alpha_HIP_MCaid_FHP1.pdf
ConnectiCare VIP Medicare Formulary	ConnectiCare VIP (HMO) and ConnectiCare VIP (HMO-POS) plans	www.connecticare.com/medicare/PDF/FORMULARY.pdf

Pharmacy Benefit Designs

We offer several pharmacy benefit designs, which determine coverage of certain drugs as well as copay amounts for our members. Each pharmacy benefit plan is subject to regulations, state and federal laws, clinical guidelines, a prior approval process and quantity limitations, unless otherwise specified. Covered pharmacy services must be listed on the Commercial or Medicare formularies, unless the member's benefit includes nonformulary/nonpreferred drugs. (The drug formularies may describe drugs as either "formulary" or "preferred" or "nonformulary" or "nonpreferred.")

Generic Versus Brand Medications

Our prescription benefit design is formatted into three categories of prescription medications. Due to the number of drugs on the market, the continuous introduction of new drugs, new applications of existing drugs and new information regarding safety, the design is continually revised.

Tier 1 - Preferred Generic Drugs

Generic drugs (tier 1) are chemically identical to brand drugs, but are priced at a fraction of the cost and offer an excellent value to the member. To gain FDA approval, a generic drug must:

- Contain the same active ingredients as the branded drug (inactive ingredients may vary).
- Be identical to the brand drug in strength, dosage form, safety and route of administration.
- Be of the same quality, performance characteristics and use indications.

- Be manufactured under the same strict standards of the FDA's good manufacturing practice regulations required for branded products.

If a generic is chosen, the practitioner must leave blank the "DAW" (Dispense As Written) box. This way, the pharmacist will fill the prescription with the generic drug.

Tier 2 - Preferred Brand Drugs

We have identified a listing of formulary brand drugs (tier 2) available at a lower copay than drugs in the nonpreferred drug category. This generally happens when there are several equally effective, FDA-approved brand name drugs by different manufacturers for treatment of a particular condition. (Some plans also include single source generics in Tier 2.)

Tier 3 - Nonpreferred Brand and Generic Drugs

Drugs in the nonpreferred category (tier 3) generally have a similar, more cost effective drug available in either the preferred generic drug category (tier 1) or the preferred brand drug category (tier 2).

Most new FDA-approved drugs are initially placed in tier 3 for about excluded from coverage for up to six months until the P&T Committee reviews them for safety, efficacy and clinical comparisons.

Copay Designs

The following table outlines the more common benefit structures with regards to copayment.

Copay Designs

Benefit Levels	Benefit Structure
Single Tier Copay (with or without a deductible)	- The same copay for covered generic, preferred brand and nonpreferred brand or generic drugs
Two-Tier Copay (with or without a deductible)	- A lower copay for covered generic drugs - A higher copay for covered preferred brand and nonpreferred brand or generic drugs
Three-Tier Copay (with or without a deductible)	- A lower copay for covered generic drugs - A middle copay for covered preferred brand drugs - A higher copay for covered nonpreferred brand or generic drugs
Percentage Coinsurance (with or without a deductible)	- Coinsurance is based on a defined or set percentage of the actual cost for covered generic, preferred brand and nonpreferred brand or generic drugs

Members must pay a copay and/or deductible (as specified on their ID card) for each supply of medicine received at

a participating pharmacy or through an affiliated mail order pharmacy.

Note: EmblemHealth Medicaid members cannot be denied health care services based on their inability to pay the copay at the time of service. However, providers may bill these members or take other action to collect the owed copay amount.

Prior approval and/or quantity limits apply to certain medications. Please read the Nonpreferred Drugs section of this chapter for more details.

Depending on the specifics of a member's pharmacy plan, a 90-day supply mail order prescription drug service may be available. Please read the Home Delivery Pharmacy Program section in this chapter for more information.

Nonpreferred Drugs

FDA-Approved

Practitioners prescribing an FDA-approved nonpreferred (tier 3) drug for a member whose benefit does not cover nonpreferred drugs should contact Pharmacy Benefit Services at 1-877-362-5670.

The requesting practitioner and an EmblemHealth clinical pharmacist will discuss the parameters to determine whether the member requires a nonpreferred medication. Practitioners must submit proper documentation and, if appropriate criteria are met, a physician's prior approval (PPA) number will be issued while the member is in the practitioner's office (whenever possible). If the prior approval criteria are not met, the EmblemHealth clinical pharmacist will contact an EmblemHealth medical director for approval/denial of the request. If our medical director denies the request, the practitioner will be notified and a denial letter issued to the member. For information on disputing a denial, please refer to the Dispute Resolution chapters.

Non-FDA-Approved

Practitioners requesting a non-FDA-approved drug or an approved drug for a non-FDA-approved usage must complete and submit a Non-FDA-Approved Drug Use and/or Dose Request Form via fax to 1-877-300-9695 or mail to:

EmblemHealth
Pharmacy Benefit Services
Attn: Pharmacy Services
55 Water Street
New York, NY 10041

The request is evaluated by an EmblemHealth medical director to determine if an expedited review is necessary. If the prescribing physician requests an expedited review, it will be processed as such. EmblemHealth Pharmacy Benefit Services will notify the requesting practitioner of the decision.

Additions to the Formulary

Following the introduction of any new drug in the U.S. market, the P&T Committee will typically allow for at least a six-month period of study before any final decision is made on inclusion of the drug to the formulary. During this time, the P&T Committee carefully observes the use and experience of the newly marketed drug in the general population, with regard to its efficacy, safety and drug interactions, and evaluates members' needs to determine

whether there are any advantages of the new drugs over the existing formulary drugs. After this study period, a final recommendation will be made.

Practitioners who would like to request the inclusion of a drug in the Commercial Formulary can complete an Addition to Formulary Request Form. Such requests must be completed and submitted with pertinent clinical data and/or literature justifying the addition of the drug to the formulary. The requests will be reviewed by the appropriate specialty subcommittee(s) for their recommendation and then sent to the P&T Committee for a final decision. Completed Addition to Formulary Request Forms can be submitted via fax to 1-877-300-9695 or mail to:

EmblemHealth
Pharmacy Benefit Services
Attn: Formulary Management Team
55 Water Street
New York, NY 10041

Medicaid Pharmacy Program

Under this program, EmblemHealth promotes the use of less expensive, equally effective prescription drugs when medically appropriate. EmblemHealth Medicaid members must use pharmacies that will accept their benefit ID card; pharmacies must comply with all applicable Medicaid program requirements.

We cover the following pharmacy services for members with EmblemHealth Medicaid coverage:

- As of October 1, 2011, EmblemHealth covers pharmacy benefit services for all EmblemHealth Medicaid members. The benefit includes prescription drugs, all Medicaid covered over-the-counter medications, diabetic supplies, select durable medical equipment and medical supplies.
- EmblemHealth covers medical/surgical supplies routinely furnished or administered as part of an office visit for EmblemHealth Medicaid members. Note: Medical/surgical supplies dispensed in a doctor's office or other non-inpatient setting, or by a certified home health aide as part of an at-home visit, are not covered as separate billable items.

For more details on coverage of medical/surgical supplies, please refer to Appendix B in the Provider Networks and Member Benefit Plans chapter.

Effective January 1, 2017, our Medicaid/HARP members will no longer be able to fill prescriptions at CVS or Target. When writing prescriptions for these members, especially when ePrescribing or prescribing controlled substances, please ask them to designate a new pharmacy. Although members can arrange to have certain prescriptions moved from CVS or Target to a new pharmacy, if you are able to have the prescription sent to the right place, it will improve the member's experience and increase the likelihood of medication compliance.

Use the Medicaid Pharmacy Locator to find alternate pharmacies to recommend to your Medicaid members.

NYSDOH Medicaid Prior Authorization Request Form for Prescriptions

The New York State Department of Health (NYSDOH) has created a New York State Medicaid Prior Authorization Request Form for Prescriptions to streamline managed care organizations' prior approval procedures for medications prescribed to members covered by Medicaid. EmblemHealth is complying with NYSDOH's requirement to use this form.

If the drug you want to prescribe to your EmblemHealth Medicaid patient requires prior approval, please download and complete the New York State Medicaid Prior Authorization Request Form for Prescriptions and fax it to 1-877-300-9695.

The member may also download this form and present it to you for completion. Please fill out the form and fax it to the number above.

Prior Approval

Prior approval is required for:

- Non-preferred medications (except for typical anti-psychotics, anti-depressants, anti-rejection drugs and anti-retroviral drugs used for HIV/AIDS)
- Drugs with coverage limitations (e.g., frequency, quantity, duration limits)
- Drugs that require clinical review (e.g., step protocols, certificate of medical necessity)
- Generics when the cost of the brand name is less than the generic

Prior approvals may be obtained by calling 1-866-447-9717. Prior approvals are valid for up to six months, with a maximum of five refills.

Excluded Medications

The EmblemHealth Medicaid Formulary excludes medications used for:

- Weight loss
- Erectile dysfunction
- Promotion of fertility
- Cosmetic purposes

It also excludes drugs without a National Drug Code (NDC). In addition, under the Mandatory Generic Program, coverage for brand name medications is excluded when the FDA has approved an A-rated generic equivalent, unless a prior approval is obtained or the drug is exempted.

For more information on the EmblemHealth Medicaid Formulary click here.

Vaccines for Children Program

EmblemHealth requires all eligible Child Health Plus (CHPlus) and Medicaid providers to participate in the Vaccines for Children (VFC) Program. The VFC Program is a New York State Department of Health (NYSDOH) and New York City Department of Health and Mental Hygiene (NYCDOHMH) program that distributes free vaccines to eligible providers that serve CHPlus/Medicaid members under 19 years of age within New York City (Bronx, Kings, New York, Queens, Richmond counties) and Nassau, Suffolk and Westchester counties. Members that meet these criteria are commonly referred to as VFC-eligible members.

Although vaccinations are a covered benefit for CHPlus/Medicaid members, EmblemHealth is not responsible for the cost of the vaccines available through the VFC Program.

EmblemHealth will only reimburse Providers for the cost of administering vaccines to VFC-eligible members. Providers are required to bill vaccine administration code 90460 for administration of vaccines supplied by VFC, including influenza and pneumococcal administration. For reimbursement purposes, the administration of the components of a combination vaccine continues to be considered as one vaccine administration. More than one vaccine administration is reimbursable under vaccine administration code 90460 on a single date of service.

The following is a list of the CPT codes for vaccines that will be auto-denied when administered to any VFC-eligible members under the age of 19 years: 90633, 90636, 90647, 90648, 90649, 90650, 90670, 90672, 90680, 90681, 90685, 90686, 90696, 90698, 90700, 90707, 90710, 90713, 90715, 90716, 90718, 90723, 90732, 90734, 90744, 90748.

Regulations Regarding Known Sex Offenders in Government Programs

As per government legislation, we do not cover supplies for the treatment of erectile dysfunction (ED) for sex offenders enrolled in any state-sponsored programs.

For more information regarding the prior approval program created by the New York State Department of Health for Medicaid members for the provision of ED procedures and supplies, see Prior Approval for Procedures, Supplies and Drugs for Erectile Dysfunction Treatment in the Care Management chapter.

Medicaid Pharmacy Behavioral Health Carve-in

EmblemHealth expanded the Behavioral Health Benefit offered to Medicaid members. The Behavioral Health Pharmacy services previously covered under Fee-for-Service Medicaid through SSI will now be covered through EmblemHealth.

Emergency Pharmacy for Members with a Behavioral Health Condition

Except where otherwise prohibited by law:

1. EmblemHealth allows immediate access without prior authorizations to a seventy-two (72) hour emergency supply of the prescribed drug or medication for an individual with a behavioral condition experiencing an emergency condition as defined in the Medicaid Managed Care Model Contract.
2. EmblemHealth will immediately authorize a seven day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization.

Injectable Anti-Psychotic Agent Access

Medicaid members are entitled to obtain injectable anti-psychotic agents through their medical or pharmacy benefit.

Medical Benefit Process

- Buy and Bill - A prescriber can purchase, and bill for, an inventory of injectable anti-psychotic agents directly from the manufacturer or willing licensed pharmacy and store them in the office for administration to patients.
- Voluntary Specialty Pharmacy Program - A prescriber can request injectable anti-psychotic agents through Specialty Pharmacy Services. After the prescriber satisfies any existing prior approval (PA) criteria, Specialty Pharmacy Services will issue a prior approval and the prescription can be sent directly to Accredo, our contracted medical provider, who will ship the anti-psychotic agent to the prescriber's office for administration to the patient at no additional cost to the prescriber.

Pharmacy Benefit Prior Approval Process

Medicaid members may obtain first-generation injectable anti-psychotic agents from any network retail pharmacy that participates in our Specialty Pharmacy Network without prior approval. Medicaid members may require prior approval for selected second-generation injectable anti-psychotic agents.

Requesting Injectable Anti-Psychotics

Please review the *EmblemHealth Medicaid Behavioral Health Injectable Medication Procedures* below for detailed instructions on how to request injectable anti-psychotics.

Note: Injectable anti-psychotic agents cannot be obtained without a valid prescription.

For additional information on EmblemHealth's Specialty Pharmacy Program please call: 1-888-447-0295, Monday through Friday, 8:30 am to 5 pm.

Drugs Used for the Treatment of Substance Use Disorder

Medicaid members are entitled to obtain naloxone vials, naloxone prefilled syringes, and extended-release naltrexone through the medical or pharmacy benefit. In addition, at least one formulation of buprenorphine and buprenorphine/naloxone are to be maintained on the Medicaid Formulary.

Medical Benefit Process

- Buy and Bill - A prescriber can purchase, and bill for, an inventory of naloxone vials, naloxone prefilled syringes, and extended-release naltrexone directly from the manufacturer or willing licensed pharmacy and store them in the office for administration to patients.
- Voluntary Specialty Pharmacy Program - A prescriber can request extended-release injectable naltrexone, without prior approval, by contacting Accredo, our contracted medical provider. They will ship the opioid antagonist to the prescriber's office for administration to the patient at no additional cost to the prescriber.

Pharmacy Benefit Process

Medicaid members may obtain naloxone vials, and naloxone prefilled syringes from any network retail pharmacy without prior approval. Extended-release injectable naltrexone may be obtained from any pharmacy that participates in our Specialty Pharmacy Network without prior approval.

Prior approval is no longer required for generic buprenorphine/naloxone, however, select branded buprenorphine/naloxone products may still require prior approval. Both may be obtained from any network retail pharmacy.

Requesting Naloxone and Vivitrol

Please review the *EmblemHealth Medicaid Behavioral Health Injectable Medication Procedures* for formulary status and detailed instructions on how to request naloxone and vivitrol.

Note: Buprenorphine, buprenorphine/naloxone, naloxone vials, naloxone syringes, and extended-release naltrexone cannot be obtained without a valid prescription.

For additional information on EmblemHealth's Specialty Pharmacy Program please call: 1-888-447-0295, Monday through Friday, 8:30 am to 5 pm.

Smoking Cessation Products

Medicaid members with a diagnosis of mental illness or substance use disorder are entitled to obtain unlimited courses of smoking cessation therapy and are permitted the concomitant utilization of two smoking cessation products.

The EmblemHealth Medicaid Formulary currently includes all categories of smoking cessation products. Medicaid members have access to these products without prior approval criteria or quantity limits.

EmblemHealth Medicaid Formulary

For more information on the EmblemHealth Medicaid Formulary, visit express-scripts.com.

EmblemHealth Medicaid Behavioral Health Injectable Medication Procedures

For patient pick-up at a retail pharmacy (PHARMACY BENEFIT):

Long-Acting Injectable First Generation Antipsychotics, Extended-Release Injectable Naltrexone, and Injectable Naloxone:

1. Send the prescription to a retail pharmacy that participates in our Specialty Pharmacy Network.
   - Injectable Naloxone may be obtained from any retail pharmacy.
2. Once filled, your patient can pick up the medication from the retail pharmacy for proper storage until office administration.

Select Long-Acting Injectable Second Generation Antipsychotics:

1. Submit the Medicaid Behavioral Health Injectable Form to EmblemHealth's Specialty Pharmacy Services via fax to 1-877-243-4812. The prescriber can also call Specialty Pharmacy Services directly at 1-888-447-0295 to submit the request telephonically.
   - Please be sure to indicate you are requesting this medication as part of your patient's pharmacy benefit and submit all relevant information including, but not limited to, medication, dose, frequency, diagnosis in words, ICD-10 code and relevant medication history.
2. Once approved, send the prescription to a retail pharmacy that participates in our Specialty Pharmacy Network.
3. Once filled, your patient can pick up the medication from the retail pharmacy for proper storage until office administration.

If you want the medication shipped to your office (MEDICAL BENEFIT):

Long-Acting Injectable First Generation Antipsychotics, Extended-Release Injectable Naltrexone, and Injectable Naloxone:

1. Prescriptions should be submitted directly to Accredo, our contracted medical provider, via phone at 855-216-2166.
2. Accredo will then call to schedule delivery to your office.

Select Long-Acting Injectable Second Generation Antipsychotics:

1. Submit the Medicaid behavioral health injectable form to EmblemHealth's Specialty Pharmacy Services via fax to 1-877-243-4812.
   - Please be sure to indicate you are requesting this medication as part of your patient's medical benefit and submit all relevant information including, but not limited to, drug, dose, frequency, diagnosis in words, ICD-10 code and relevant medication history.

2. Once approved, submit the prescription to Accredo, our contracted medical provider, via phone at 855-216-2166.
3. Accredo will then call your office to schedule delivery.

*NOTE: Long-Acting Injectable First Generation Antipsychotics, Extended-Release Injectable Naltrexone, and Injectable Naloxone DO NOT REQUIRE PRIOR APPROVAL.

Medication Therapy Management Program

EmblemHealth offers the Medication Therapy Management (MTM) program to EmblemHealth Medicare members who meet all of the following criteria:

- Take seven or more chronic medications
- Have high medication costs
- Have at least three of the five conditions:
  - Rheumatoid arthritis
  - Chronic heart failure
  - Chronic obstructive pulmonary disease (COPD)
  - Diabetes
  - High cholesterol

How the Program Works

The MTM program helps EmblemHealth Medicare members better manage their conditions by providing a telephonic medication review as follows:

- A pharmacist will review the member's prescription medicines, over-the-counter drugs and any herbal supplements to ensure they are safe and working.
- A personal medication list will be mailed to the member after the call. The personal medication list includes all medicine the member is taking and explains how and why the medication is taken. The member will also receive a medication action plan to remind the member what was talked about during the call and what the member needs to do.
- The member will receive educational material on his or her chronic condition.
- A pharmacist will answer any questions or concerns the member has about his or her medications.
- A pharmacist will monitor the member's progress and may provide drug alerts or recommendations to the practitioner to optimize therapy.

For more information about the MTM program, call 1-888-447-0321, Monday through Friday, from 9 am to 5 pm.

Participating Pharmacies

EmblemHealth's has more than 60,000 independent, chain and corporately owned participating pharmacies nationwide. The following list includes the participating nationwide chain pharmacies with stores in the New York area:

- Duane Reade
- King Kullen
- Medicine Shoppe Pharmacies
- Pathmark
- Price Club/Costco
- Rite Aid
- ShopRite
- Target
- Walgreens

Note: Medicaid members can fill their prescriptions only at Medicaid-approved pharmacies.

Home Delivery Pharmacy Program

For EmblemHealth, GHI, HIP and Vytra Plans

We contract with Express Scripts, Inc. (ESI), a home delivery vendor, to serve our EmblemHealth, GHI, HIP and Vytra plan members. Practitioners may call 1-888-327-9791 for instructions on how to fax a prescription to ESI.

Members may order medications taken on a regular basis from ESI in three ways:

- Online - Register at www.StartHomeDelivery.com.
- Mail - Send the order form included in your member packet, along with your 90-day prescription and copayment to ESI.
- Phone - Commercial members: 1-877-866-5798; Medicare members: 1-877-866-5828; Medicaid members: 1-877-866-4165.

We have also teamed up with ESI to provide prescriptions through our website, allowing members to fill their prescriptions from any location with Internet access.

Home delivery and Internet pharmacy programs are especially convenient for individuals on maintenance prescription medications that treat long-term conditions such as high blood pressure, diabetes or thyroid disorders. Additionally, members using the mail order pharmacy program may receive a reduction in their formulary prescription copayments of up to 50 percent.

For GHI City of New York Group Plans

We contract with Express Scripts, Inc. (ESI) to provide home delivery services to our GHI City of New York group

plans. Practitioners may call 1-888-327-9791 for instructions on how to fax a prescription to ESI. This line is available seven days a week, from 8 am to 8:30 pm. Users of TTY/TDD can call 1-800-899-2114, 24 hours a day, seven days a week.

GHI City of New York members may also request their medications. Commercial plan members can call 1-877-534-3682. Medicare members can call 1-800-585-5786, 24 hours a day, seven days a week.

Drug Quantity Management - GHI and GHI HMO

EmblemHealth's Drug Quantity Management program establishes and monitors appropriate levels of use for selected drugs or drug categories that are high-cost and/or prone to overuse, misuse, waste or abuse.

Medications in this program include*:

- Erectile dysfunction therapy
- Caverject
- Edex
- Muse
- Viagra
- Migraine medications
- Relenza
- Smoking cessation aids
- Smoking cessation therapy
- Bupropion sustained-release tablet
- Nicotine inhalation system
- Nicotine nasal spray
- Nicotine transdermal patch
- Nicotine polacrilex gum
- Tamiflu

*This is not a comprehensive list.

Injectables and Specialty Pharmacy Program

EmblemHealth works with Accredo, a leading specialty pharmacy, to administer complex specialty pharmacy medications through our Specialty Pharmacy Program. Network practitioners may also order medical benefit injectables — which are routinely administered in their office or clinical setting — from Accredo. Other vendors may be used for limited distribution of specialty drugs not available from Accredo.

For more information, please refer to the Injectables and Specialty Pharmacy Program chapter or contact our Specialty Pharmacy Services at 1-888-447-0295.

We offer Medicare Advantage plans with Part D benefits (MAPD) under the EmblemHealth Medicare HMO and EmblemHealth Medicare PPO programs. We also offer a stand-alone Medicare Part D prescription drug plan (PDP): EmblemHealth Medicare PDP. These plans are defined in the Medicare Product Summary section of the Provider Networks and Member Benefit Plans chapter.

EmblemHealth Medicare Prescription Drug Plan

EmblemHealth Medicare PDP is a free-standing Medicare Part D plan available to Medicare members in New York State who do not have prescription drug coverage through another Medicare Advantage prescription drug plan.

More information about the prescription drug benefits covered by this plan and the Medicare PDP formulary can be found here.

For prior approval of prescription drugs for members in our Medicare PDP, please call 1-877-362-5670.

For prior approval of prescription drugs for members in our Medicare PDP (City of New York), please call 1-888-447-8175.

Identification Card

Members should provide their ID card to access Medicare Part D benefits. The card contains important information the pharmacy needs to process the claim.

Coverage Determinations

A coverage determination is a decision:

- Not to provide or pay for a Part D drug because the drug is either not medically necessary, not obtained from a participating pharmacy or not on our formulary
- About an exceptions request from the tiering structure
- About an exceptions request for a non-formulary Part D drug
- About the amount of cost sharing for a drug

Failure to make a decision about one of the above in a timely manner when a delay would adversely affect the health of the enrollee is also considered a coverage determination.

Coverage determinations may be requested by a member of our Medicare plans, the prescribing physician or other prescriber, or an officially designated representative (as filed with EmblemHealth).

For standard requests, we will notify the member (and prescribing physician or other prescriber, as appropriate) of

the determination no later than 72 hours after receipt of the request and/or physician's supporting statement.

For expedited requests, we will notify all parties within 24 hours of receipt of the request and/or physician's supporting statement. If the expedited request is denied, we will contact all parties to:

- Explain our standard process
- Provide instructions about our grievance process and its time frames
- Inform the member of the right to file expedited grievance
- Inform the member of the right to resubmit the request with a physician's supporting documentation

Note: Expedited coverage determinations are not permitted for payment requests.

Exception Requests

Exception requests fall under coverage determination process. Practitioners may request an exception in the following instances:

- If the formulary tiering structure has changed mid-year and an enrollee is adversely affected by the change
- When a formulary drug would not be as effective (or has been ineffective) as a non-formulary drug
- When a formulary drug would have adverse effects and a non-formulary drug is available

For an exception to be evaluated, the practitioner must provide supporting documentation of the diagnosis and a supporting statement that must indicate that the preferred drug for the treatment of the enrollee's condition would not be as effective as the requested non-preferred drug and/or would have adverse effects. All drugs approved under the exceptions process must meet the definition of a Part D drug.

Members will be notified of changes to the formulary (including cost-sharing changes) as they occur. Updates to the EmblemHealth Medicare formulary can be found on EmblemHealth's Clinical Corner

Grievance and Appeal (Redetermination) Procedures

See the Dispute Resolution - Medicare chapter.

Medicare Prescription Drug Plans - Contacts

Medicare Prescription Drug Plans - Contacts

Benefit Plans	All Correspondence (e.g., claims, billing and member ID card questions)	Pharmaceutical Coverage Determinations	Exceptions (e.g., drugs not listed in formulary requiring prior approval)

EmblemHealth Medicare HMO	EmblemHealth Medicare HMO Attn: Customer Service 55 Water St. New York, NY 10041-8190 Call 1-800-447-8255 Fax 1-631-719-0911	EmblemHealth Medicare HMO PO Box 1520 JAF Station New York, NY 10116-1520 Call 1-877-444-7097 Fax 1-877-300-9695	Pharmacy Services PO Box 1520 JAF Station New York, NY 10116-1520 Call 1-877-444-7097 Fax 1-877-300-9695
EmblemHealth Medicare PDP	EmblemHealth Medicare PDP Attn: Customer Service PO Box 2820 New York, NY 10116-2820 Call 1-877-444-7241 Fax 1-954-965-2163	EmblemHealth Medicare PDP Pharmacy Services PO Box 1520 JAF Station New York, NY 10116-1520 Call 1-877-444-7097 Fax 1-877-300-9695	Pharmacy Services PO Box 1520 JAF Station New York, NY 10116-1520 Call 1-877-444-7097 Fax 1-877-300-9695
EmblemHealth Medicare PDP (City of New York)	EmblemHealth Medicare PDP Attn: Customer Service PO Box 2872 New York, NY 10117-2037 Call 1-800-585-5786	EmblemHealth Medicare PDP Pharmacy Services PO Box 1520 JAF Station New York, NY 10116-1520 Call 1-888-447-8175 Fax 1-877-300-9695	EmblemHealth Medicare PDP Pharmacy Services PO Box 1520 JAF Station New York, NY 10116-1520 Call 1-888-447-8175 Fax 1-877-300-9695
EmblemHealth Medicare PPO	EmblemHealth Medicare PPO Attn: Customer Service PO Box 2807 New York, NY 10017-2807 Call 1-866-557-7300 Fax 1-888-382-1031	EmblemHealth Medicare PPO PO Box 1520 JAF Station New York, NY 10116-1520 Call 1-877-444-7097 Fax 1-877-300-9695	Pharmacy Services PO Box 1520 JAF Station New York, NY 10116-1520 Call 1-877-444-7097 Fax 1-877-300-9695

Pharmaceutical Management Procedures

We provide information about our pharmaceutical management procedures and our formularies at least annually and whenever we make changes. These updates may include the following:

- Pharmacy benefit designs
- Formulary changes
- Prior approval criteria
- Procedures for generic substitution, therapeutic interchange, step therapy or other management methods the practitioner's prescribing decisions are subject to
- Any other requirements, restrictions, limitations or incentives that apply to the use of certain pharmaceuticals

For the latest updates to our Commercial and Medicare formularies, please go to Formulary Updates on Clinical Corner.

If you require printed copies or have any questions regarding our pharmaceutical management procedures, please call Clinical Pharmacy Services at 1-877-362-5670.

Forms

Please see the following pages for our pharmacy forms:

- Non-FDA-Approved Drug Use and/or Dose Request Form
- Addition to Formulary Request Form
- Physician Specialty Program Enrollment Form
- Medicaid Behavioral Health Injectable Form

EmblemHealth

Provider Manual

Chapter 11: EmblemHealth Specialty Pharmacy Program

This chapter contains information on the EmblemHealth Injectables and Specialty Pharmacy Program.

Overview

Certain specialty pharmacy medications are complex to administer and often entail frequent dosage adjustments, severe side effects, and special storage or handling instructions. They may have a narrow therapeutic range and require periodic lab or diagnostic testing.

The FDA has approved some injectables for multiple indications. They may be covered as either a pharmacy or medical benefit. How injectables are covered depends on the diagnosis, specific formulations, and administration setting and method.

EmblemHealth works with Accredo , an industry leader, to provide these types of specialty pharmacy medications. Accredo offers:

- Experience providing specialty pharmacy services to members.
- Educational materials to support at-home administration.
- Free syringes and needles to members for self-administered specialty drugs.
- Comprehensive coordination of care, including refill reminders.
- Dedicated pharmacists and nurses available to patients and physicians 24 hours a day, seven days a week. They provide comprehensive support to help maximize formulary compliance and improve patient outcomes.

Medical Benefit Injectables

Certain medical benefit injectable drugs require prior approval from EmblemHealth. Drugs requiring prior approval must be reviewed by EmblemHealth's Specialty Pharmacy department by completing and submitting the Specialty Program Request Form.

Practitioners must write each prescription to reflect the specific needs of the patient. When ordering patient-specific injectable drugs, practitioners must complete both a prescription order form and the New York State prescription

form and submit them to EmblemHealth. When refills are needed and the order has not changed, the practitioner need only complete the order form for prescribed refills. If the dosage or frequency of the order has changed, the EmblemHealth Specialty Pharmacy Program physician must submit a separate New York State prescription form.

To request any of the forms mentioned above, call our Specialty Pharmacy department at 1-888-447-0295. To submit the forms, send them to us either by fax at 1-877-243-4812 or via our provider portal.

Once EmblemHealth receives the order, our Specialty Pharmacy department reviews it for appropriate dosing and indications based on FDA and EmblemHealth medical guidelines. We also verify patient eligibility and coverage, including the following:

Specialty pharmacy services begin when a prescription is sent to Accredo by a patient (via phone or mail) or a physician (via phone or secure fax). The intake team conducts an administrative review of the prescription to verify the patient's name, telephone number, address, physician's name, and drug coverage. Pharmacy staff complete reviews for mailed or faxed prescriptions and handle verbal prescriptions that are called in by physicians.

To determine clinical appropriateness, our expert team of specialty clinicians performs a series of clinical reviews and protocols based on the programs [Client] has in place, such as Prior Authorization and Step Therapy; drug interactions with prescription and nonprescription medications, as well as those administered outside of the prescription adjudication system (for example, at the doctor's office); and other waste management edits. When necessary, a pharmacist contacts the prescribing physician's office to confirm the member's treatment plan.

Next, our patient care advocates place an outbound call to the member to verify the shipping address and to determine when the member will be available to accept delivery of the prescription. During this call, a specialty clinician is available to counsel the patient. Once the representative confirms delivery arrangements and billing information, the prescription is processed to ensure the most efficient method of dispensing and shipping is utilized. Pharmacy router technology directs the dispensing of the prescription to take place at the pharmacy closest to the member, depending on inventory, capacity, and hours of operation.

Accredo dispenses and packages the prescription order with member literature on the proper administration, product usage, and appropriate ancillary supplies required for self-administration. For those therapies requiring nursing and administration supplies (such as pumps and tubing), a specialized nurse contacts the patient or caregiver to coordinate an appointment time for initiation of therapy and any necessary training. In some cases, unless the member requests not to be contacted, a nurse or pharmacist places a follow-up call to the member for counseling and training on self-administration, if needed.

Coordinating Medication Delivery

A patient care advocate schedules delivery of the specialty medication based on the member's unique requirements. For example, if the member is new to therapy and requires instruction on proper injection technique from a nurse, we coordinate delivery at a date and time convenient to both the member and home care nurse, if applicable. As an alternative, we can also arrange to deliver the medicine to the member's physician's office for administration and instruction.

Our specialty pharmacy makes every effort to dispense product within 24 hours of receipt of a complete referral. However, physicians, patients, or caregivers may request shipment dates beyond 24 hours. We have found that

flexibility around the shipment time enhances the member experience. In these instances, we coordinate deliveries based on a need-by date, enabling the member to receive packages on the date and time the member or the member's caregiver is available to receive the order.

All injectables categorized as a medical benefit are shipped to the prescribing practitioner or call 1-888-447-0295. Submit completed forms by fax to 1-877-243-4812 or submit via our physician portal.

Note: Certain controlled substances, such as testosterone, may not be covered as a medical benefit through our Specialty Pharmacy program. Practitioners may, however, request reimbursement for the cost of these controlled substances if they are administered in the practitioner's office.

Oral and Self-Administered Specialty Drugs

All commercial plan members requiring oral specialty and self-administered specialty injectables must obtain medications from Accredo. Accredo is the preferred specialty pharmacy for Medicaid and Medicare members requiring oral or self-administered specialty injectables. The list of self-administered specialty drugs includes:

- Calcium regulators
- Growth hormones
- Hepatitis C agents
- HIV fusion inhibitors
- Infertility agents
- Injectable contraceptives (e.g., progestin)
- Multiple sclerosis agents
- Plaque psoriasis agents
- Rheumatoid arthritis agents

Some specialty drugs require submission of a Certificate of Medical Necessity (CMN) or a physician's prior approval (PPA). To order a CMN or PPA, practitioners should contact the EmblemHealth Specialty Pharmacy department at 1-888-447-0295.

Accredo Specialty Pharmacy Services fills prescriptions and delivers them directly to the member's home. To ensure member privacy, all prescriptions are delivered by courier service and packaged in nondescript materials. A signature is required at the time of delivery, unless other arrangements have been made. Members are instructed to check that their order is accurate and, if necessary, refrigerate the medication.

All prescriptions, including transfers of existing prescriptions, must be submitted to Accredo by phone at 1-888-615-3144or by fax at 1-800-391-9709. For more information, contact the EmblemHealth Specialty Pharmacy department at 1-888-447-0295.

For prior approval processes for medications not on the EmblemHealth Injectable Drug Utilization Management Program list that follows, see the Pharmacy Benefit Designs, Nonpreferred Drugs or Medicaid Pharmacy Program sections of the Pharmacy Services chapter.

Reimbursement

Reimbursement Methodology for Radiopharmaceuticals

Invoices are not required for claims payment when billing radiopharmaceutical codes.

With respect to the radiopharmaceutical codes below, defined by Health Common Procedure Coding System (HCPCS), EmblemHealth will pay health care professionals the Average Sales Price (ASP) plus 15%. If ASP is not available, the reimbursement rate is Average Wholesale Pricing (AWP) minus 15%.

- A9500-A9700
- A4641-A4647
- Q9949-Q9969

Reimbursement Methodology for Injectables and In-Office Medications

EmblemHealth periodically reviews and adjusts reimbursement levels to reflect changes in market prices for acquiring and administering drugs. The following reimbursement methodology for our Injectables and Other In-Office Medication Fee Schedule becomes effective February 1, 2017.

- Maximum Allowable Cost (MAC): Utilized for select therapeutic categories where a clinically equivalent, lower-cost alternative is available. Pricing is at the maximum allowable cost, giving increased reimbursement over current Average Sales Price (ASP) rates, with margins comparable to higher-cost agents within the same therapeutic class.
- High-Cost Maximum Allowable Cost (High-Cost MAC): Utilized for select-branded, single-source drugs with no lower-cost alternative that provides fair and typical margin.
- Average Sales Price (ASP) plus 15%: Utilized for multisource or generic drugs with an ASP available.
- Average Sales Price (ASP) plus 10%: Utilized for branded or single-source drugs with an ASP available.
- Average Sales Price (ASP) plus 8%: Utilized for preferred hyaluronic acid product.
- Average Sales Price (ASP) plus 6%: Utilized for branded or single-source drugs not included in the ASP plus 10% category.
- Average Wholesale Price (AWP) minus 15%: Utilized for drugs without an available ASP except where otherwise stated.
- Average Wholesale Price (AWP) minus 10%: Utilized for all vaccines.
- Average Wholesale Price (AWP): Utilized for all implants and contraceptives.

Injectables and Other In-Office Medication Fee Schedule

HCPCS for injectables and other in-office medications priced at MAC are listed in the table below.

Code	Code Description
90283	Immune Globulin (IgIV), human, for intravenous use (Code Price is per 500 mg) (Use 90283 for CPT billing requirements ONLY - see also J1459, J1557, J1561, J1566, J1568, J1569, J1572 and J1599 for non-CPT billing)

J0640	Injection, leucovorin calcium, per 50 mg
J0641	Injection, levoleucovorin calcium, 0.5 mg
J1442	Injection, filgrastim (G-CSF), 1 microgram
J1447	Injection, tbo-filgrastim, 1 microgram
J1459	Injection, immune globulin, intravenous, non-lyophilized (e.g liquid), 500 mg
J1556	Injection, immune globulin (Bivigam), 500 mg (For billing prior to 1/1/14 see C9130 or J1599)
J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg (For billing prior to 1/1/12 use 90283, J1599 or C9270)
J1561	Injection, immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg
J1566	Injection, immune globulin, intravenous, lyophilized (e.g powder), not otherwise specified, 500 mg (Only Carimune NF, Panglobulin NF and Gammagard S/D should be billed using this code)
J1568	Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard liquid), non-lyophilized, (e.g. liquid), 500 mg
J1572	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1626	Injection, granisetron hydrochloride, 100 mcg

J2405	Injection, ondansetron hydrochloride, per 1 mg
J2430	Injection, pamidronate disodium, per 30 mg
J2469	Injection, palonosetron HCl, 25 mcg
J3489	Injection, zoledronic acid, 1 mg
J9171	Injection, docetaxel, 1 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
J9267	Injection, paclitaxel, 1 mg
Q5101	Injection, filgrastim, (G-CSF), biosimilar, 1 microgram (Code became effective for Medicare billing 3/6/15)

HCPCS for injectables and other in-office medications priced at High Cost MAC are listed in the table below.

Code	Code Description
J0202	Injection, alemtuzumab, 1 mg
J1300	Injection, eculizumab, 10 mg
J2860	Injection, siltuximab, 10 mg (Code re-used by CMS effective 1/1/16) (For billing prior to 1/1/16 use C9455 or J3590)
J9032	Injection, belinostat, 10 mg (For billing prior to 1/1/16 use C9442 or J9999)
J9039	Injection, blinatumomab, 1 microgram (For billing prior to 1/1/16 use C9449 or J9999)

J9042	Injection, brentuximab vedotin, 1 mg (For billing prior to 1/1/13 use C9287 or J9999)
J9043	Injection, cabazitaxel, 1 mg (For billing prior to 1/1/12 use J9999 or C9276)
J9228	Injection, ipilimumab, 1 mg (For billing prior to 1/1/12 use J9999 or C9284)
J9264	Injection, paclitaxel protein-bound particles, 1 mg
J9271	Injection, pembrolizumab, 1 mg (For billing prior to 1/1/16 use C9027 or J9999)
J9299	Injection, nivolumab, 1 mg (For billing prior to 1/1/16 use C9453 or J9999)
J9306	Injection, pertuzumab, 1 mg (For billing prior to 1/1/14 use C9292 or J9999)
J9308	Injection, ramucirumab, 5 mg (For billing prior to 1/1/16 use C9025 or J9999)
J9315	Injection, romidepsin, 1 mg (For billing prior to 1/1/11 use J9999 or C9265)
J9354	Injection, ado-trastuzumab emtansine, 1 mg (For billing prior to 1/1/14 use C9131 or J9999)
Q2043	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion (Code Price is per 250 mL)

HCPCS for injectables and other in-office medications priced at ASP plus 10% are listed in the table below.

Code	Code Description
J0129	Injection, abatacept, 10 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug self administered)

J0135	Injection, adalimumab, 20 mg
J0180	Injection, agalsidase beta, 1 mg
J0220	Injection, alglucosidase alfa, 10 mg, not otherwise specified
J0221	Injection, alglucosidase alfa, (Lumizyme), 10 mg (For billing prior to 1/1/12 use J3590 or C9277)
J0490	Injection, belimumab, 10 mg
J0587	Injection, rimabotulinumtoxinB,100 units
J0597	Injection, C-1 esterase inhibitor (human), Berinert, 10 units (For billing prior to 1/1/11 use J3590 or C9269)
J0598	Injection, C1 esterase inhibitor (human), Cinryze, 10 units
J0717	Injection, certolizumab pegol, 1 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg (For billing prior to 1/1/11 use J3590 or C9266)
J0875	Injection, dalbavancin, 5 mg (For billing prior to 1/1/16 use C9443 or J3490)
J1290	Injection, ecallantide, 1 mg (For billing prior to 1/1/11 use J3590 or C9263)
J1438	Injection, etanercept, 25 mg (Code may be used for Medicare when drug administered under the direct supervision of a physician; not for use when drug is self-administered)

J1602	Injection, golimumab, 1 mg, for intravenous use (For billing prior to 1/1/14 use C9399 or J3590)
J1745	Injection, infliximab, 10 mg
J1786	Injection, imiglucerase, 10 units
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J2278	Injection, ziconotide, 1 microgram
J2323	Injection, natalizumab, 1 mg
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg
J2357	Injection, omalizumab, 5 mg
J2407	Injection, oritavancin, 10 mg (For billing prior to 1/1/16 use C9444 or J3490)
J2507	Injection, pegloticase, 1 mg (For billing prior to 1/1/12 use J3590 or C9281)
J2562	Injection, plerixafor, 1 mg (For billing prior to 1/1/10 use J3490 or C9252)
J2783	Injection, rasburicase, 0.5 mg
J2791	Injection, Rho(D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 IU (See also 90384 and 90386 for CPT billing requirements)
J2792	Injection, rho D immune globulin, intravenous, human, solvent detergent, 100 IU (See also 90384 and 90386 for CPT billing requirements)

J2796	Injection, romiplostim, 10 micrograms (For billing prior to 1/1/10 use J3590 or C9245)
J3060	Injection, taliglucerase alfa, 10 units
J3090	Injection, tedizolid phosphate, 1 mg (For billing prior to 1/1/16 use C9446 or J3490)
J3240	Injection,thyrotropin alpha, 0.9 mg, provided in 1.1 mg vial (Code Price is per 1 vial)
J3262	Injection, tocilizumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9264)
J3357	Injection, ustekinumab, 1 mg (For billing prior to 1/1/11 use J3590 or C9261)
J3380	Injection, vedolizumab, 1 mg (For billing prior to 1/1/16 use C9026 or J3590)
J3385	Injection, velaglucerase alfa, 100 units (For billing prior to 1/1/11 use J3490 or C9271)
J3396	Injection, verteporfin, 0.1 mg
J7183	Injection, von Willebrand factor complex (human), Wilate, 1 IU VWF:RCO
J7185	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU
J7186	Injection, antihemophilic factor VIII/Von Willebrand factor complex (human), per factor VIII I.U.
J7187	Injection, Von Willebrand factor complex (Humate-P), per IU, VWF:RCO
J7189	Factor VIIa (antihemophilic factor, recombinant), per 1 microgram

J7190	Factor VIII (antihemophilic factor [human]) per IU
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified
J7193	Factor IX (antihemophilic factor, purified, non-recombinant) per IU
J7194	Factor IX, complex, per IU
J7195	Injection factor IX (antihemophilic factor, recombinant) per IU, not otherwise specified
J7205	Injection, factor VIII, Fc fusion protein (recombinant), per IU
J7313	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg (For billing prior to 1/1/16 use C9450 or J3490)
J7316	Injection, ocriplasmin, 0.125 mg (For billing prior to 1/1/14 use C9298 or J3590) (Code re-used by CMS 1/1/14)
J8655	Netupitant 300 mg and palonosetron 0.5 mg (Code Price is per 1 capsule)
J9019	Injection, asparaginase (Erwinaze), 1,000 IU (For billing prior to 1/1/13 use C9289 or J9999)
J9027	Injection, clofarabine, 1 mg
J9033	Injection, bendamustine HCl, 1 mg
J9035	Injection, bevacizumab, 10 mg
J9041	Injection, bortezomib, 0.1 mg

J9047	Injection, carfilzomib, 1 mg (For billing prior to 1/1/14 use C9295 or J9999)
J9055	Injection, cetuximab, 10 mg
J9179	Injection, eribulin mesylate, 0.1 mg (For billing prior to 1/1/12 use J9999 or C9280)
J9207	Injection, ixabepilone, 1 mg
J9266	Injection, pegaspargase, per single dose vial
J9302	Injection, ofatumumab, 10 mg (For billing prior to 1/1/11 use J9999 or C9260)
J9303	Injection, panitumumab, 10 mg
J9305	Injection, pemetrexed, 10 mg
J9307	Injection, pralatrexate, 1 mg (For billing prior to 1/1/11 use J9999 or C9259)
J9310	Injection, rituximab, 100 mg
J9330	Injection, temsirolimus, 1 mg
J9355	Injection, trastuzumab, 10 mg
J9357	Injection, valrubicin, intravesical, 200 mg
J9395	Injection, fulvestrant, 25 mg
J9400	Injection, ziv-aflibercept, 1 mg (For billing prior to 1/1/14 use C9296 or J9999)

Q2049	Injection, doxorubicin hydrochloride, liposomal, imported Lipodox, 10 mg

HCPCS for injectables and other in-office medications priced at ASP plus 8% are listed in the table below.

Code	Code Description
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose

HCPCS for injectables and other in-office medications priced at ASP+6% are listed in the table below.

Code	Code Description
J0178	Injection, aflibercept, 1 mg
J0585	Injection, onabotulinumtoxinA, 1 unit
J0897	Injection, denosumab, 1 mg (For billing prior to 1/1/12 use J3590 or C9272)
J2503	Injection, pegaptanib sodium, 0.3 mg
J2505	Injection, pegfilgrastim, 6 mg
J2778	Injection, ranibizumab, 0.1 mg
J7321	Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose (Hyalgan dose is 20 mg/2 mL and Supartz dose is 25 mg/2.5 mL) (Note: Total dose regimen = 3 - 5 injections)
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose (20 mg/2 mL) (Note: Total dose regimen = 3 injections)
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose (30 mg/2 mL) (Note: Total dose regimen = 3 - 4 injections)

J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg (For billing prior to 1/1/10 see J7322 for Synvisc and J3490 for Synvisc-One)
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose (For billing prior to 1/1/15 use C9399 or J3490) (Dose 88 mg/4 mL) (Note: Total dose regimen = 1 dose)
J7328	Hyaluronan or derivative, Gel-Syn, for intra-articular injection, 0.1 mg
Q9980	Hyaluronan or derivative, Genvisc 850, for intra-articular injection, 1 mg

HCPCS for injectables and other in-office medications priced at AWP are listed in the table below.

Code	Code Description
J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration
J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration
J7300	Intrauterine copper contraceptive
J7301	Levonorgestrel-releasing intrauterine contraceptive system,13.5 mg
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies (Code Price is per 1 implant system)
J7311	Fluocinolone acetonide, intravitreal implant
J7312	Injection, dexamethasone, intravitreal implant, 0.1 mg (For billing prior to 1/1/11 use J3490 or C9256)
J7330	Autologous cultured chondrocytes, implant

J9225	Histrelin implant (Vantas), 50 mg
J9226	Histrelin implant (Supprelin LA), 50 mg
S1090	Mometasone furoate sinus implant, 370 micrograms - see also C2625 or J3490

EmblemHealth Injectable Drug Utilization Management Program

EmblemHealth provides utilization management for certain medical injectable drugs(see the Specialty Injectable Drugs Prior Approval List below).

Prior Approval for Provider-Administered Injectable Drugs

Prior approval is required when the drug will be administered by a practitioner in their office (POS 11), in an outpatient hospital clinic (POS 22), or in an ambulatory surgery center (POS 24). Prior approval from EmblemHealth Injectables and Specialty Pharmacy Program is not required for medications administered at home or during emergency room visits, observation unit visits, or inpatient stays.

Urgent medical requests for prior approval will be completed within 72 hours of receipt. Non-urgent requests will be completed within 14 calendar days of receiving all necessary information. If the request requires additional clinical review or eligibility verification, the review and determination processes may take longer.

The list below identifies medical groups and members that are excluded from the EmblemHealth Specialty Pharmacy Program.

- HealthCare Partners
- Montefiore
- City of New York Commercial

Note: 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

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.

Member Coverage

The following table identifies which members are covered by or excluded from the EmblemHealth Injectable Drug Utilization Management Program.

Provider Network	Member Assigned to a Advantage Care Physicians*	EmblemHealth/ HIP Is Managing Entity*	HealthCare Partners Is Managing Entity*	Montefiore CMO Is Managing Entity*
HIP-underwritten commercial plans - NY Metro Network (Retired August 1, 2018) - Premium Network - Prime Network (including GHI HMO and Vytra HMO)	Yes	Yes	Excluded from program	Excluded from program
State Sponsored Programs - Enhanced Care Prime Network	Yes	Yes	Excluded from program	Excluded from program
Medicare - Medicare Choice PPO Network - Medicare Essential Network - VIP Prime Network	Yes	Yes	Excluded from program	Excluded from program
FEHB plans	Yes	Yes	Excluded from program	Excluded from program
GHI-underwritten commercial plans - CBP, National, Tristate Networks - Network Access Network	Excluded from program	Excluded from program	n/a	n/a
Vytra Networks (Vytra HMO & ASO Plans)	Yes	Yes	Excluded from program	Excluded from program

* Managing entity assignment is on the back of the member's ID card. It can also be found on the Member Details

page of the Eligibility/Benefits lookup feature. You can access this feature on our secure provider website: www.emblemhealth.com/Providers.

Who Requests Prior Approval

It is the responsibility of the referring practitioner (i.e., a PCP or specialist ordering the injectable drug) to obtain the prior approval before services are rendered. If the referring and rendering practitioners are different, the rendering practitioner is responsible for ensuring that a prior approval is on file before services are rendered.

Prior Approval Processes

To request a prior approval, you can contact EmblemHealth's Specialty Pharmacy department by calling 1-888-447-0295or submit completed forms by fax to 1-877-243-4812.

Visit our Provider Portal then select the "Prescriber" and submit the request online.

Call EmblemHealth's Specialty Pharmacy department 1-888-447-0295, Monday through Friday, 8 a.m. to 6 p.m.

To request prior approval for a member to obtain drugs in an outpatient setting or from another provider, then:

1. Select the "Prescribers" icon.
2. Click "Next "Enter the member's information
3. Enter the drug and dosing information
4. Enter the prescriber information
5. Enter the diagnosis
6. Answer the questionnaire
7. Attach any/all supporting document for the request
8. Submit
9. Continue entering the prior approval request

Specialty Injectable Drugs Prior Approval List

Additional Codes that Require Prior Approval Effective January 12, 2018

Drug Brand Name	Drug Generic Name	Procedure Code
Actemra	Tocilizumab	J3262
Acthar_hp	Corticotropin	J0800
Aldurazyme	Laronidase	J1931
Benlysta	Belimumab	J0490
Berinert	C1 esterase inhibitor (human)	J0597
Cerezyme	Imiglucerase	J1786

Cimzia	Certolizumab pegol	J0717
Cinryze	C1 esterase inhibitor (human)	J0598
Elaprase	Idursulfase	J1743
Elelyso	Taliglucerase alfa	J3060
Entyvio	Vedolizumab	J3380
Eylea	Aflibercept	J0178
Fabrazyme	Agalsidase beta	J0180
Fusilev	Levoleucovorin calcium	J0641
Halaven	Eribulin	J9179
Hizentra	Subcutaneous immune globulin	J1559
Hyqvia	Subcutaneous immune globulin	J1575
Inflectra	Infliximab-dyyb	Q5102
Jevtana	Cabazitaxel	J9043
Kadcyla	Ado-trastuzumab emtansine	J9354
Keytruda	Pembrolizumab	J9271
Lemtrada	Alemtuzumab	J0202
Lucentis	Ranibizumab	J2778
Lumizyme	Alglucosidase alfa	J0221
Naglazyme	Galsulfase	J1458
Nplate	Romiplostim	J2796
Opdivo	Nivolumab	J9299
Perjeta	Pertuzumab	J9306
Prolia	Denosumab	J0897
Simponi aria	Golimumab	J1602
Stelara	Ustekinumab	J3357
Tysabri	Natalizumab	J2323
Vpriv	Velaglucerase alfa	J3385

Xeomin	Incobotulinumtoxina	J0588
Xgeva	Denosumab	J0897
Yervoy	Ipilimumab	J9228

Current as of July 29, 2015

Code	IVIG Drugs
J1556	Bivigam
J1566	Carimune NF and Gammagard S/D
J1572	Flebogamma
J1569	Gammagard
J1557	Gammaplex
J1561	Gamunex-C and Gammaked
J1568	Octagam
J1459	Privigen
J-Code	**RA Drugs**
J0129	Orencia
J1745	Remicade
J-Code	**Brand Name**
J9264	Abraxane
J9305	Alimta
J2469	Aloxi
J0881	Aranesp
J9035	Avastin (for cancer only)
J0585	Botox
J0885	Epogen/Procrit
J9055	Erbitux

J9355	Herceptin
J2820	Leukine
J0587	Myobloc
J2505	Neulasta
J1442	Neupogen
Q2043	Provenge
J9310	Rituxan
J2353	Sandostatin LAR
J1300	Soliris
J9225	Vantas
J9303	Vectibix
J3489	Zoledronic acid

Claims Submission

Submit all claims to Accredo. You should continue to submit claims to the same address or, if submitting electronically, using the same Payor ID you use now. For instructions on submitting claims, see the Directory and Claims chapters.

Claims submitted without obtaining a required prior approval number will be denied and the member may not be billed.

Billing for Drug Waste

FThe portion of the drug that was administered should be submitted on one line. The JW modifier must be submitted on a separate claim line with the discarded amount. The JW modifier should only be used on the claim line with the discarded amount.

Denials and Appeals

Pre-Service Adverse Determinations
Before a final decision is made, you will have an opportunity to speak with a pharmacist and a physician, as well as to submit relevant medical records. If you still disagree with EmblemHealth's determination, you may exercise your reconsideration and appeal rights. These rights differ for our Commercial, Medicaid and Medicare plans and are outlined in separate dispute resolution chapters.

Post-Service Adverse Determinations
The practitioner or member may file a clinical appeal with EmblemHealth. Please follow the instructions for filing an appeal that accompanies the denial. These processes differ for our Commercial, Medicaid and Medicare plans and are outlined in separate dispute resolution chapters.

Continuity of Care

Members in an Active Course of Treatment Before January 1, 2019
To ensure correct claims payment for members who, before January 1, 2019, received any of the specialty injectable drugs in the Code List table above (i.e., a valid referral was obtained or claims for these drugs were already submitted and paid), the administering provider must contact EmblemHealth Injectables and Specialty Pharmacy Program to obtain a prior approval number.

For ongoing treatment, a new prior approval must be submitted once the current prior approval expires.

Current Forms (Retired as of January 12, 2018)

Chemotherapy Order Form for HIP Drug Replacement Program - (Retired as of January 12, 2018)

Injectable Order Form for HIP Drug Replacement Program - (Retired as of January 12, 2018)

EmblemHealth

Provider Manual

Chapter 12: EmblemHealth Spine Surgery and Pain Management Therapies Program

This chapter contains policies and procedures for the EmblemHealth Spine Surgery and Pain Management Therapies Program:

- Place of service for select spine surgery and interventional pain management therapy procedures
- Program inclusion and exclusions
- ICD-10 Procedure/Diagnosis Codes
- Prior approval procedures
- Grievance and appeal process

Overview

The EmblemHealth Spine Surgery and Pain Management Therapies Program is managed by OrthoNet, LLC and requires providers to contact OrthoNet directly to obtain prior approval for select spine surgery and interventional pain management therapy procedures.

Service Locations

For services provided on or after November 16, 2015, a prior approval is required for all codes defined in the Spine Surgery and Pain Management Procedure Therapy Code table, when performed in the following settings:

- Practitioner's office (POS 11)
- Outpatient hospital setting (POS 22)
- Inpatient hospital (POS 21)

- Ambulatory surgery center (POS 24)

Affected Networks

The EmblemHealth Spine Surgery and Pain Management Therapies Program will apply to members* who participate in benefit plans associated with the following networks:

- Prime Network
- Enhanced Care Prime Network
- Select Care Network

Prior Approval Procedures

Which procedures require prior approval by OrthoNet?

Refer to the Spine Surgery and Pain Management Procedure Therapy Codes section for the list of codes that apply require prior approval. These codes are subject to change.

Does this program require referrals?

The EmblemHealth Spine Surgery and Pain Management Therapies Program does not require referrals. Prior approval is required for any service or procedure included in the code list. However, most plans do require a referral to access network specialists. Providers are reminded to verify member eligibility and benefits, and ensure there is a valid referral on file prior to the patient's appointment.

How do providers request prior approval from OrthoNet?

To request prior approval, providers must complete and fax the correct *OrthoNet EmblemHealth Prior Authorization Request* form for the services being requested along with any supporting clinical notes, including relevant clinical history, imaging reports and other pertinent clinical information to: 1-844-296-4440.

What information do providers need to submit?

1. Complete the fax request form and make sure to include the following information when submitting requests:

- Provider Information section: of the fax request form, include either the facility name or the treating provider name along with the corresponding NPI or Tax ID number.
- To identify offices with multiple locations, please provide the full address of the location where the member will be treated.
- Member Information section: provide the member's name, date of birth and the EmblemHealth member identification number.
- Request Information section: please complete all fields including:
  - Diagnosis code(s)
  - Requested procedure
  - Spinal level

- Service setting*
- Anticipated date of service

**Please note - OrthoNet will also review for appropriateness of location.*

2. Fax the completed request form along with any supporting clinical information to OrthoNet at 1-844-296-4440.

Only prior approval request forms and any associated documents should be faxed to this number.

What documentation will OrthoNet need to render a decision?

OrthoNet will need sufficiently detailed, patient-specific clinical information to make a decision. This will include, at minimum, a relevant patient history that includes any prior treatments for this condition(s) including surgery, pain management, etc. Also required are copies of reports of significant imaging, such as MRI, CT, plain films and copies of relevant electro-diagnostic studies, if they have been performed. A proposed treatment plan/description of the proposed surgery, including the use of any implants is also essential. While a list of possible CPT-4 codes can be submitted, it is far more preferable to provide a written statement of the proposed clinical procedure(s). It is important to include a contact telephone number and fax number with the submission. This will help expedite any requests for additional information.

How long will it take to obtain prior approval?

For pre-service requests, it is OrthoNet's goal to review the supporting clinical data, verify eligibility/ benefits, render a determination and assign an authorization number, if approved, within one (1) to two (2) business days following the receipt of all necessary information. All utilization management decisions will meet accreditation (NCQA) and regulatory time frames. Providers will be notified and given the following information, both verbally and via fax:

- Authorization number
- Number of approved visits and/or units
- Next review date

For procedures performed at locations other than the clinician's office, OrthoNet will also notify the facility.

Who reviews the prior approval requests?

All prior approval requests will be reviewed for medical necessity by a licensed health care professional who has received additional training in his/her specialty and who is supported by board certified MDs and DOs.

How do providers file requests for continued pain management therapy services?

Complete an *OrthoNet EmblemHealth Pain Management Fax Request* form and fax it to OrthoNet at 1-844-296-4440. For questions, contact OrthoNet's Customer Service Department at 1-844-730-8503, Monday through Friday, 8:30 a.m. to 5:30 p.m.

Is it possible to check the status of a prior approval request?

To check on the status of a prior approval request, providers may contact OrthoNet's Customer Service Department at 1-844-730-8503, Monday through Friday, 8:30 am to 5:30 pm. Once a determination has been made providers will be notified, both verbally and via fax, on the day the decision is made.

Please note: An authorization is not a guarantee of payment and it is contingent upon the member's benefits, contract

limitations and eligibility at the time of service.

Can providers still request prior approval from EmblemHealth?

No. Providers may not submit requests through emblemhealth.com. Requestors will be directed to contact OrthoNet.

How long will the prior approval be valid?

Prior approvals are valid for 90 days from the date they are issued.

Where can I find the OrthoNet Prior Authorization Fax Request form?

The *OrthoNet Prior Authorization Fax Request* form can be downloaded from orthonet-online.com or the Provider Toolkit at emblemhealth.com. Providers may also call OrthoNet Provider Services at 1-844-730-8503 to request forms.

Where do I send my claims?

OrthoNet has only been engaged to oversee utilization management. Providers should continue to submit claims to EmblemHealth. Instructions for submitting claims are available in the Claims chapter.

Note: Claims submitted without the required prior approval will be denied.

How do providers request a peer-to-peer review?

For Commercial and Medicaid members, providers may ask for a reconsideration or peer-to-peer discussion upon receipt of the notice of a denial of service from OrthoNet. Providers may also contact OrthoNet's Customer Service department at 1-844-730-8503.

For Medicare members, providers may request a peer -to-peer discussion, but the decision cannot be changed. However, providers may request a "Re-Open," which must be submitted in writing to OrthoNet with the additional clinical information the provider would like OrthoNet to review. Written requests must be faxed to OrthoNet at 1-844-296-4440.

How do providers file an appeal?

All commercial and Medicaid member appeals will be reviewed by OrthoNet. If a provider still disagrees with the decision, the provider may exercise his/her rights as outlined in the adverse determination notice. For Medicare, the member, or practitioner on behalf of the member, may file a clinical appeal with EmblemHealth in accordance with the instructions that accompany the denial.

Where do providers send appeals?

A prior approval request that is denied by OrthoNet for spine surgery and pain management therapies may be appealed through OrthoNet. Provider appeals should be mailed to OrthoNet at the following address:

OrthoNet

EmblemHealth Appeals

P.O. Box 5046

White Plains, NY 10602-5046

Fax: 1-844-296-4440

Where can providers find more information?

For additional information, contact OrthoNet directly using one of the options provided below. To ask additional questions, you may sign in to use the Message Center at emblemhealth.com. Select “General Information” from the drop down menu on the “Ask a Question” page.

EmblemHealth Spine Surgery and Pain Management Therapies Program Guide

Key Contact Information

OrthoNet Customer Service	(844) 730-8503
OrthoNet Fax Number	(844) 296-4440
OrthoNet website	orthonet-online.com/provider.html

Procedure Codes

The following spine surgery and pain management procedure therapy codes require prior approval for both inpatient and outpatient procedures and therapies as part of this Program.

Spine Surgery and Pain Management Procedure Therapy Codes

Type of Procedure	CPT/HCPCS Codes	ICD-9 Procedure/ Diagnosis Codes	ICD-10 Procedure/Diagnosis Codes
			0RG0070, 0RG0071, 0RG007J, 0RG00J0, 0RG00J1, 0RG00JJ, 0RG00K0, 0RG00K1, 0RG00KJ, 0RG00Z0, 0RG00Z1, 0RG00ZJ, 0RG0370, 0RG0371, 0RG037J, 0RG03J0, 0RG03J1, 0RG03JJ, 0RG03K0, 0RG03K1, 0RG03KJ, 0RG03Z0, 0RG03Z1, 0RG03ZJ, 0RG0470, 0RG0471, 0RG047J, 0RG04J0, 0RG04J1, 0RG04JJ, 0RG04K0, 0RG04K1, 0RG04KJ, 0RG04Z0, 0RG04Z1, 0RG04ZJ, 0RG1070, 0RG1071, 0RG107J, 0RG10J0, 0RG10J1, 0RG10JJ, 0RG10K0, 0RG10K1, 0RG10KJ, 0RG10Z0, 0RG10Z1, 0RG10ZJ, 0RG1370, 0RG1371, 0RG137J, 0RG13J0, 0RG13J1, 0RG13JJ, 0RG13K0, 0RG13K1, 0RG13KJ, 0RG13Z0, 0RG13Z1, 0RG13ZJ, 0RG1470, 0RG1471, 0RG147J, 0RG14J0, 0RG14J1, 0RG14JJ, 0RG14K0, 0RG14K1, 0RG14KJ, 0RG14Z0, 0RG14Z1, 0RG14ZJ,

Spinal Fusion	0195T, 0196T, 0309T, 22532, 22533, 22534, 22548, 22551, 22552, 22554, 22556, 22558, 22585, 22586, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22633, 22634, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22850,	81.0, 81.00, 81.02, 81.03, 81.04, 81.05, 81.06, 81.07, 81.08, 81.62	0RG4070, 0RG4071, 0RG407J, 0RG40J0, 0RG40J1, 0RG40JJ, 0RG40K0, 0RG40K1, 0RG40KJ, 0RG40Z0, 0RG40Z1, 0RG40ZJ, 0RG4370, 0RG4371, 0RG437J, 0RG43J0, 0RG43J1, 0RG43JJ, 0RG43K0, 0RG43K1, 0RG43KJ, 0RG43Z0, 0RG43Z1, 0RG43ZJ, 0RG4470, 0RG4471, 0RG447J, 0RG44J0, 0RG44J1, 0RG44JJ, 0RG44K0, 0RG44K1, 0RG44KJ, 0RG44Z0, 0RG44Z1, 0RG44ZJ, 0RG6070, 0RG6071, 0RG607J, 0RG60J0, 0RG60J1, 0RG60JJ, 0RG60K0, 0RG60K1, 0RG60KJ, 0RG60Z0, 0RG60Z1, 0RG60ZJ, 0RG6370, 0RG6371, 0RG637J, 0RG63J0, 0RG63J1, 0RG63JJ, 0RG63K0, 0RG63K1, 0RG63KJ, 0RG63Z0, 0RG63Z1, 0RG63ZJ, 0RG6470, 0RG6471, 0RG647J, 0RG64J0, 0RG64J1, 0RG64JJ, 0RG64K0, 0RG64K1, 0RG64KJ, 0RG64Z0, 0RG64Z1, 0RG64ZJ, 0RGA070, 0RGA071, 0RGA07J, 0RGA0J0, 0RGA0J1, 0RGA0JJ, 0RGA0K0, 0RGA0K1, 0RGA0KJ, 0RGA0Z0, 0RGA0Z1, 0RGA0ZJ, 0RGA370, 0RGA371, 0RGA37J, 0RGA3J0, 0RGA3J1, 0RGA3JJ, 0RGA3K0, 0RGA3K1, 0RGA3KJ, 0RGA3Z0, 0RGA3Z1, 0RGA3ZJ, 0RGA470, 0RGA471, 0RGA47J, 0RGA4J0, 0RGA4J1, 0RGA4JJ, 0RGA4K0, 0RGA4K1, 0RGA4KJ, 0RGA4Z0, 0RGA4Z1, 0RGA4ZJ, 0SG0070, 0SG0071, 0SG007J, 0SG00J0, 0SG00J1, 0SG00JJ, 0SG00K0, 0SG00K1, 0SG00KJ, 0SG00Z0, 0SG00Z1, 0SG00ZJ, 0SG0370, 0SG0371, 0SG037J, 0SG03J0, 0SG03J1, 0SG03JJ, 0SG03K0, 0SG03K1, 0SG03KJ, 0SG03Z0, 0SG03Z1, 0SG03ZJ, 0SG0470, 0SG0471, 0SG047J, 0SG04J0, 0SG04J1, 0SG04JJ, 0SG04K0, 0SG04K1, 0SG04KJ, 0SG04Z0, 0SG04Z1, 0SG04ZJ, 0SG3070, 0SG3071, 0SG307J, 0SG30J0, 0SG30J1, 0SG30JJ, 0SG30K0, 0SG30K1, 0SG30KJ, 0SG30Z0, 0SG30Z1, 0SG30ZJ, 0SG3370, 0SG3371, 0SG337J, 0SG33J0, 0SG33J1, 0SG33JJ, 0SG33K0, 0SG33K1, 0SG33KJ, 0SG33Z0, 0SG33Z1, 0SG33ZJ, 0SG3470, 0SG3471, 0SG347J, 0SG34J0, 0SG34J1, 0SG34JJ, 0SG34K0, 0SG34K1, 0SG34KJ, 0SG34Z0, 0SG34Z1, 0SG34ZJ, 0SG504Z, 0SG507Z, 0SG50JZ, 0SG50KZ, 0SG50ZZ, 0SG534Z, 0SG537Z, 0SG53JZ, 0SG53KZ, 0SG53ZZ, 0SG544Z, 0SG547Z, 0SG54JZ, 0SG54KZ, 0SG54ZZ0SG604Z, 0SG607Z, 0SG60JZ, 0SG60KZ, 0SG60ZZ, 0SG634Z, 0SG637Z, 0SG63JZ, 0SG63KZ, 0SG63ZZ, 0SG644Z, 0SG647Z, 0SG64JZ, 0SG64KZ, 0SG64ZZ, 0RG1070, 0RG10A0, 0RG10J0, 0RG10K0, 0RG10Z0, 0RG1370, 0RG13A0, 0RG13J0, 0RG13K00RG13Z0, 0RG1470, 0RG14A0, 0RG14J0, 0RG14K0, 0RG14Z0, 0RG2070, 0RG20J0, 0RG20K0, 0RG20Z0, 0RG2370, 0RG23A0, 0RG23J0, 0RG23K0, 0RG23Z0, 0RG2470, 0RG24A0, 0RG24J0, 0RG24K0, 0RG24Z0, 0RG4070, 0RG40A0, 0RG40J0, 0RG40K0, 0RG40Z0, 0RG4370, 0RG43A0, 0RG43J0, 0RG43K0, 0RG43Z0, 0RG4470, 0RG44A0, 0RG44J0, 0RG44K0, 0RG44Z0, 0RG1071, 0RG107J, 0RG10A1, 0RG10AJ, 0RG10J1, 0RG10JJ, 0RG10K1, 0RG10KJ, 0RG10Z1, 0RG10ZJ, 0RG1371, 0RG137J, 0RG13A1, 0RG13AJ, 0RG13J1, 0RG13JJ, 0RG13K1, 0RG13KJ, 0RG13Z1, 0RG13ZJ, 0RG1471, 0RG147J, 0RG14A1, 0RG14AJ, 0RG14J1, 0RG14JJ, 0RG14K1, 0RG14KJ, 0RG14Z1, 0RG14ZJ, 0RG2071, 0RG207J, 0RG20A1, 0RG20AJ, 0RG20J1, 0RG20JJ, 0RG20K1, 0RG20KJ, 0RG20Z1, 0RG2371, 0RG237J, 0RG23A1, 0RG23AJ, 0RG23J1, 0RG23JJ, 0RG23K1, 0RG23KJ, 0RG23Z1, 0RG23ZJ, 0RG2471, 0RG247J, 0RG24A1, 0RG24AJ, 0RG24J1, 0RG24JJ, 0RG24K1, 0RG24KJ, 0RG24Z1, 0RG24ZJ, 0RG4071, 0RG407J, 0RG40A1, 0RG40AJ, 0RG40J1, 0RG40JJ, 0RG40K1, 0RG40KJ, 0RG40Z1, 0RG40ZJ, 0RG4371, 0RG437J, 0RG43A1, 0RG43AJ, 0RG43J1, 0RG43JJ, 0RG43K1, 0RG43KJ, 0RG43Z1, 0RG43ZJ, 0RG4471, 0RG447J, 0RG44A1, 0RG44AJ, 0RG44J1, 0RG44JJ, 0RG44K1, 0RG44KJ, 0RG44Z1, 0RG44ZJ, 0RG6070, 0RG60A0, 0RG60J0, 0RG60K0, 0RG60Z0, 0RG6370, 0RG63A0, 0RG63J0, 0RG63K0, 0RG63Z0, 0RG6470, 0RG64A0, 0RG64J0, 0RG64K0, 0RG64Z0, 0RG70A0, 0RG7370, 0RG73A0, 0RG73K0, 0RG7470 0RG74A0, 0RG74J0, 0RG74K0, 0RG8070, 0RG80A0, 0RG80J0, 0RG80K0, 0RG8370, 0RG83A0, 0RG83J0,

	22851, 22852		0RG83K0, 0RG8470, 0RG84A0, 0RG84J0, 0RG84K0, 0RGA070, 0RGA0A0, 0RGA0J0, 0RGA0K0, 0RGA0Z0, 0RGA370, 0RGA3A0, 0RGA3J0, 0RGA3K0, 0RGA3Z0, 0RGA470, 0RGA4A0, 0RGA4J0, 0RGA4K0, 0RGA4Z0, 0RG6071, 0RG607J, 0RG60A1, 0RG60AJ, 0RG60J1, 0RG60JJ, 0RG60K1, 0RG60KJ, 0RG60Z1, 0RG60ZJ, 0RG6371, 0RG637J, 0RG63A1, 0RG63AJ, 0RG63J1, 0RG63JJ, 0RG63K1, 0RG63KJ, 0RG63Z1, 0RG63ZJ, 0RG6471, 0RG647J, 0RG64A1, 0RG64AJ, 0RG64J1, 0RG64JJ, 0RG64K1, 0RG64KJ, 0RG64Z1, 0RG64ZJ, 0RG7071, 0RG707J, 0RG70A1, 0RG70AJ, 0RG70J1, 0RG70JJ, 0RG70K1, 0RG70KJ, 0RG70Z1, 0RG70ZJ, 0RG7371, 0RG737J, 0RG73A1, 0RG73AJ, 0RG73J1, 0RG73JJ, 0RG73K1, 0RG73KJ, 0RG73Z1, 0RG73ZJ, 0RG7471, 0RG747J, 0RG74A1, 0RG74AJ, 0RG74J1, 0RG74JJ, 0RG74K1, 0RG74KJ, 0RG74Z1, 0RG74ZJ, 0RG8071, 0RG807J, 0RG80A1, 0RG80AJ, 0RG80J1, 0RG80JJ, 0RG80K1, 0RG80KJ, 0RG80Z1, 0RG80ZJ, 0RG8371, 0RG837J, 0RG83A1, 0RG83AJ, 0RG83J1, 0RG83JJ, 0RG83K1, 0RG83KJ, 0RG83Z1, 0RG83ZJ, 0RG8471, 0RG847J, 0RG84A1, 0RG84AJ, 0RG84J1, 0RG84JJ, 0RG84K1, 0RG84KJ, 0RG84Z1, 0RG84ZJ, 0RGA071, 0RGA07J, 0RGA0A1, 0RGA0AJ, 0RGA0J1, 0RGA0JJ, 0RGA0K1, 0RGA0KJ, 0RGA0Z1, 0RGA0ZJ, 0RGA371, 0RGA37J, 0RGA3A1, 0RGA3AJ, 0RGA3J1, 0RGA3JJ, 0RGA3K1, 0RGA3KJ, 0RGA3Z1, 0RGA3ZJ, 0RGA471, 0RGA47J, 0RGA4A1, 0RGA4AJ, 0RGA4J1, 0RGA4JJ, 0RGA4K1, 0RGA4KJ, 0RGA4Z1, 0RGA4ZJ, 0SG0070, 0SG00A0, 0SG00J0, 0SG00K0, 0SG00Z0, 0SG0370, 0SG03A0, 0SG03J0, 0SG03K0, 0SG03Z0, 0SG0470, 0SG04A0, 0SG04J0, 0SG04K0, 0SG04Z0, 0SG1070, 0SG10A0, 0SG10J0, 0SG10K0, 0SG10Z0, 0SG1370, 0SG13A0, 0SG13J0, 0SG13K0, 0SG13Z0, 0SG1470, 0SG14A0, 0SG14J0, 0SG14K0, 0SG14Z0, 0SG3070, 0SG30A0, 0SG30J0, 0SG30K0, 0SG30Z0, 0SG3370, 0SG33A0, 0SG33J0, 0SG33K0, 0SG33Z0, 0SG3470, 0SG34A0, 0SG34J0, 0SG34K0, 0SG34Z0, 0SG0071, 0SG00A1, 0SG00J1, 0SG00K1, 0SG00Z1, 0SG0371, 0SG03A1, 0SG03J1, 0SG03K1, 0SG03Z1, 0SG0471, 0SG04A1, 0SG04J1, 0SG04K1, 0SG04Z1, 0SG1071, 0SG10A1, 0SG10J1, 0SG10K1, 0SG10Z1, 0SG1371, 0SG13A1, 0SG13J1, 0SG34ZJ
	63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63055, 63056, 63057, 63064, 63066,		00C30ZZ, 00C33ZZ, 00C34ZZ, 00CT0ZZ, 00CT3ZZ, 00CT4ZZ, 00CW0ZZ, 00CW3ZZ, 00CW4ZZ, 00CX0ZZ, 00CX3ZZ, 00CX4ZZ, 00CY0ZZ, 00CY3ZZ, 00CY4ZZ, 00JU0ZZ, 00JV0ZZ, 009T00Z, 009T0ZZ, 009T30Z, 009T3ZZ, 009T40Z, 009T4ZZ, 009U00Z, 009U0ZZ, 009W00Z, 009W0ZZ, 009W30Z, 009W3ZZ, 009W40Z, 009W4ZZ, 009X00Z, 009X0ZZ, 009X30Z, 009X3ZZ, 009X40Z, 009X4ZZ, 009Y00Z, 009Y0ZZ, 009Y30Z, 009Y3ZZ, 009Y40Z, 009Y4ZZ, 00JU0ZZ, 00JV0ZZ, 00NW0ZZ, 00NW3ZZ, 00NW4ZZ, 00NX0ZZ, 00NX3ZZ, 00NX4ZZ, 00NY0ZZ, 00NY3ZZ, 00NY4ZZ, 0RB00ZZ, 0RB03ZZ, 0RB04ZZ, 0RB10ZZ, 0RB13ZZ, 0RB14ZZ, 0RB40ZZ, 0RB43ZZ, 0RB44ZZ, 0RB60ZZ, 0RB63ZZ, 0RB64ZZ, 0RBA0ZZ, 0RBA3ZZ, 0RBA4ZZ, 0SB00ZZ, 0SB03ZZ, 0SB04ZZ, 0SB30ZZ, 0SB33ZZ, 0SB34ZZ, 0SB50ZZ, 0SB53ZZ, 0SB54ZZ, 0SB60ZZ, 0SB63ZZ, 0SB64ZZ, 0SB70ZZ, 0SB73ZZ, 0SB74ZZ, 0SB80ZZ, 0SB83ZZ, 0SB84ZZ, 009U30Z, 009U3ZZ, 009U40Z, 009U4ZZ, 009T0ZX, 009T3ZX, 009T4ZX, 009U0ZX, 009U3ZX, 009U4ZX, 009W0ZX, 009W3ZX, 009W4ZX, 009X0ZX, 009X3ZX, 009X4ZX, 009Y0ZX, 009Y3ZX, 009Y4ZX, 00BT0ZX, 00BT3ZX, 00BT4ZX, 00BW0ZX, 00BW3ZX, 00BW4ZX, 00BX0ZX, 00BX3ZX,

Decompression Surgery	63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200, 63250, 63251, 63252, 63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63295, 63300, 63301, 63302, 63303, 63304, 63305, 63306, 63307,	03.0, 03.01, 03.02,03.09, 03.3, 03.31,03.32, 03.39, 03.4,03.5, 03.51, 03.52,03.59, 03.6, 03.8,84.51, 84.52, 84.55,84.59, 84.8, 84.81, 84.82, 84.83, 84.84, 84.85	00BX4ZX, 00BY0ZX, 00BY3ZX, 00BY4ZX, 00JU3ZZ, 00JU4ZZ, 00JV3ZZ, 00JV4ZZ, 005T0ZZ, 005T3ZZ, 005T4ZZ, 005W0ZZ, 005W3ZZ, 005W4ZZ, 005X0Z Z, 005X3ZZ, 005X4ZZ, 005Y0ZZ, 005Y3Z, Z, 005Y4ZZ, 00BT0ZZ, 00BT3ZZ, 00BT4ZZ, 00BW0ZZ, 00BW3ZZ, 00BW4ZZ, 00BX0ZZ, 00BX3ZZ, 00BX4ZZ, 00BY0ZZ, 00BY3ZZ, 00BY4ZZ, 005T0ZZ, 005T3ZZ, 005T4ZZ, 00QT0ZZ, 00QT3ZZ, 00QT4ZZ, 00QW0ZZ, 00QW3ZZ, 00QW4ZZ, 00Q X0ZZ, 00QX3ZZ, 00QX4ZZ, 00QY0ZZ, 00QY3ZZ, 00QY4ZZ, 00NW0ZZ, 00NW3ZZ, 00NW4, ZZ, 00NX0ZZ, 00NX3ZZ, 00NX4ZZ, 00NY0ZZ, 00NY3ZZ, 00NY4ZZ, 3E0R3TZ, 3E0S3TZ, 0RG00A0, 0RG00A1, 0RG00AJ, 0RG03A0, 0RG03A1, 0RG03AJ, 0RG04A0, 0RG04A1, 0RG04AJ, 0RG10A0, 0RG10A1, 0RG10AJ, 0RG13A0, 0RG13A1, 0RG13AJ, 0RG14A0, 0RG14A1, 0RG14AJ, 0RG20A0, 0RG20A1, 0RG20AJ, 0RG23A0, 0RG23A1, 0RG23AJ, 0RG24A0, 0RG24A1, 0RG24AJ, 0RG40A0, 0RG40A1, 0RG40AJ, 0RG43A0, 0RG43A1, 0RG43AJ, 0RG44A0, 0RG44A1, 0RG44AJ, 0RG60A0, 0RG60A1, 0RG60AJ, 0RG63A0, 0RG63A1, 0RG63AJ, 0RG64A0, 0RG64A1, 0RG64AJ, 0RG70A0, 0RG70A1, 0RG70AJ, 0RG73A0, 0RG73A1, 0RG73AJ, 0RG74A0, 0RG74A1, 0RG74AJ, 0RG80A0, 0RG80A1 0RG80AJ, 0RG83A0, 0RG83A1, 0RG83AJ, 0RG84A0, 0RG84A1, 0RG84AJ, 0RGA0A0, 0RGA0A1, 0RGA0AJ, 0RGA3A0, 0RGA3A1, 0RGA3AJ, 0RGA4A0, 0RGA4A1, 0RGA4AJ, 0SG00A0, 0SG00A1, 0SG00AJ, 0SG03A0, 0SG03A1, 0SG03AJ, 0SG04A0, 0SG04A1, 0SG04AJ, 0SG10A0, 0SG10A1, 0SG10AJ, 0SG13A0, 0SG13A1 0SG13AJ, 0SG14A0, 0SG14A1, 0SG14AJ, 0SG30A0, 0SG30A1, 0SG30AJ, 0SG33A0 0SG33A1, 0SG33AJ, 0SG34A0, 0SG34A1, 0SG34AJ, 3E0U0GB, 3E0U3GB, 3E0V0GB,3E0V3GB, 3E0V3GC, 0RH00DZ, 0RH03DZ, 0RH04DZ, 0RH10DZ, 0RH13DZ, 0RH14DZ, 0RH40DZ, 0RH43DZ, 0RH44DZ, 0RH60DZ, 0RH63DZ, 0RH64DZ, 0RHA0DZ, 0RHA3DZ, 0RHA4DZ, 0RU00JZ, 0RU03JZ, 0RU04JZ, 0RU10JZ, 0RU13JZ, 0RU14JZ, 0RU40JZ, 0RU43JZ, 0RU44JZ, 0RU50JZ, 0RU53JZ, 0RU54JZ, 0RU60JZ, 0RU63JZ, 0RU64JZ, 0RUA0JZ, 0RUA3JZ, 0RUA4JZ, 0SH00DZ, 0SH03DZ, 0SH04DZ, 0SH30DZ, 0SH33DZ, 0SH34DZ, 0SU00JZ, 0SU03JZ, 0SU04JZ, 0SU30JZ, 0SU33JZ, 0SU34JZ, 0SU50JZ, 0SU53JZ, 0SU54JZ, 0SU60JZ, 0SU63JZ, 0SU64JZ, 0RH00BZ, 0RH03BZ, 0RH04BZ, 0RH10BZ, 0RH13BZ, 0RH14BZ, 0RH40BZ, 0RH43BZ, 0RH44BZ, 0RH60BZ, 0RH63BZ, 0RH64BZ, 0RHA0BZ, 0RHA3BZ, 0RHA4BZ, 0SH00BZ, 0SH03BZ, 0SH04BZ, 0SH30BZ, 0SH33BZ, 0SH34BZ, 0RW004Z, 0RW034Z, 0RW044Z, 0RW104Z, 0RW134Z, 0RW144Z, 0RW404Z, 0RW434Z, 0RW444Z, 0RW604Z, 0RW634Z, 0RW644Z, 0RWA04Z, 0RWA34Z, 0RWA44Z, 0SW004Z, 0SW034Z, 0SW044Z, 0SW304Z, 0SW334Z, 0SW344Z, 0RH00CZ, 0RH03CZ, 0RH04CZ, 0RH10CZ, 0RH13CZ, 0RH14CZ, 0RH40CZ, 0RH43CZ, 0RH44CZ, 0RH60CZ, 0RH63CZ, 0RH64CZ, 0RHA0CZ, 0RHA3CZ, 0RHA4CZ, 0SH00CZ, 0SH03CZ, 0SH04CZ, 0SH30CZ, 0SH33CZ, 0SH34CZ, 0RW004Z, 0RW034Z, 0RW044Z, 0RW104Z, 0RW134Z, 0RW144Z, 0RW404Z, 0RW434Z, 0RW444Z, 0RW604Z, 0RW634Z, 0RW644Z, 0RWA04Z, 0RWA34Z, 0RWA44Z, 0SW004Z, 0SW034Z, 0SW044Z, 0SW304Z, 0SW334Z, 0SW344Z, 0RH00DZ, 0RH03DZ, 0RH04DZ, 0RH10DZ, 0RH13DZ, 0RH14DZ, 0RH40DZ, 0RH43DZ, 0RH44DZ, 0RH60DZ, 0RH63DZ, 0RH64DZ, 0RHA0DZ, 0RHA3DZ, 0RHA4DZ, 0SH00DZ, 0SH03DZ, 0SH04DZ, 0SH30DZ, 0SH33DZ, 0SH34DZ, 0RW00JZ, 0RW03JZ, 0RW04JZ, 0RW10JZ, 0RW13JZ, 0RW14JZ, 0RW40JZ, 0RW43JZ, 0RW44JZ, 0RW60JZ, 0RW63JZ, 0RW64JZ, 0RWA0JZ, 0RWA3JZ, 0RWA4JZ, 0SW00JZ, 0SW03JZ, 0SW04JZ, 0SW30JZ, 0SW33JZ, 0SW34JZ

	63308, S2350, S2351		
Kyphoplasty	22523, 22524, 22525, 22520, 22521, 22522, S2360	81.66, 81.65	0PS33ZZ, 0PS43ZZ, 0QS03ZZ, 0QS13ZZ, 0QSS3ZZ
Vertebroplasty	S2361, 22310, 22315, 22325, 22326, 22327, 22510 22512, 22513, 22514, 22515		0PU33JZ, 0PU34JZ, 0PU43JZ, 0PU44JZ, 0QU03JZ, 0QU04JZ, 0QU13JZ, 0QU14JZ
Epidural Injections	62310, 62311, 64479, 64480, 64483, 64484		Intentionally left blank – Listed CPT codes always require Prior Approval
Facet Injections	64490, 64491, 64492, 64493, 64494, 64495		Intentionally left blank – Listed CPT codes always require Prior Approval
Spinal Cord Stimulator	0282T, 0283T, 0284T, 0285T, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688	03.93, 86.94, 86.95, 86.96, 86.97, 86.98	00HU0MZ, 00HU3MZ, 00HU4MZ, 00HV0MZ, 00HV3MZ, 00HV4MZ, 0JH60BZ, 0JH63BZ, 0JH70BZ, 0JH73BZ, 0JH80BZ, 0JH83BZ, 0JH60DZ, 0JH63DZ, 0JH70DZ, 0JH73DZ, 0JH80DZ, 0JH83DZ, 0JH60MZ, 0JH63MZ, 0JH70MZ, 0JH73MZ, 0JH80MZ, 0JH83MZ, 0JH60CZ, 0JH63CZ, 0JH70CZ, 0JH73CZ, 0JH80CZ, 0JH83CZ, 0JH60EZ, 0JH63EZ, 0JH70EZ, 0JH73EZ, 0JH80EZ, 0JH83EZ
			07HK03Z, 07HK33Z, 07HK43Z, 07HL03Z, 07HL33Z, 07HL43Z, 07HM03Z, 07HM33Z, 07HM43Z, 07HN03Z, 07HN33Z, 07HN43Z, 07HP03Z, 07HP33Z, 07HP43Z, 0FH003Z, 0FH033Z, 0FH043Z, 0FH103Z, 0FH133Z, 0FH143Z, 0FH203Z, 0FH233Z, 0FH243Z, 0FH403Z, 0FH433Z, 0FH443Z, 0FHB03Z, 0FHB33Z, 0FHB43Z, 0FHB73Z, 0FHB83Z, 0FHD03Z, 0FHD33Z, 0FHD43Z, 0FHD73Z, 0FHD83Z, 0FHG03Z, 0FHG33Z, 0FHG43Z, 0JH60VZ, 0JH63VZ, 0JH70VZ, 0JH73VZ, 0JH80VZ, 0JH83VZ, 0JHD0VZ, 0JHD3VZ, 0JHF0VZ, 0JHF3VZ, 0JHG0VZ, 0JHG3VZ, 0JHH0VZ, 0JHH3VZ, 0JHL0VZ, 0JHL3VZ, 0JHM0VZ, 0JHM3VZ, 0JHN0VZ, 0JHN3VZ,

Pain Pump	62318, 62355, 62365 62319, 62360, 62350, 62361, 62351, 62362	86.06 Please note, Pain Pumps are only eligible for coverage they when are billed in conjunction with the following diagnosis codes: 721.*-724.*, 338.1, 338.2, 338.4	oJHPoVZ, oJHP3VZ, oJHSo3Z, oJHS33Z, oJHTo3Z, oJHToVZ, oJHT33Z, oJHT3VZ, oJHVo3Z, oJHV33Z, oJHWo3Z, oJHW33Z, oRHoo3Z, oRHo33Z, oRHo43Z, oRH103Z, oRH133Z, oRH143Z, oRH303Z, oRH333Z, oRH343Z, oRH403Z, oRH433Z, oRH443Z, oRH503Z, oRH533Z, oRH543Z, oRH603Z, oRH633Z, oRH643Z, oRH903Z, oRH933Z, oRH943Z, oRHAo3Z, oRHA33Z, oRHA43Z, oRHBo3Z, oRHB33Z, oRHB43Z, oRHEo3Z, oRHE33Z, oRHE43Z, oRHFo3Z, oRHF33Z, oRHF43Z, oRHGo3Z, oRHG33Z, oRHG43Z, oRHHo3Z, oRHH33Z, oRHH43Z, oRHJo3Z, oRHJ33Z, oRHJ43Z, oRHKo3Z, oRHK33Z, oRHK43Z, oRHLo3Z, oRHL33Z, oRHL43Z, oRHMo3Z, oRHM33Z, oRHM43Z, oRHNo3Z, oRHN33Z, oRHN43Z, oRHPo3Z, oRHP33Z, oRHP43Z, oRHQo3Z, oRHQ33Z, oRHQ43Z, oRHRo3Z, oRHR33Z, oRHR43Z, oRHSo3Z, oRHS33Z, oRHS43Z, oRHTo3Z, oRHT33Z, oRHT43Z, oRHUo3Z, oRHU33Z, oRHU43Z, oRHVo3Z, oRHV33Z, oRHV43Z, oRHWo3Z, oRHW33Z, oRHW43Z, oRHXo3Z, oRHX33Z, oSHD33Z, oSHD43Z, oSHFo3Z, oSHF33Z, oSHF43Z, oSHGo3Z, oSHG33Z, oSHG43Z, oSHHo3Z, oSHH33Z, oSHH43Z, oSHJo3Z, oSHJ33Z, oSHJ43Z, oSHKo3Z, oSHK33Z, oSHK43Z, oSHLo3Z, oSHL33Z, oSHL43Z, oSHMo3Z, oSHM33Z, oSHM43Z, oSHNo3Z, oSHN33Z, oSHN43Z, oSHPo3Z, oSHP33Z, oSHP43Z, oSHQo3Z, oSHQ33Z, oSHQ43Z, oTH503Z, oTH533Z, oTH543Z, oTH573Z, oTH583Z, oTH903Z, oTH933Z, oTH943Z, oTH973Z, oTH983Z, oTHBo3Z, oTHB33Z, oTHB43Z, oTHB73Z, oTHB83Z, oTHDo3Z, oTHD33Z, oTHD43Z, oTHD73Z, oTHD83Z, oTHDX3Z, oUH303Z, oUH333Z, oUH343Z, oUH803Z, oUH833Z, oUH843Z, oUH873Z, oUH883Z, oVH403Z, oVH433Z, oVH443Z, oVH473Z, oVH483Z, oVH803Z, oVH833Z, oVH843Z, oVH873Z, oVH883Z, oVHDo3Z, oVHD33Z, oVHD43Z, oVHD73Z, oVHD83Z, oVHMo3Z, oVHM33Z, oVHM43Z, oVHM73Z, oVHM83Z, oVHRo3Z, oVHR33Z, oVHR43Z, oVHR73Z, oVHR83Z, oVHSo3Z, oVHS33Z, oVHS43Z, oVHSX3ZM47.011, M47.012, M47.013, M47.014, M47.015, M47.016, M47.019, M47.021, M47.022, M47.029, M50.20, M50.21, M50.22, M50.23, M51.26, M51.27, M51.24, M51.25, M51.9, M51.9, M51.44, M51.45, M51.46, M51.47, M51.9, M50.30, M50.31, M50.32, M50.33, M51.34, M51.35, M51.36, M51.37, M51.34, M51.35, M51.36, M51.37, M51.9, M50.00, M50.01, M50.02, M50.03, M51.04, M51.05, M51.06, M96.1, M96.1, M96.1, M96.1, M46.40, M46.48, M46.49, M51.9, M46.41, M46.42, M46.43, M50.10, M50.11, M50.12, M50.13, M50.80, M50.81, M50.82, M50.83, M50.90, M50.91, M50.92, M50.93, M46.44, M46.45, M51.84, M51.85, M46.46, M46.47, M51.86, M51.87, M48.01, M48.02, M48.03, M99.20, M99.21, M99.30, M99.31, M99.40, M99.41, M99.50 M99.51, M99.60, M99.61, M99.70, M99.71, M54.2, M53.0, M53.1, M54.11, M54.12, M54.13, M43.6, M54.00, M54.01, M54.02, M67.88, M53.81, M53.82, M53.83, M54.81, M53.82 M47.21, M47.22, M47.23, M47.811, M47.812, M47.813, M47.891, M47.892, M47.893, M47.11, M47.12, M47.13, M47.24, M47.25, M47.814, M47.815, M47.894, M47.895, M47.26, M47.27, M47.28, M47.816, M47.817, M47.818, M47.896, M47.897, M47.898, M47.14, M47.15, M47.16, M48.20, M48.21, M48.22, M48.23, M48.24, M48.25, M48.26, M48.27, M48.10, M48.11, M48.12, M48.13, M48.14, M48.15, M48.16, M48.17, M48.18, M48.19, M48.30, M48.31, M48.32, M48.33, M48.34, M48.35, M48.36, M48.37, M48.38, M25.78, M48.9, M47.20, M47.819, M47.899, M47.9, M47.10, M48.00, M48.04, M48.05, M99.22, M99.32, M99.42, M99.52, M99.62, M99.72, M48.06, M48.07, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M48.00, M48.08, M99.24, M99.25, M99.26, M99.27, M99.28, M99.29, M99.34, M99.35, M99.36, M99.37, M99.38, M99.39, M99.44, M99.45, M99.46, M99.47, M99.48, M99.49, M99.54, M99.55, M99.56, M99.57, M99.58, M99.59, M99.64, M99.65, M99.66, M99.67, M99.68, M99.69, M99.74, M99.75, M99.76, M99.77, M99.78, M99.79, M54.6, M54.5, M54.30, M54.31, M54.32, M54.40, M54.41, M54.42, M51.14, M51.15, M51.16, M51.17, M54.14,

			M54.15, M54.16, M54.17, M54.5, M54.89, M54.9, M43.27, M43.28, M53.2X7, M53.2X8, M53.3, M53.86, M53.87, M53.88, M53.3, M53.2X8, M53.3, M54.03, M54.04, M54.05, M54.06, M54.07, M54.08, M54.09, M62.830, M43.20, M43.21, M43.22, M43.23, M43.24, M43.25, M43.26, M43.27, M43.28, M43.8X9, M53.80, M53.83, M53.84, M53.85, M53.9
Other	22818, 22819, 22855, 22856, 22857, 22861, 22862, 22864, 22865		Intentionally left blank – Listed CPT codes always require Prior Approval

*Includes all codes within range.

Forms

To request prior approval, providers must complete and fax the correct OrthoNet EmblemHealth Prior Authorization Request form for the services being requested along with any supporting clinical notes, including relevant clinical history, imaging reports and other pertinent clinical information to: 1-844-296-4440.

- Pain Management Prior Authorization Request Form
- Spinal Surgery Prior Authorization Request Form

Members Exempt from the EmblemHealth Spine Surgery and Pain Management Program

Members whose care is managed by Montefiore Medical Group (CMO) or HealthCare Partners (HCP) must contact the applicable organization for prior approval. Check the member's ID card or eligibility information on emblemhealth.com to determine whether HIP, CMO, or HCP is the managing entity responsible for managing a member's care; if HIP is the managing entity, then OrthoNet is the organization to contact for prior approval.

EmblemHealth

Provider Manual

Chapter 13: Durable Medical Equipment

This chapter includes our policies for the prescription of durable medical equipment to our members.

Overview

This chapter describes our policies for the prescription of durable medical equipment (DME). DME coverage is subject to the Member's benefit plan. Members may be responsible for paying a portion of the DME's cost in the form of a copay/coinsurance and/or deductible. The DME vendor will notify the member when copays/coinsurance and/or deductibles are due.

Prior Approval/Pre-Certification may be needed before certain services can be rendered or equipment supplied. Who evaluates the Prior Approval/Pre-Certification request depends on which networks the members access and who has financial risk for their care.

Because of changes starting in 2018, this chapter has been restructured. To find the applicable policy, first look for the section that applies to the member's network. Then, look for the time period the rules apply to.

With minor exceptions, the lists of included or excluded services apply to all members. Please select the table for the applicable date of service to see whether Prior Approval/Pre-Certification was/is needed.

Starting on January 1, 2018, seven (7) new codes in the E category "durable medical equipment" and one hundred and six (106) new codes in the L category "orthotic and prosthetic procedure, devices" will require prior approval/pre-certification for all EmblemHealth members. See table Durable Medical Equipment Will Require Prior Approval/Pre-Certification.

Customized DME Defined
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.

Rental DME Defined
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.

Members Managed by eviCore

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

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

Exceptions to These Rules

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

How to Find a Network DME Provider

To find a DME provider, go to emblemhealth.com/findadoctor.

What Requires Prior Approval

Refer to Durable Medical Equipment Prior Approval Rules in Clinical Corner for the list of Healthcare Procedural Codes (HCPCS) that require prior approval through eviCore.

Hearing aids - Traditional hearing aids are not part of this program. However, there will be a prior approval process for certain hearing aids including Auditory Osseointegrated Devices.

Who Needs to Request Prior Approval

Required Information

Before requesting prior approval from eviCore, the requesting provider should submit:

- Patient's medical records
- Appropriate request form
- Details such as: admitting diagnosis, history and physical, progress notes, medication list and wound or incision/location

The request forms are available at: evicore.com/healthplan/emblem.

Please send eviCore the supporting clinical documents and the prior approval forms.

How to Obtain Prior Approval

Managing Entity	Methods to Submit Prior Approval Requests
eviCore	eviCore offers three convenient methods to request prior approval, depending on the Program: 1. Web Portal submissions are the most efficient way to request prior approvals. Please visit evicore.com/pages/providerlogin.aspx. 2. Telephone: Clinical information can be called in to eviCore healthcare at 866-417-2345, choose option 3 for HIP members; then option 4 DME and prompt 1 for CPAP and BIPAP or 2 for other DME services. 3. Facsimile: DME required documentation can be faxed to 866-663-7740. For DME requests prior to January 1, 2018, fax to 1-866-426-1509. On or after, December 28, 2017,submit requests to eviCore for anticipated dates of service on or after January 1, 2018. DME Suppliers may obtain prior approval details via the eviCore web portal at: evicore.com/pages/providerlogin.aspx or by calling eviCore at: 866-417-2345, option 3 for HIP, then option 4.
HealthCare Partners	Call (800) 877-7587 or fax your request to (888) 746-6433.
Montefiore CMO	Call (888) 666-8326 .

DME Prior Approval Overview

Notifications to members and providers will be both written and verbal.

Notification to COMMERCIAL AND MEDICAID MEMBERS:

Written notification in the form of a letter will be:

- Faxed to both the referring Physician and DME Supplier
- Mailed to the member via standard US Mail
- Available for review on the portal

Verbal notification:

- Verbal outreach to members will occur for all determinations

Notification to MEDICARE MEMBERS

Written notification in the form of a letter will be:

- Faxed to both the referring Physician and DME Supplier
- Mailed to the member via standard US Mail
- Available for review on the portal

After the Unable to Approve process has been completed, written notification in the form of a denial letter will be:

- Faxed to both the referring Physician and DME Supplier
- Mailed to the member via standard US Mail
- Available for review on the portal.

Determination will be made within 2 business days for a routine request and within 3 hours for an Urgent Request.

Evidence based/Proprietary guidelines for DME Medical Necessity Criteria

Medicare:
Medicare Benefit Policy Manual
National and Local Coverage Determination
McKesson InterQual® Criteria
eviCore Clinical Guidelines for PAP devices and supplies

Medicaid:
New York State Medicaid Program Criteria
Durable Medical Equipment, Orthotics, Prosthetics, and Supplies Procedure Code and Coverage Guidelines
eviCore Clinical Guidelines for PAP devices and supplies
McKesson InterQual® Criteria

Commercial:
McKesson InterQual® Criteria
eviCore Clinical Guidelines for PAP devices and supplies

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

eviCore Healthcare Sleep Program/CPAP Compliance - Program Therapy Support:

- Beginning January 1, 2018, PAP compliance data will be monitored for Emblem/HIP Commercial, Medicare and Medicaid members by eviCore healthcare. Please visit https: evicore.com/healthplan/emblem for additional program information and reference guides.

eviCore healthcare DME Reconsideration and Appeals Process:
Cases that do not meet Medical Necessity may be Reconsidered or Appealed.

Group Health Incorporated Members

The following rules apply to our members whose services are managed by EmblemHealth and access the following networks:

- Commercial
  - CBP Network
  - National Network
  - Network Access
  - Tri-State Network

- Medicare
  - EmblemHealth Medicare Choice PPO Network

Retired Network

- GHI HMO

How to Find a Network DME Provider
DME must be ordered from a contracted DME vendor. Most DME vendors will work with your office to complete the pre-certification request (including the applicable forms).

To locate an appropriate DME provider in your area, please visit emblemhealth.com/findadoctor. After inputting the member's ZIP code and clicking on the member's benefit plan, select "Hospital, Facility or Urgent Care Center" and choose "Durable Medical Equipment" from the "Other Facilities" drop-down menu.

Special Member Benefits

Diabetic Medications
For information regarding diabetic medications, please refer to the Pharmacy Services chapter.

Blood Glucose Meters and Testing Supplies - EmblemHealth EPO/PPO, GuildNet Plan Members and GHI HMO Members before January 1, 2016.

Items not requiring prior approval, such as blood glucose meters and diabetic testing supplies (with the exception of insulin pumps and related supplies, which do require approval), may be directly requested from CCS Medical for the above-referenced plan members. EmblemHealth's formulary for diabetic testing supplies consists of the complete line of Abbott/Medisense and Bayer Diagnostics testing equipment and supplies.

A written order must be faxed and/or mailed to CCS Medical. They will work with the provider and the member, as

necessary, to complete arrangements for the requested item(s).

Mail:

CCS Medical
3601 Thirlane Rd NW, Suite 4 Roanoke, VA 24019

Phone: 1-800-881-4008
Fax for CMN form(s) and other documentation: 1-800-860-4326
Fax for prescriptions: 1-800-248-9505

Blood Glucose Meters and Testing Supplies - EmblemHealth Medicare PPO and Medicare Prescription Drug Plan Members

For the above-referenced plan members, EmblemHealth will cover blood glucose meters and testing supplies for Abbott Diabetes Care products only.

Patients who need a change in their testing frequency or the type of meter or supplies used will need a new prescription. Patients new to our plans may obtain a prescribed Abbott meter at no cost by calling 1-888-522-5226 or by visiting the Abbott Diabetes Care website: AbbottDiabetesCare.com.

Questions, product support or meter replacement?

Please direct your EmblemHealth patients to call Abbott Diabetes Care Product Support at 1-888-522-5226 or go online at AbbottDiabetesCare.com.

Blood Glucose Meters and Testing Supplies - All Other Members
For all other members, medical/surgical supplies are covered as specified under the medical benefit with the participating vendor.

What Requires Pre-Certification

What Requires Pre-Certification for Commercial Members and Who Needs to Request It
Pre-Certification is required only for DME in excess of $2,000, such as wheelchairs and electric beds. Pre-Certification is required for all custom DME with the exception of canes, crutches and walkers.

Benefit Plans associated with the CBP, National, Network Access & Tristate Networks do not require prior approval for rental DME.

The treating health care professional is responsible for requesting pre-certification and, when necessary, completing the applicable Certificate of Medical Necessity form(s).

What Requires Pre-Certification for Medicare PPO Members
Pre-Certification is required only for DME in excess of $500 for Medicare Advantage members. Pre-Certification is required for all custom and rental DME with the exception of canes, crutches and walkers for members who access the EmblemHealth Medicare Choice PPO Network. DME required prior approval unless it was included on the following list: 2015 HCPCS Codes That Do Not Require Prior Approval/Pre-Certification.

How To Submit a Pre-Certification Request
The How To Obtain a Prior Approval/Pre-Certification chart in the Care Management chapter provides contacts for each of our plans and managing entities. Please send requests for approval directly to EmblemHealth and managing entities, not the DME vendor.

What To Include in the Pre-Certificaiton Request

1. Request for prior approval
2. Written prescription
3. Applicable Certificate of Medical Necessity (CMN) Form(s)

Electronic requests for DME prior approval should be accompanied by a fax containing the written prescription and any applicable CMN forms. All paperwork must be signed by the provider. Signature stamps are not acceptable.

Written Prescription
To initiate coverage of DME, the provider must issue a prescription, or other written order on personalized stationery, which includes:

- Member's name and full address
- Provider's signature
- Date the provider signed the prescription or order
- Description of the items needed
- Start date of the order (if appropriate)
- Diagnosis
- A realistic estimate of the total length of time the equipment will be needed (in months or years)

Certificate of Medical Necessity
In addition to the written prescription, providers should fill out a Certificate of Medical Necessity (CMN) form when requesting customized equipment or oxygen therapy or when providing clinical information. Filling out the CMN form involves:

Certifying the patient's need. The treating physician must certify in writing the patient's medical need for equipment and attest that the patient meets the criteria for medical devices and/or equipment.

Issuing a plan of care. The treating physician must issue a plan of care for the patient that specifies:
The type of medical devices, equipment and/or services to be provided
The nature and frequency of these services

Note: For home oxygen therapy procedures, current blood gas levels and oxygen saturation levels must be noted in the CMN form.

Providers, not DME vendors, are responsible for properly and conscientiously completing the CMN form for all

prescribed DME items.

EmblemHealth accepts any of the standard CMN forms provided by the Centers for Medicare & Medicaid Services (CMS). These forms can be found on the forms section of the CMS website: cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html. Providers must complete Section B of the forms accurately and clearly and transfer adequate notation into the patient's chart to corroborate the answers supplied on the CMN form.

EmblemHealth's DME prior approval procedure is consistent with the CMS/Local Medicare Coverage Guidelines for all lines of business. These guidelines are readily accessible at cms.gov and Empire Medicare.

Pre-Certification Issuance
EmblemHealth's Care Management program will review each prior approval request to determine the member's eligibility to receive the benefit and the medical necessity for the prescribed equipment or supply.

After Hours Pre-Certification
In the event that there is an urgent request for equipment requiring pre-certification that needs to be ordered on a weekend (5 p.m. Friday through 8 a.m. Monday) or on a holiday (5 p.m. the evening before through 8 a.m. the morning after), the provider should contact our emergency 24-hour prior approval line at 1-866-447-9717. All non-urgent requests will be processed on the next business day.

Discharge Planning

Please notify EmblemHealth of the need for DME as soon as possible. Delays in ordering DME may compromise or delay a discharge from the hospital or rehabilitation center. Only in emergency situations should EmblemHealth be contacted on the day of discharge for DME.

Record Keeping and Clamis Submission

DME suppliers who submit bills to EmblemHealth are required to keep the provider's original written order or prescription in their files.

Providers are required to document the medical need for and utilization of DME items in the member's chart and to ensure that information about the member's medical condition is correct. In the event of a medical audit, EmblemHealth may require copies of relevant portions of the patient's chart to establish the existence of medical need as indicated in the CMN form submitted with the prior approval request.

HIP Members – Prior to January 1, 2018

The following rules apply to our Medicare PPO and HIP members managed by EmblemHealth with the following networks for services up to and including December 31, 2017.

- Commercial and Child Health Plus
  - Prime Network
  - Select Care Network

- Medicaid/HARP
  - Enhanced Care Prime Network

- Medicare and Special Needs Plans
  - Medicare Essential Network
  - VIP Prime Network

- IDA for ASO Clients
  - Associated Dual Assurance Network

Retired Networks
The policies described in this section also applied to members who accessed one of these now retired networks:

- EmblemHealth Dual Assurance Network
- GHI HMO
- NY Metro Network
- Premium Network
- Vytra Premium Network
- Vytra Network

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

How to Find a Network DME Provider

To locate an appropriate DME provider in your area, please visit emblemhealth.com/FindaDoctor. After inputting the member's ZIP code and clicking on the member's benefit plan, select "Hospital, Facility or Urgent Care Center" and choose "Durable Medical Equipment" from the "Other Facilities" drop-down menu.

Special Member Benefits –DIABETIC, Medical & Surgical SUPPLIES

Diabetic Medications
For information regarding diabetic medications, please refer to the Pharmacy Services chapter.

Blood Glucose Meters and Testing Supplies - HIP Commercial, EmblemHealth Medicaid, EmblemHealth Medicare HMO and Medicare Prescription Drug Plan Members

For the above-referenced plan members, EmblemHealth will cover blood glucose meters and testing supplies for Abbott Diabetes Care products only. For EmblemHealth Medicaid members, this coverage went into effect October 1, 2011.

Patients who need a change in their testing frequency or the type of meter or supplies used will need a new prescription. Patients new to our plans may obtain a prescribed Abbott meter at no cost by calling 1-888-522-5226 or by visiting the Abbott Diabetes Care website: AbbottDiabetesCare.com.

Questions, product support or meter replacement?

Please direct your EmblemHealth patients to call Abbott Diabetes Care Product Support at 1-888-522-5226 or go online at AbbottDiabetesCare.com.

Blood Glucose Meters and Testing Supplies -All Other Members
For all other members, medical/surgical supplies are covered as specified under the medical benefit with the participating vendor.

MEDICAL AND SURGICAL SUPPLIES - EmblemHealth Medicaid Members
Effective October 1, 2011, EmblemHealth covers pharmacy benefit services for all Medicaid members. The benefit includes all Medicaid covered over-the-counter medications, diabetic supplies, select durable medical equipment and medical supplies.

EmblemHealth covers medical/surgical supplies routinely furnished or administered as part of an office visit.

Note: Medical/surgical supplies dispensed in a doctor's office or other non-inpatient setting, or by a certified home health aide as part of an at-home visit, are not covered as separate billable items.

MEDICAL AND SURGICAL SUPPLIES - Child Health Plus Members
EmblemHealth does not cover most medical/surgical supplies for Child Health Plus members. However, items such as diabetic supplies are covered, as well as smoking cessation products, enteral formulae, canes, walkers, commode accessories and equipment for respiratory care. Providers can contact EmblemHealth at 1-877-842-3625 for a complete listing of items covered by the Child Health Plus program.

Prior Approval

What Required Prior Approval

Prior approval is required for all custom and rental DME with the exception of canes, crutches and walkers. DME required prior approval unless it was included on the following list: 2015 HCPCS Codes That Do Not Require Prior Approval.

Who Needed To Request Prior Approval
DME must be ordered from a contracted DME vendor. Most DME vendors will work with your office to complete the prior approval request (including the applicable forms). To locate an appropriate DME provider in your area, please visit emblemhealth.com/FindaDoctor. After inputting the member's ZIP code and clicking on the member's benefit plan, select "Hospital, Facility or Urgent Care Center" and choose "Durable Medical Equipment" from the "Other Facilities" drop-down menu.

Exception: Prior to January 1, 2016, Vytra network-based plans allowed either the provider or the DME vendor to obtain the DME prior approval. Starting January 1, 2016, Vytra members were moved to the Vytra Premium Network and began following the same plan rule as all other members accessing the standard Premium Network. During 2017, members with Vytra plans were migrated to the Prime Network. Starting in 2018, they will follow eviCore's DME processes.

How To Submit a Prior Approval Request
The How To Obtain a Prior Approval chart in the Care Management chapter provides contacts for each of our plans and managing entities. Please send requests for approval directly to EmblemHealth and managing entities, not the

DME vendor.

What To Include in the Prior Approval Request

- Request for prior approval
- Written prescription
- Applicable Certificate of Medical Necessity (CMN) Form(s)

Electronic requests for DME prior approval should be accompanied by a fax containing the written prescription and any applicable CMN forms. All paperwork must be signed by the provider. Signature stamps are not acceptable.

Written Prescription
To initiate coverage of DME, the provider must issue a prescription, or other written order on personalized stationery, which includes:

- Member's name and full address
- Provider's signature
- Date the provider signed the prescription or order
- Description of the items needed
- Start date of the order (if appropriate)
- Diagnosis
- A realistic estimate of the total length of time the equipment will be needed (in months or years)

Certificate of Medical Necessity
In addition to the written prescription, providers should fill out a Certificate of Medical Necessity (CMN) form when requesting customized equipment or oxygen therapy or when providing clinical information. Filling out the CMN form involves:

Certifying the patient's need. The treating physician must certify in writing the patient's medical need for equipment and attest that the patient meets the criteria for medical devices and/or equipment.

Issuing a plan of care. The treating physician must issue a plan of care for the patient that specifies:
The type of medical devices, equipment and/or services to be provided The nature and frequency of these services

Note: For home oxygen therapy procedures, current blood gas levels and oxygen saturation levels must be noted in the CMN form.

Providers, not DME vendors, are responsible for properly and conscientiously completing the CMN form for all prescribed DME items.

EmblemHealth accepts any of the standard CMN forms provided by the Centers for Medicare & Medicaid Services (CMS). These forms can be found on the forms section of the CMS website: cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html. Providers must complete Section B of the forms accurately and clearly and transfer

adequate notation into the patient's chart to corroborate the answers supplied on the CMN form.

EmblemHealth's DME prior approval procedure is consistent with the CMS/Local Medicare Coverage Guidelines for all lines of business. These guidelines are readily accessible at cms.gov and Empire Medicare.

Prior Approval Issuance
EmblemHealth's Care Management program will review each prior approval request to determine the member's eligibility to receive the benefit and the medical necessity for the prescribed equipment or supply.

After Hours Prior Approval
In the event that there is an urgent request for equipment requiring prior approval that needs to be ordered on a weekend (5 p.m. Friday through 8 a.m. Monday) or on a holiday (5 p.m. the evening before through 8 a.m. the morning after), the provider should contact our emergency 24-hour prior approval line at 1-866-447-9717. All non-urgent requests will be processed on the next business day.

Discharge Planning

Please notify EmblemHealth of the need for DME as soon as possible. Delays in ordering DME may compromise or delay a discharge from the hospital or rehabilitation center. Only in emergency situations should EmblemHealth be contacted on the day of discharge for DME.

Record Keeping and Claims Submission

DME suppliers who submit bills to EmblemHealth are required to keep the provider's original written order or prescription in their files.

Providers are required to document the medical need for and utilization of DME items in the member's chart and to ensure that information about the member's medical condition is correct. In the event of a medical audit, EmblemHealth may require copies of relevant portions of the patient's chart to establish the existence of medical need as indicated in the CMN form submitted with the prior approval request.

HCPCS Codes That Do Not Need Prior Approval

2015 HCPCS Codes That Do Not Require Prior Approval/Pre-Certifcation

Healthcare Common Procedure Coding System (HCPCS) Level II is a standardized coding system used primarily to identify products, supplies and services not included in the CPT codes, such as durable medical equipment, prosthetics, orthotics and supplies when used outside a physician’s office.

The table below lists the HCPCS codes that do not require prior approval for any benefit plans associated with the following networks:

• Commercial and Child Health Plus

• Prime Network
• Select Care Network

• Medicaid/HARP

- Enhanced Care Prime Network
- Medicare and Special Needs Plans
- Medicare Choice PPO Network
- Essential Network
- VIP Prime Network
- FIDA for ASO Clients
- Associated Dual Assurance Network

HCPCS Codes That Do Not Require Prior Approval

HCPCS Codes	Description
A4561	Pessary, rubber, any type
A4562	Pessary, nonrubber, any type
A4565	Slings
A4624	Tracheal suction catheter, any type than closed system, each
A4629	Tracheostomy care kit
A6258	Transparent film > 16 <= 48 inches
A6402	Sterile gauze <= 16 square inches
A6531	Compression Stockings, below the knee, 30-40 mg Hg each
A6532	Compression Stockings, below the knee, 40-50 mg Hg each
A7003	Administration set, with small volume nonfiltered pneumatic nebulilzer, disposable
A7005	Nondisposable nebulizer set
A7007	Large-volume nebulizer, disposable
A7010	Disposable corrugated tubing
A7013	Disposable compressor filter
A7015	Aerosol mask, used with nebulizer
A7032	Replacement nasal cushion
A7034	Nasal application device
A7035	Positive airway pressure headgear
A7036	Positive airway pressure chinstrap

A7037	Positive airway pressure tubing
A7038	Positive airway pressure filter
A7039	Filter, nondisposable with PAP
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each
A7520	Tracheostomy/laryngectomy tube, non-cuffed poluvinylchloride (PVC), silicone or equal, each
E0100	Cane, inc. canes of all materials, adjustable
E0110	Crutch, forearm, pair
E0114	Crutch, underarm, pari, no wood
E0130	Walker, rigid adjustable or fixed height
E0135	Walker, folding, adjustable or fixed height
E0143	Walker, folding, wheeled, adjustable or fixed height
E0147	Walker, heavy-duty, multiple braking system, variable wheel resistance
E0148	Heavy-duty walker, no wheels
E0149	Heavy-duty walker, wheeled
E0153	Forearm crutch, platform attachment
E0154	Walker, platform attachment
E0155	Walker, wheel attachment, pair
E0156	Walker, seat attachment
E0158	Walker, leg extenders, (set of 4)
E0163	Commode chair with fixed arms
E0165	Commode chair with detached arms
E0167	Commode chair, pail or pan
E0168	Commode chair, extra wide &/or heavy-duty, stationary or mobile, with or without arms, any type, each
E0188	Synthetic sheepskin pad
E1081	APP (alternating pressure pad) mattress/overlay, powered, Group I
E0185	Gel-like pressure pad for mattress, Group I
E0199	Dry pressure pad for mattress

E0202	Phototherapy (bilirubin) light with photometer
E0482	Cough stimulating device, alternating positive & negative airway pressure
E0500	IPPB machines, all types
E0570	Nebulizer, with compressor
E0560	Humidifier, durable, for supplemental humidification
E0565	Compression, air, power source
E0600	Respiratory suction pump, home model, portable or stationary, electric
E0602	Breast pumps, manual
E0603	Breast pumps, electric
E0604	Breast pumps, hospital grade
E0618	Apnea monitor without recording feature
E0619	Apnea monitor with recording feature
E0621	Patient lift, sling or seat
E0630	Hoyer lift
E0705	Transfer board or device, any type, each
E0720	Tens unit, 2 leads, localized
E0730	Transcutaneous electrical nerve stimulation device
E0731	Form fitting conductive garment for delivery of Tens unit
E0830	Ambulatory traction devices, all types
E0840	Traction frame for headboard, cervical traction
E0849	Traction equipment, FreestANDing frame, pneumatic, cervical
E0850	Traction st, FreestANDing, cervical
E0855	Cervical traction equipment not requiring additional st& or frame
E0856	Cervical traction device, cervical collar with inflatable bladder
E0860	Traction equipment, over door, cervical
E0870	Traction, FreestANDing, extremity (e.g. Bucks)
E0880	Traction, FreestANDing, extremity (e.g. Bucks)

E0890	Traction frame attached to footboard, pelvic
E0900	Traction st FreestANDing, pelvic
E0910	Trapeze bars, aka Patient Helper, attached to bed, with grab bar
E0911	Trapeze bar attached to bed with grab bar, weight greater than 250 lbs.
E0912	Trapeze bar, heavy duty with grab bar, weight greater than 250 lbs., freest&ing
E0958	Manual wheelchair accessory, one-arm drive attachment, each
E0966	Manual wheelchair accessory, headrest extension, each
E0968	Commode seat, wheelchair
E0971	Manual wheelchair accessory, anti-tipping device, each
E1020	Residual limb support system for wheelchair
E1031	Rollabout chair, any & all types, with castors
E1035	Multi-position transfer system
E1037	Transport chair, pediatric size
E1038	Transport chair, adult size
E1039	Transport chair, adult size, heavy duty, weight greater than 300 lbs.
E1354	Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only
E2601	General use wheelchair seat cushion, width less than 22 in., any depth
E2602	General use wheelchair seat cushion, width 22 in. or greater, any depth
E2603	Skin protection wheelchair seat cushion, width less than 22 in., any depth
E2604	Skin protection wheelchair seat cushion, width 22 in. or greater, any depth
E2605	Positioning wheelchair seat cushion, width less than 22 in., any depth
E2606	Positioning wheelchair seat cushion, width 22 in. or greater, any depth
E2607	Skin protection & positioning wheelchair seat cushion, width less than 22 in., any depth
E2608	Skin protection & positioning wheelchair seat cushion, width 22 in. or greater, any depth
K0669	Wheelchair accessory, wheelchair seat or back cushion
K0734	Skin protection wheelchair seat cushion, adjustable, width less than 22 in., any depth
K0735	Skin protection wheelchair seat cushion, adjustable, width 22 in. or greater, any depth

K0736	Skin protection & positioning wheelchair seat cushion, adjustable, width less than 22in., any depth
K0737	Skin protection & positioning wheelchair seat cushion, adjustable, width 22 in. or greater, any depth
L0112	Cranial-cervical orthotic
L0120	Cervical, flexible, nonadjustable (foam collar)
L0130	Cervical, flexible, thermoplastic collar, moded to patient
L0140	Cervical, semi-rigid, adjustable, plastic collar
L0150	Cervical, semi-rigid, adjustable, molded chin cup (plastic collar with m&ibular/occipital piece)
L0160	Cervical, semi-rigid, wire frame occipital/m&ibular support
L0170	Cervical, moded to patient
L0172	Cervical, semi-rigid, thermoplastic foam, two-piece
L0174	Cervical, simi-rigid, thermoplastic foam, two-piece with thoracic extenstion
L0180	Cervical, multiple-post collar, occipital/m&ibular supports, adjustable
L0190	Cervical, multiple post collar, occipital/m&ibular supports, adjustable cervical bars
L0200	Cervical, multiple post collar, occipital/m&ibular supports, adjustable cervical bars, thoracic extension
L0220	Thoracic, rib belt, custom-fabricated
L0430	Dewall Posture Protector
L0450	Thoracis-lumbar-sacral orthotic (TLSO), flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), inc. shoulder straps & closures, prefabricated, inc. fitting & adjustment
L0452	Throacic-lumbar-sacral orthotic (TLSO), flexible, custom-fabricated
L0454	Thoracic-lumbar-sacral orthotic (TLSO), flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), inc. shoulder straps & closures, prefabricated, inc. fitting & adjustment
L0456	Thoracic-lumbar-sacral orthotic (TLSO), flexible, provides trunk support, thoracic region, rigid posterior panel & soft anterior apron, extends from the sacrococcygeal junction & terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, inc. straps & closures, prefabricated, inc. fitting & adjustment
L0458	Thoracic-lumbar-sacral orthotic (TLSO), 2 rigid plastic shells, posterior extends from the sacrococcygeal junction & terminates just infericor to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal & transverse planes, lateral strength is provided by overlapping plastic & stabilizing closures, inlcudes straps & closures, prefabricated, inc. fitting & adjustment

L0460	Thoracic-lumbar-sacral orthotic (TLSO), 2 rigid plastic shells, posterior extends from the sacrococcygeal junction & terminates just inferiror to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal & transverse planes, lateral strength is provided by overlapping plastic & stabilizing closures, inc. straps & closures, prefabricated, inc. fitting & adjustment
L0462	Thoracic-lumbar-sacral orthotic (TLSO), 3 rigid platic shells, posterior extends from the sacrococcygeal junction & terminates just inferior to the scapular spine, anterior extends from the symphysis pubis ot the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal & transverse planes, lateral strength is provided by overlapping plastic & stabilizing closures, inc. straps & closures, prefabricated, inc. fitting & adjustment
L0464	Thoracic-lumbar-sacral orthotic (TLSO), 4 rigid plastic shells, posterior extends from sacrococcygeal junction & terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal & transverse planes, lateral strength is provided by overlapping plastic & stabilizing closure, inc. straps & closures, prefabricated, inc. fitting & adjustment
L0466	Thoracic-lumbar-sacral orthotic (TLSO), sagittal control, rigid posterior frame, flexible soft anterior apron with straps, closures & padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, inc. fitting & shaping the frame, prefabricated, inc. fitting & adjustment
L0468	Thoracic-lumbar-sacral orthotic (TLSO), sagittal-coronal control, rigid posterior frame, flexible soft anterior apron with straps, closures & padding, extends from the sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic & lateral frame pieces, restricts gross trunk motion in sagittal & coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, inc. fitting & shaping the frame, prefabricated, inc. fitting & adjustment
L0470	Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, rigid posterior frame, flexible soft anterior apron with straps, closures & padding, extends from the sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic & lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal & transverse planes, produces intracavitary pressure to reduce load on the intervertebral disks, inc. fitting & shaping the frame, prefabricated, inc. fitting & adjustment
L0472	Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, hyperextension, rigid anterior & lateral frame extends from symphysis pubis to sternal notch with 2 anterior componenets (one public & one sternal), posterior & lateral pads with straps & closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal & transverse planes, inc. fitting & shaping the frame, prefabricated, inc. fitting & adjustment
L0480	Thoracic-lumbar-sacral orthotic (TLSO), rigid plastic, custom-fabricated
L0482	Thoracic-lumbar-sacral orthotic (TLSO), triplanar control
L0484	Thoracic-lumbar-sacral orthotic (TLSO), rigid plastic, custom-fabricated
L0486	Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, 2 piece rigid plastic shell with interface liner, multiple straps & closures, posterior extends from sacrococcygeal junction & terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal & transverse planes, inc. a carved plaster or CAD-CAM model, custom fabricated
L0488	Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, 1 piece rigid plastic shell with interface liner, multiple straps & closures, posterior extends from sacrococcygeal junction & terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal & transverse planes, prefabricated, inc. fitting & adjustment

L0490	Thoracic-lumbar-sacral orthotic (TLSO), sagittal-coronal control, 1 piece rigid plastic shell with overlapping reinforced anterior, multiple straps & closures, posterior extends from sacrococcygeal junction & terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal & coronal planes, prefabricated, inc. fitting & adjustment
L0491	Thoracic-lumbar-sacral orthotic (TLSO), sagittal-coronal control, modular segmented spinal system, 2 rigid plastic shells, posterior extends from the sacrococcygeal junction & terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal & coronal planes, lateral strength is provided by overlapping plastic & stabilizing closures, inc. straps & closures, prefabricated, inc. fitting & adjustment
L0492	TLSO, sagittal-coronal control, modular segmented spinal system, 3 rigid plastic shells, posterior extends from the sacrococcygeal junction & terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal & coronal planes, lateral strength is provided by overlapping plastic & stabilizing closures, inc. straps & closures,prefabricated, inc. fitting & adjustment
L0621	Sacroiliac orthotic, flexible, provides pelvic-sacral support, reduces motion about the sacroillac joint, inc. straps & closures, may inc. pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0622	Sacroiliac orthotic (SIO), flexible pelvisacral, custom-fabricated
L0623	Sacroiliac orthotic, provides pelvic-sacral support, with rigid or semirigid panels over the sacrum & abdomen, reduces motion about the sacroillac joint, inc. straps & closures, may inc. pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0625	Lumbar orthotic, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, inc. straps, closures, may inc. pendulous abdomen design, shoulder straps, stays, prefabricated, inc. fitting & adjustment
L0626	Lumbar orthotic, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intevertebral discs, inc. straps & closures, may inc. padding, stays, shoulder straps, pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0627	Lumbar orthotic, sagittal control, with rigid posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, inc. straps & closures, may inc. padding, shoulder straps, pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0628	Lumbar-sacral orthotic (LSO), flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, inc. straps & closures, may inc. stays, shoulder straps, pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0629	Lumbar-sacral orthotic (LSO), flexible, provides lumbar-sacral support, posterior
L0630	Lumbar-sacral orthotic (LSO), sagittal control, rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, inc. straps & closures, may inc. padding, stays, shoulder straps, pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0631	Lumbar-sacral orthotic (LSO), sagittal control, with rigid anterior & posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, inc. straps & closures, may inc. padding, stays, shoulder straps, pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0632	Lumbar-sacral orthotic (LSO), sagittal, rigid frame, custom-fabricated

L0633	Lumbar-sacral orthotic (LSO), sagittal-coronal control, rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, inc. straps & closures, may inc. padding, stays, shoulder straps, pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0634	Lumbar-sacral orthotic (LSO), flexion control, custom-fabricated
L0635	Lumbar-sacral orthotic (LSO), sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral fame/ panel(s), produces intracavitary pressure to reduce load on intervertebral discs, inc. straps & closures, may inc. padding, anterior panel, pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0636	Lumbar-sacral orthotic (LSO), sagittal, rigid panel, custom-fabricated
L0637	Lumbar-sacral orthotic (LSO), sagittal-coronal control, rigid anterior & posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, inc. straps & closures, may inc. padding, stays, shoulder straps, pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0638	Lumbar-sacral orthotic (LSO), sagittal-coronal panel, custom-fabricated
L0639	Lumbar-sacral orthotic (LSO), sagittal-coronal control, rigid shell(s)/ panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material & stabilizing closures, inc. straps & closures, may inc. soft interface, pendulous abdomen design, prefabricated, inc. fitting & adjustment
L0640	Lumbar-sacral orthotic (LSO), sagittal-coronal control, with rigid shell(s)
L0700	Cervical-thoracic-lumbar-sacral orthotic (CTLSO), A-P-L control, molded
L0710	Cervical-thoracic-lumbar-sacral orthotic (CTLSO), A-P-L control, with interface material
L0810	Halo, cervical, incorporated into jacket vest
L0820	Halo, cervical, incorporated into body jacket
L0830	Halo, cervical, incorporated into Milwaukee type
L0859	Addition to halo procedure, magnetic resonance image compatible systems, rings & pins, any material
L0861	Addition to halo procedure, replacement liner/interface material
L0970	TLSO, corset front
L0972	LSO, corset front
L0974	TLSO, full corset
L0976	LSO, full corset
L0984	Protective body sock, each
L1000	Cervical-thoracic-lumbar-sacral orthotic (CTLSO), Milwaukee, initial model

L1001	Cervical-thoracic-lumbar-sacral orthotic (CTLSO) immobilizer, infant size, prefabricated, inc. fitting & adjustment
L1005	Tension based scoliosis orthotic & accessory pads, inc. fitting & adjustment
L1010	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, axilla sling
L1020	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, kyphosis pad
L1025	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, kyphosis pad floating
L1030	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, lumbar bolster pad
L1040	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, lumbar or lumbar rib pad
L1050	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, sternal pad
L1060	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, thoracic pad
L1070	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, trapezius sling
L1080	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, outrigger
L1085	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, outrigger, bilateral with vertical extensions
L1090	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, lumbar sling
L1100	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, ring flange, plastic or leather
L1110	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, ring flange, plastic or leather, molded to patient model
L1120	Addition to cervical-thoracic-lumbar-sacral orthotic (CTLSO) or scoliosis orthotic, cover for upright, each
L1200	Thoracic-lumbar-sacral-orthotic (TLSO), inclusive
L1210	Addition to Thoracic-lumbar-sacral orthotic (TLSO) (low profile), lateral thoracic extension
L1220	Addition to Thoracic-lumbar-sacral orthotic (TLSO) (low profile), anterior thoracic extension
L1230	Addition to Thoracic-lumbar-sacral orthotic (TLSO)(low profile), Milwaukee type superstructure
L1240	Addition to Thoracic-lumbar-sacral orthotic (TLSO) (low profile), lumbar derotation pad
L1250	Addition to Thoracic-lumbar-sacral orthotic (TLSO) (low profile), anterior ASIS pad
L1260	Addition to Thoracic-lumbar-sacral orthotic (TLSO) (low profile), anterior thoracic derotation pad
L1270	Addition to Thoracic-lumbar-sacral orthotic (TLSO) (low profile), abdominal pad
L1280	Addition to Thoracic-lumbar-sacral orthotic (TLSO) (low profile), rib gusset (elastic), each

L1290	Addition to Thoracic-lumbar-sacral orthotic (TLSO) (low profile), lateral trochanteric pad
L1300	Other scoliosis procedure, body jacket molded to patient model
L1310	Other scoliosis procedure, postoperative body jacket
L1500	Thoracic hip-knee-ankle orthotic (THKAO), mobility frame
L1510	Thoracic hip-knee-ankle orthotic (THKAO), st&ing frame, with or without tray & accessories
L1520	Thoracic hip-knee-ankle orthotic (THKAO), swivel walker
L1600	Hip orthotic (HO), abduction control of hip joints, flexible, Frejka type with cover, prefabricated, inc. fitting & adjustment
L1610	Hip orthotic (HO), abduction control of hip joints, flexible, Frejka cover only, prefabricated, inc. fitting & adjustment
L1620	Hip orthotic (HO), abduction control of hip joints, flexible, Pavlik harness, prefabricated, inc. fitting & adjustment
L1650	Hip orthotic, abduction control of hip joint(s), static, adjustable, (ilfled type), prefabricated, inc. fitting & adjustment
L1652	Hip orthotic (HO), bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, inc. fitting & adjustment, any type
L1660	Hip orthotic (HO), abduction control of hip joints, static, plastic, prefabricated, inc. fitting & adjustment
L1686	Hip orthotic, abduction control of hip joint(s), postoperative hip abduction type, prefabricated, inc. fitting & adjustment
L1690	Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction & internal rotation control, prefabricated, inc. fitting & adjustment
L1700	Legg perthes orthosis, Toronto type, custom-fabricated
L1710	Legg perthes orthosis, Newington type, custom-fabricated
L1720	Legg perthes orthosis, trilateral, Tachdijan type, custom-fabricated
L1730	Legg perthes orthosis, Scottish rite type, custom-fabricated
L1755	Legg perthes orthosis, patten bottom type, custom-fabricated
L1810	Knee orthotic (KO), elastic, with joints, prefabricated
L1820	Knee orthothic (KO), elastic, with condylar pads & joints, with or without patellar control, prefabricated, inc. fitting & adjustment
L1830	Knee orthotic (KO), immobilizer, canvas longitudinal, prefabricated, inc. fitting & adjustment
L1831	Knee orthotic (KO), locking knee joint(s), positional orthotic, prefabricated, inc. fitting & adjustment

L1832	Knee orthotic, adjustable knee joints (unicentric or polycentric), positional orthotic, rigid support, prefabricated, inc. fitting & adjustment
L1834	Knee orthotic (KO), without knee joint, rigid, custom-fabricated
L1836	Knee orthotic (KO), rigid, without joint(s), inc. soft interface material, prefabricated, inc. fitting & adjustment
L1843	Knee orthotic (KO), single upright, thigh & calf, with adjustable flexion & extension joint (unicentric or polycentric), medial-lateral & rotation control, with or without varus/valgus adjustment, custom fabricated
L1845	Knee orthotic (KO), double upright, thigh & calf, with adjustable flexion & extension joint (unicentric or polycentric), medial-lateral & rotation control, with or without varus/valgus adjustment, prefabricated, inc. fitting & adjustment
L1847	Knee orthotic (KO), double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, inc. fitting & adjustment
L1850	Knee orthotic (KO), Swedish type, prefabricated, inc. fitting & adjustment
L1900	Ankle-foot orthotic (AFO), spring wire, dorsiflexion assist calf b&, custom fabricated
L1901	Ankle-foot orthotic (AFO), elastic, prefabricated, inc. fitting & adjustment (e.g., neoprene, Lycra)
L1902	Ankle-foot orthtotic (AFO), ankle gauntlet, prefabricated, inc. fitting & adjustment
L1904	Ankle-foot orthotic (AFO), molded ankle gauntlet, custom fabricated
L1906	Ankle-foot orthotic (AFO), multiligamentus ankle support, prefabricated, inc. fitting & adjustment
L1907	Ankle-foot orthotic (AFO), supramalleolar with straps, with or without interface/pads, custom fabricated
L1910	Ankle-foot orthotic (AFO), posterior, single bar, clasp attachment to shoe counter, prefabricated, inc. fitting & adjustment
L1920	Ankle-foot orthotic (AFO), single upright with static or adjustable stop (Phelps or Perlstein type), custom fabricated
L1930	Ankle-foot orthotic (AFO), plastic or other material, prefabricated, inc. fitting & adjustment
L1932	Ankle-foot orthotic (AFO), rigid anterior tibial section, total carbon fiber or equal material, prefabricated, inc. fitting & adjustment
L1940	Ankle-foot orthotic (AFO), plastic or other material, custom fabricated
L1945	Ankle-foot orthotic (AFO), plastic, rigid anterior tibial section (floor reaction), custom fabricated
L1950	Ankle-foot orthotic (AFO), spiral, institute of Rehabilitative Medicine type, plastic, custom fabricated
L1951	Ankle-foot orthtotic (AFO), spiral, institute of Rehabilitative Medicine type, plastic or other material, prefabricated, inc. fitting & adjustment
L1960	Ankle-foot orthotic (AFO), posterior solid ankle, plastic, custom fabricated
L1970	Ankle-foot orthotic (AFO), plastic with ankle joint, prefabricated, inc. fitting & adjustment

L1971	Ankle-foot orthotic (AFO), plastic or other material with ankle joint, prefabricated, inc. fitting & adjustment
L1980	Ankle-foot orthotic (AFO), single upright free plantar dorsiflexion, solid stirrup, calf b&/cuff (single bar 'BK' orthotic), custom fabricated
L2000	Knee-ankle-foot-orthotic (KAFO), single upright, free knee, free ankle, solid stirrup, thigh & calf b&s/cuffs (single-bar 'ak' orthotic), custom-fabricated
L2005	Knee-ankle-foot-orthotic (KAFO), any material, single or double upright, stance control, automatic lock & swing-phase release, mechanical activation, inc. ankle joint, any type, custom fabricated
L2010	Knee-ankle-foot-orthotic (KAFO), single upright, free ankle, solid stirrup, thigh & calf b&s/cuffs (single bar 'ak' orthotic), without knee joint, custom-fabricated
L2020	Knee-ankle-foot-orthotic (KAFO), double upright, free ankle, solid stirrup, thigh & calf b&s/cuffs (double bar 'ak' orthotic), custom-fabricated
L2030	Knee-ankle-foot-orthotic (KAFO), double upright, free ankle, solid stirrup, thigh & calf b&s/cuffs, (double bar 'ak' orthotic), without knee joint, custom-fabricated
L2034	Knee-ankle-foot-orthotic (KAFO), full plastic, single upright, with or without free motion knee, medial lateral rotation control, with or without free motion ankle, custom-fabricated
L2035	Knee-ankle-foot orthotic (KAFO), full plastic, static, pediatric size without free motion ankle, prefabricated, inc. fitting & adjustment
L2036	Knee-ankle-foot-orthotic (KAFO), full plastic, double upright, with or without free motion knee, with or without free motion ankle, custom-fabricated
L2037	Knee-ankle-foot-orthotic (KAFO), full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom-fabricated
L2038	Hip-knee-ankle-foot-orthotic (HKAFO), full Plastic, with or without free motion knee, multi-axis ankle, custom-fabricated
L2040	Hip-knee-ankle-foot-orthotic (HKAFO), torsion control, bilateral rotation straps, pelvic b&/belt, custom-fabricated
L2050	Hip-knee-ankle-foot-orthotic (HKAFO), torsion control, bilateral torsion cables, hip joint, pelvic b&/belt, custom-fabricated
L2060	Hip-knee-ankle-foot-orthotic (HKAFO), torsion control, bilateral torsion cables, ball bearing hip joint, pelvic b&/belt, custom-fabricated
L2070	Hip,Knee, Ankle foot Orthotic/straps
L2080	Hip,Knee, Ankle foot Orthotic/torsion cable
L2090	Hip,Knee, Ankle foot Orthotic/torsion cable/Ball Bearing
L2106	AFO/Thermo plastic casting material
L2108	AFO/Custom Fabricated
L2112	AFO/Soft Pre fabricated inc. fit & adjustment

L2114	AFO/Semi Rigid inc. fit & adjustment
L2116	AFO/Rigid pre fabricated
L2126	KAFO/Thermo plastic casting material/custom
L2128	KAFO/custom fabricted
L2132	KAFO/soft/prefabricated
L2134	KAFO/semi rigid pre fabricated
L2136	KAFO/Rigig,pre fabricated
L2180	Plastic shoe insert with ankle joints
L2182	Orthotic drop lock knee joint
L2184	limited motion knee joint
L2186	Adjustable motion knee joint
L2188	quadilateral brim
L2190	in addition to ---waist belt
L2200	Addition to lower extremityorthotic/ limited ankle motion/each joint
L2210	dorsiflexion assist & plantar flexion resist/each joint
L2220	Addition to lower extremityorthotic/ dorsiflexion & plantar/each joint
L2230	Addition to/split flat caliper stirrups
L2232	Rocker bottom for total contact ankle-foot
L2240	Round caliper & plate attachment
L2250	foot plate molded to patient
L2260	reinforced solid stirrup
L2265	long toungue stirrup
L2270	varsus/valgus correction
L2275	in addition to ---plastic modification
L2280	Addition to/ molded inner boot
L2300	Abduction bar, bilateral jointed adjustable
L2310	Addition to lower extermity, abduction bar straight

L2320	nonmolded lacer, for custom fabricated orthotic only
L2330	lacer molded to patient model
L2335	Additon to lower extremity,anterior swing b&
L2340	Pretibal shell
L2350	prosthetic type
L2360	extended steel shank
L2370	Peatten bottom
L2375	torsion control, ankle joint & half solid stirrup
L2380	torsion control, straight knee joint
L2385	Straight knee joint heavy duty
L2387	Polycentric knee joint
L2390	offset knee joint
L2395	offset knee joint heavy duty
L2397	orthotic suspensive sleeve
L2405	Drop lock each
L2415	drop lock w/integrated release mech
L2425	Disc or dial lock
L2430	Rachet lock for active & progressive knee ext
L2492	knee joint, lift loop for dy lock ring
L2500	thigh weight bearing, gluteal/ischial weight
L2510	thigh weight bearing, quadilateral brim, ,molded to model
L2520	thigh weight bearing, quadilateral brim, ,molded to model/custom fit
L2525	thigh weight bearing, ischial containment
L2526	thigh weight bearing, ischial containment/custom fit
L2530	Thigh weight bearing, lacer, non molded
L2540	Thigh weight bearing, lacer,molded
L2550	Thigh weight bearing,high roll cuff

L2570	Addition to lower extemity
L2580	Addition to lower extremity
L2600	Addition to lower extremity
L2610	addition to lower extremity
L2620	pelvic control, hip joint, heavy duty, each
L2622	adjustable flexion each
L2624	addition to lower extremity
L2627	Addition to lower extremity
L2628	pelvic control, metal frame
L2630	pelvic control, b& & belt
L2640	pelvic control, b& & belt, bilateral
L2650	pelvic & thoracic control
L2660	thoracic control, thoracic b&
L2670	Thoracic contol, paraspinal uprights
L2680	Thoracic control, lateral supports
L2750	Addition to lower extermity orthotic
L2755	high strength lightweight material
L2760	Orthotic Extension
L2768	Orthotic side bar disconnect device
L2770	Orthotic any material
L2780	orthotic non corrusive finish
L2785	orthotic drop lock retainer
L2795	orthotic knee control
L2800	Additon to lower extremity,orthotic knee control
L2810	knee control, condylar pad
L2820	soft interface for molded plastic
L2830	orthotic soft interface

L2840	Orthotic tibial length
L2850	Orthotic femoral length
L2860	Addition to lower extermity joint
L3002	Foot, Insert, Removable, Molded To Patient Model
L3140	Foot abduction rotation bar
L3150	Foot abduction rotation bar/w/o shoes
L3160	foot, adjustable shoe style positioning device
L3170	Foot plastic silicone or equal heel stabilizer
L3202	Oxford w/ supinat/pronator c
L3208	Surgical boot infant
L3209	Surgical boot child
L2311	Surgical boot Junior
L2312	Benesch boot pair infant
L3213	Benesch boot pair child
L3214	Benesch boot pair junior
L3224	Woman's shoe oxford brace
L3225	Man's shoe oxford brace
L3260	Surgical boot/shoe each
L3265	Pastazote s&al each
L3300	lift,elveation heel
L3310	lift,elveation heel & sole neoprene per inch
L3320	Lift elevation heel & sole cork per inch
L3332	Lift elevation inside shoe tapered
L3334	Lift elevation heel per inch
L3340	Heel wedge, solid ankle heel cusion
L3350	Heel wedge
L3360	Sole wedge outside sole

L3370	Sole wedge between sole
L3380	Club foot wedge
L3390	Outflare Wedge
L3400	Metatarsal bar wedge
L3410	Metatarsal bar wedge
L3420	Full sole & heel wedge
L3430	Heel Counter
L3440	Heel Counter
L3450	Heel solid ankle cushion
L3455	Heel new leather
L3460	Heel new rubber
L3465	Heel thomas with wedge
L3470	Heel thomas extended
L3480	Heel pad
L3485	Heel pad
L3500	Orthopedic shoe addition insole
L3510	Orthopedic shoe addition insole
L3520	Orthopedic shoe addition insole
L3530	Orthopedic shoe addition sole
L3540	Orthopedic shoe addition sole
L3550	Orthopedic shoe addition toe tap
L3560	Orthopedic shoe addition toe tap
L3570	Orthopedic shoe addition special extension
L3580	Orthopedic shoe ext. conert instep
L3590	Orthopedic shoe insert, firm to soft
L3595	orthopedic shoe addition, march bar
L3600	Transfer of orthotic caliper plate

L3610	Transfer of orthotic caliper plate
L3620	Transfer of orthotic Solid stirrup
L3630	Transfer of orthotic Solid stirrup
L3640	Transfer of orthotic dennis brown splint
L3649	Orthopedic shoe modification
L3650	Shoulder Orthotic
L3652	Shoulder Orthotic
L3660	Shoulder Orthotic
L3670	Shoulder Orthotic
L3671	Shoulder Orthotic
L3672	Shoulder Orthotic
L3673	Shoulder Orthotic/abduction positioning
L3675	Shoulder Orthotic/vest type
L3677	Shoulder Orthotic/hard plastic
L3701	Elbow Orthotic, elastic, pre fabricated
L3710	Elbow Orthotic, elastic with metal joints
L3760	Ellow Orthotic, w/adjustable position locking joints
L3762	Elbow Orthotic, rigid, w/o joints
L3765	Elbow wrist h& finger orthotic
L3766	Elbow wrist h& finger orthotic w/one or more montorsion joint
L3806	WHFO non torsion joints, elastic b&s, turnbuckles
L3807	WHFO without joints pre-fabricated
L3808	WHFO rigid may inc. soft interface material, straps
L3905	WHO with non torsion joints elastic b&s turnbuckles
L3906	WHO w/o Joints, may inc. soft interface, straps
L3908	WHO wrist ext control cock-up, non molded, pre fabricated
L3909	WO elastic, pre fabricated, inc. fitting

L3911	WHFO flexion glove with elastic finger
L3913	HFO without joints custom fabricated
L3915	WHO inc. one or more nontorsion joint
L3917	HO metacarpal fracture orthotic
L3919	HFO without joints custom fabricated
L3921	HFO with joints custom fabricated
L3923	HFO, without joints soft interface straps
L3925	FO proximal PIP without joint/spring extension/flexion
L3927	FO distal DIP w/o joint, spring, ext/flexion
L3929	HFO inc. one or more nontorsion joints, turnbuckles
L3931	HFO inc. one or more nontorsion joints, turnbuckles
L3932	FO safety pin
L3933	FO without joints custom fabricated
L3934	FO safety pin
L3935	FO nontorsion joint custom fabricated
L3956	Additon of upper joint to upper extermity orthotic
L3960	Shoulder elbow wrist h& orthotic
L3961	SEWHO shoulder cap design w/o joints
L3962	SEWHO abduction positioning
L3964	SEO mobile arm support attached to wheelchair
L3965	SEO mobile arm support attached to wheelchair balanced adjustable
L3966	SEO mobile arm support attached to wheelchair balanced reclining
L3967	SEWHO airplane design without joints custom fabricated
L3968	SEO mobile arm support attached to wheelchair balanced friction arm
L3969	SEO mobile arm support monosuspension arm & h& support
L3971	SEWHO cap design with joints
L3973	SEWHO airplane design without joints custom fabricated

L3975	SEWHO shoulder cap design w/o joints
L3976	SEWHO airplane design without joints custom fabricated
L3977	SEWHO shoulder cap design inc. nontorsion joints
L3978	SEWHO airplane design thoracic component
L3980	Upper extremity orthotic, humeral, prefabricated
L3982	Upper extremity fracture orthotic
L3984	Upper extremity fracture orthotic, wrist, prefabricated
L3995	Addition to upper extremity orthotic, sock
L4000	Replace girdle for spinal orthotic
L4045	Replace non molded thigh lacer, custom fabricated
L4050	Replace molded calf lacer, custom fabricated
L4055	Replace non molded calf lacer, custom fabricated
L4060	Replace high roll cuff
L4070	Replace proximal & distal upright for KAFO
L4080	Replace metal b&s KAFO proximal thigh
L4090	Replace metal b&s KAFO or AFO
L4100	Replace leather KAFO proximal thigh
L4110	Replace leather KAFO-AFO calf or distal thigh
L4130	Replace pretibial shell
L4205	Repair of orthotic device, labor component per 15 mins
L4210	Repair of orthotic device, repair or replace minor parts
L4350	Ankle control orthotic stirrup style, rigid
L4360	Walking boot, pneumatic with or w/o joints
L4370	Pneumatic full leg splint, pre fabricated
L4380	Pneumatic knee splint pre fabricated
L4386	Walking boot, nonpneumatic with or without joints
L4392	Replacement soft interface material

L4394	Replace soft interface material, foot drop splint
L4396	AFO including soft inerface material, adjustable for fit
L4398	Foot drop splint, recumbent positioning device, prefabricated, inc. fitting & adjustment
L5000	Partial foot, shoe insert with longitudinal arch, toe filler
L5010	Partial foot, molded socket, ankle height, with toe filler
L5020	Partial foot, molded socket, tibial tubercle height, with toe filler
L5510	Preparatory, below knee Patellar-tendon bearing (PTB) type socket, nonalignable system, pylon, no cover, Solid ankle cushion heal (SACH) foot, plaster socket, molded to model
L5520	Preparatory, below knee Patellar-tendon bearing (PTB) type socket, nonalignable system, pylon, no cover, Solid ankle cushion heal (SACH) foot, thermoplastic or equal, direct formed
L5530	Preparatory, below knee Patellar-tendon bearing (PTB) type socket, nonalignable system, pylon, no cover, Solid ankle cushion heal (SACH) foot, thermoplastic or equal, molded to model
L5535	Preparatory, below knee Patellar-tendon bearing (PTB) type socket, nonalignable system, pylon, no cover, Solid ankle cushion heal (SACH) foot, prefabricated, adjustable open end socket
L5540	Preparatory, below knee Patellar-tendon bearing (PTB) type socket, nonalignable system, pylon, no cover, Solid ankle cushion heal (SACH) foot, laminated socket, molded to model
L5560	Preparatory, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, Solid ankle cushion heal (SACH) foot, plaster socket, molded to model
L5570	Preparatory, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, Solid ankle cushion heal (SACH) foot, thermoplastic or equal, direct formed
L5580	Preparatory, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, Solid ankle cushion heal (SACH) foot, thermoplastic or equal, molded to model
L5585	Preparatory, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, Solid ankle cushion heal (SACH) foot, prefabricated adjustable open end socket
L5590	Preparatory, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, Solid ankle cushion heal (SACH) foot, laminated socket, molded to model
L5595	Preparatory, hip disarticulation/hemipelevectomy, pylon, no cover, Solid ankle cushion heal (SACH) foot, thermoplastic or equal, molded to patient model
L5600	Preparatory, hip disarticulation/hemipelevectomy, pylon, no cover, Solid ankle cushion heal (SACH) foot, laminated socket, molded to patient model
L5673	Addition to lower extremity, below knee/above knee, customfabricated from existing mold or prefabricated, socket insert, silicone gel, elastometric or equal, for use with locking mechanism
L8000	Breast prosthesis, mastectomy bra
L8010	Breast prosthesis, mastectomy sleeve

L8030	Breast prosthesis, silicone or equal
L8300	Truss, single with st&ard pad
L8310	Truss, double with st&ard pads
L8420	Prosthetic sock, multiple ply, below knee, each
L8440	Prosthetic shrinker, below knee, each
L8460	Prosthetic shrinker, above knee, each
L8470	Prosthetic sock, single ply, fitting, below knee
L8501	Tracheostomy speaking valve
L8505	Artificial larynx replacement battery
L8507	Tracheoesophageal voice prosthesis, patient inserted, any type, each
L8509	Tracheo-esoph voice pros
L8618	Transmitter cable for use with cochlear implant device, replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, each
L8624	Lithium ion battery for use with cochlear implant speech processor, ear level, replacement, each
V2523	Contact lens, hydrophilic, extended wear, per lens (Keratoconus)
V2624	Polishing/resurfacing of ocular prosthesis
V5014	Repair/modification of a hearing aid
A4605	Tracheal suction catheter, closed system, each
A6501	Compression burn garment, bodysuit (head to foot), custom fabricated
A6502	Compression burn garment, chin strap, custom fabricated
A6503	Compression burn garment, facial hood, custom fabricated
A6504	Compression burn garment, glove to wrist, custom fabricated
A6505	Compression burn garment, glove to elbow, custom fabricated
A6506	Compression burn garment, glove to axilla, custom fabricated
A6507	Compression burn garment, foot to knee length, custom fabricated
A6508	Compression burn garment, foot to thigh length, custom fabricated
A6509	Compression burn garment, upper trunk to waist, including arm openings (vest), custom fabricated

A6510	Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated
A6511	Compression burn garment, lower trunk, including leg openings (panty), custom fabricated
A6512	Compression burn garment, not otherwise specified
A6513	Compression burn mask, face &/or neck, plastic or equal, custom fabricated

Requesting Prior Approval

Prior approval is required for all custom and rental DME with the exception of canes, crutches and walkers for all HIP-underwritten Networks and Benefit Plans and GHI-Underwritten Medicare Benefit Plans (Medicare Choice PPO Network). Exception: GHI-underwritten Benefit Plans associated with the CBP Network, National Network, Tristate Network and Network Access Network do not require prior approval for rental DME.

The network provider is responsible for requesting prior approval and, when necessary, completing the applicable Certificate of Medical Necessity form(s). Exception: Vytra network-based plans allow either the provider or the DME vendor to obtain the DME prior approval.

DME must be ordered from a contracted DME vendor. Most DME vendors will work with your office to complete the prior approval request (including the applicable forms). To locate an appropriate DME provider in your area, please use our Find a Doctor After inputting the member's ZIP code and clicking on the member's benefit plan, select "Hospital, Facility or Urgent Care Center" and choose "Durable Medical Equipment" from the "Other Facilities" drop-down menu.

Durable Medical Equipment That Requires Prior Approval

See the Durable Medical Equipment Prior Approval Rules in Clinical Corner.

How To Submit a Prior Approval Request

The How To Obtain a Prior Approval chart in the Care Management chapter provides contacts for each of our plans and managing entities. Please send requests for approval directly to EmblemHealth and managing entities, not the DME vendor.

What To Include in the Prior Approval Request

1. Request for prior approval
2. Written prescription
3. Applicable Certificate of Medical Necessity (CMN) Form(s)

Electronic requests for DME prior approval should be accompanied by a fax containing the written prescription and any applicable CMN forms.

All paperwork must be signed by the provider. Signature stamps are not acceptable.

Written Prescription

To initiate coverage of DME, the provider must issue a prescription, or other written order on personalized stationery, which includes:

- Member's name and full address
- Provider's signature
- Date the provider signed the prescription or order
- Description of the items needed
- Start date of the order (if appropriate)
- Diagnosis
- A realistic estimate of the total length of time the equipment will be needed (in months or years)

Certificate of Medical Necessity

In addition to the written prescription, providers should fill out a Certificate of Medical Necessity (CMN) form when requesting customized equipment or oxygen therapy or when providing clinical information. Filling out the CMN form involves:

- Certifying the patient's need. The treating physician must certify in writing the patient's medical need for equipment and attest that the patient meets the criteria for medical devices and/or equipment.
- Issuing a plan of care. The treating physician must issue a plan of care for the patient that specifies:
  - The type of medical devices, equipment and/or services to be provided
  - The nature and frequency of these services

Note: For home oxygen therapy procedures, current blood gas levels and oxygen saturation levels must be noted in the CMN form.

Providers, not DME vendors, are responsible for properly and conscientiously completing the CMN form for all prescribed DME items, except if the DME is for a Vytra Network member. Vytra Network members allow either the provider or the DME vendor to obtain the DME prior approval.

EmblemHealth accepts any of the standard CMN forms provided by the Centers for Medicare & Medicaid Services (CMS). These forms can be found on the forms section of the CMS website: www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html. Providers must complete Section B of the forms accurately and clearly and transfer adequate notation into the patient's chart to corroborate the answers supplied on the CMN form.

EmblemHealth's DME prior approval procedure is consistent with the CMS/Local Medicare Coverage Guidelines for all lines of business. These guidelines are readily accessible at www.cms.gov and Empire medicare.

Prior Approval Issuance

EmblemHealth's Care Management program will review each prior approval request to determine the member's eligibility to receive the benefit and the medical necessity for the prescribed equipment or supply.

After Hours Prior Approval

In the event that there is an urgent request for equipment requiring prior approval that needs to be ordered on a weekend (5 p.m. Friday through 8 a.m. Monday) or on a holiday (5 p.m. the evening before through 8 a.m. the morning after), the provider should contact our emergency 24-hour prior approval line at 1-866-447-9717. All non-urgent requests will be processed on the next business day.

Discharge Planning

Please notify EmblemHealth of the need for DME as soon as possible. Delays in ordering DME may compromise or delay a discharge from the hospital or rehabilitation center. Only in emergency situations should EmblemHealth be contacted on the day of discharge for DME.

Record Keeping and Claims Submission

DME suppliers who submit bills to EmblemHealth are required to keep the provider's original written order or prescription in their files.

Providers are required to document the medical need for and utilization of DME items in the member's chart and to ensure that information about the member's medical condition is correct. In the event of a medical audit, EmblemHealth may require copies of relevant portions of the patient's chart to establish the existence of medical need as indicated in the CMN form submitted with the prior approval request.

Diabetic Supplies

Diabetic Medications

For information regarding diabetic medications, please refer to the Pharmacy Services chapter.

Blood Glucose Meters and Testing Supplies

HIP Commercial, EmblemHealth Medicaid, EmblemHealth Medicare HMO, EmblemHealth Medicare PPO and Medicare Prescription Drug Plan Members

For the above plan members, EmblemHealth will cover blood glucose meters and testing supplies for Abbott Diabetes Care products only. For EmblemHealth Medicaid members, this coverage went into effect October 1, 2011.

- Patients who need a change in their testing frequency or the type of meter or supplies used will need a new prescription.
- Patients new to our plans may obtain a prescribed Abbott meter at no cost by calling 1-888-522-5226 or by visiting the Abbott Diabetes Care website: www.myfreestyle.com.

Questions, product support or meter replacement?

Please direct your EmblemHealth patients to call Abbott Diabetes Care Product Support at 1-888-522-5226 or go

online at www.myfreestyle.com.

EmblemHealth EPO/PPO, GHI HMO, GHI PPO and GuildNet Plan Members
Items not requiring prior approval, such as blood glucose meters and diabetic testing supplies (with the exception of insulin pumps and related supplies, which do require approval), may be directly requested from CCS Medical for the above-referenced plan members. EmblemHealth's formulary for diabetic testing supplies consists of the complete line of Abbott/Medisense and Bayer Diagnostics testing equipment and supplies.

A written order must be faxed and/or mailed to CCS Medical. They will work with the provider and the member, as necessary, to complete arrangements for the requested item(s).

Mail:

CCS Medical
3601 Thirlane Rd NW, Suite 4
Roanoke, VA 24019

Phone: 1-800-881-4008
Fax for CMN form(s) and other documentation: 1-800-860-4326
Fax for prescriptions: 1-800-248-9505

Medical and Surgical Supplies

EmblemHealth Medicaid Members

Effective October 1, 2011, EmblemHealth covers pharmacy benefit services for all Medicaid members. The benefit includes all Medicaid covered over-the-counter medications, diabetic supplies, select durable medical equipment and medical supplies.

EmblemHealth covers medical/surgical supplies routinely furnished or administered as part of an office visit. Note:Medical/surgical supplies dispensed in a doctor's office or other non-inpatient setting, or by a certified home health aide as part of an at-home visit, are not covered as separate billable items.

Child Health Plus Members

EmblemHealth does not cover most medical/surgical supplies for CHPlus members. However, items such as diabetic supplies are covered, as well as smoking cessation products, enteral formulae, canes, walkers, commode accessories and equipment for respiratory care. Providers can contact EmblemHealth at 1-877-842-3625 for a complete listing of items covered by the CHPlus program.

All Other Members

For all other members, medical/surgical supplies are covered as specified under the medical benefit with the participating vendor.

EmblemHealth

Provider Manual

Chapter 14: Home Health Care

Overview

This chapter applies to home health care (HHC) services for most EmblemHealth Members enrolled in the Health Insurance Plan of Greater New York (HIP) starting January 1, 2018. eviCore healthcare will manage most HHC prior approvals for HIP members.

EmblemHealth will continue to manage Personal Care Assistants and Consumer Directed Personal Assistance Programs. See Care Management chapter for rules that will continue to apply to these services, excluded members, and to Group Health Incorporated (GHI) members.

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

Transitional Care Services

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

Members Managed by eviCore

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

- Commercial and Child Health Plus
  - Prime Network

- Select Care Network

- Medicaid/HARP
  - Enhanced Care Prime Network

- Medicare and Special Needs Plans
  - VIP Prime Network

Exceptions to These Rules

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

Prior Approval Process

Services Requiring Prior Approval

EmblemHealth will continue to manage Personal Care Assistants (PCA) and Consumer Directed Personal Assistance Program (CDPAP). See Care Management chapter.

eviCore healthcare (eviCore) will begin accepting prior approval requests for services on December 28, 2017 for dates of service beginning January 1, 2018 for the following HHC Services:

- Skilled Nursing
- PT/OT/ST
- Social Worker
- Home Health Aides (for members receiving skilled HHC services)

Who Requests Prior Approval

- SNF, IRF and LTAC are responsible for submitting the initial Home Health Service requests for all HIP members discharging from a PAC facility with home health services.
- HHC agencies will submit prior approval requests to eviCore for hospital discharges and community referrals.

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

Required Information

The requesting provider should be prepared to submit:

- Appropriate eviCore request form - available at: https://www.evicore.com/resources/healthplan/emblemhealth
- Patient's medical records
- Details such as:
  - Background
    - Site of Care demographics
    - Patient demographics
    - Services requested (Skilled Nursing/OT/PT/ST/SW/HHA)
    - Home Health ordering physician demographics
    - Anticipated date of discharge
  - Clinical Information
    - PAC admitting diagnosis and ICD10 code
    - Clinical Progress Notes & Oasis Assessment
    - Medication list
    - Wound or Incision/location and stage (if applicable)
    - Discharge summary (when available)
  - Mobility & Functional Status
    - Prior and Current level of functioning
    - Focused therapy goals: PT/OT/ST
    - Therapy progress notes including level of participation
    - Discharge plans (include discharge barriers, if applicable)

How to Obtain Prior Approval

Managing Entity	Methods to Submit Prior Approval Requests
eviCore	eviCore offers three convenient methods to request prior approval, depending on the Program: 1. Web Portal submissions are the most efficient way to request prior approvals. Please visit evicore.com/pages/providerlogin.aspx. 2. Telephone: Clinical information can be called in to eviCore healthcare at 866-417-2345, choose option 3 for HIP members; then option 4 DME and prompt 1 for CPAP and BIPAP or 2 for other DME services. 3. Facsimile: DME required documentation can be faxed to 866-663-7740. For DME requests prior to January 1, 2018, fax to 1-866-426-1509. On or after, December 28, 2017,submit requests to eviCore for anticipated dates of service on or after January 1, 2018. DME Suppliers may obtain prior approval details via the eviCore web portal at: evicore.com/pages/providerlogin.aspx or by calling eviCore at: 866-417-2345, option 3 for HIP, then option 4.

HealthCare Partners	Call (800) 877-7587 or fax your request to (888) 746-6433.
Montefiore CMO	Call (888) 666-8326 .

Prior Approval Time Frames
eviCore will provide Prior Approval by service type in the following ways:

Prior approval	Skilled Nursing	Home Health Aide Social Worker	PT/OT/ST
Initial	7 calendar days	N/A	7 calendar days
Concurrent	14 calendar days	14 calendar days	14 calendar days

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

Once determination is made, eviCore will provide verbal and written notification to the requesting facility or HHC Agency. The servicing HHC agencies may obtain prior approval details by calling eviCore at 866-417-2345, option 3 for HIP, then 5 for Home Health Care or Transitional Care; then either 1 for Home Health Care or 3 for Transitional Care.

Initial prior approval is valid for 7 days. During that timeframe, the services must be initiated or new prior approval is required.

Home Health Care Prior Approval Criteria

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

- McKesson InterQual® Criteria
- Medicare Benefit Policy Manual Chapter 7 Section 30.1,
- Evidence-Based Tools along with Clinical Findings.

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

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

From Home Care: Once the patient is discharged from the HHC agency, the PCP will be notified by eviCore.

From a Hospital: HHC agencies are responsible for submitting prior approval requests to eviCore for hospital discharges. For post-acute care services, (acute rehabilitation, skilled nursing facility stay, home care, durable medical equipment), the eviCore concurrent review nurse will facilitate prior approvals of medically necessary treatments if the member's benefit plan includes these services. Patients utilizing HHC services following a hospitalization will be managed by eviCore's Transitional Care Program for 90 days post hospital discharge.

From a SNF, IRF or LTAC: The discharging facility is responsible for submitting the initial Home Health Service requests.

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

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

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

Denial and Appeals Process

Unable to Provide Prior Approval for Initial HHC Request

Cases that do not meet medical necessity on initial nurse review will be sent to a second level physician for review and determination. If a potential adverse determination is made by the physician, they will reach out to the requesting provider and a Peer to Peer (P2P) Review will be offered.

Reconsiderations Process (Commercial and Medicaid only)	- A Reconsideration is a post-denial, pre-appeal opportunity to provide additional clinical information. - Reconsideration must be requested within 14 days of the Initial Denial Date. - Peer to peer (P2P) requests can be made via a Verbal or Written request. - P2P is conducted with the referring MD and one of eviCore's Medical Directors. - P2P results in either a Reversal or an Uphold of the original decision. - The DME Supplier and the Member are notified via Mail and Fax.

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

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

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

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

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

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

If a potential adverse determination is made by physician, outreach is made to the HHC Agency and a peer to peer review may be requested by the provider.

Appeals Process (Medicare, Medicaid and Commercial)	- 1st level Commercial and Medicaid appeals will be handled by eviCore. - Medicaid or Commercial members requesting to appeal a denial should follow the instructions provided on the denial letter. Appeal requests must be submitted to eviCore via phone at 800-835-7064 (Monday through Friday, 8 a.m. - 6 p.m. EST) or faxed to 866-699-8128. - Medicare appeals will be handled by EmblemHealth. - Medicare members may request an appeal of a denial by following the instructions provided in the denial letter. Providers should follow the process in the Dispute Resolution for Medicare chapter.

Member Appeals Process	- Medicaid and Commercial members requesting to appeal the decision to end HHC services should contact eviCore via phone at 800-835-7064 (Monday through Friday 8 a.m. - 6 p.m. EST) or fax to 866-699-8128. - Medicare Members requesting to appeal the decision to end HHC services should follow the QIO process outlined on the NOMNC. Providers should follow the process outlined in the Dispute Resolution for Medicare chapter. - Medicare Members may request an appeal of a denial based on the decision to end skilled care for concurrent IRF services by following the instructions provided in the denial letter. Providers should follow the process in the Dispute Resolution for Medicare chapter.
Home Health Care (Date extensions)	

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

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

Group Health Incorporated Members

The management of home health care is not transitioning to eviCore. See Care Management chapter for applicable prior approval processes.

EmblemHealth

Provider Manual

Chapter 15: SNF IRF LTAC

Overview

This chapter applies to EmblemHealth Members enrolled in the Health Insurance Plan of Greater New York (HIP) starting January 1, 2018. See Care Management chapter for rules that will apply to dates of services December 31, 2017 and prior, GHI and other excluded members.

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

Transitional Care Services

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

Members Managed by eviCore

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

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

- VIP Prime Network

Exceptions to These Rules

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

Prior Approval Process

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

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

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

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

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

Who Requests Prior Approval

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

How To Obtain a Prior Approval
All providers must verify member eligibility and benefits prior to rendering services at emblemhealth.com/Providers.

The following sections describe the information you will need to submit to eviCore and the processes for submitting prior approval requests.

Required Information

The requesting provider should be prepared to submit:

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

How to Request Prior Approval For SNF/IRF/LTAC

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

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

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

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

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

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

required.

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

SNF/IRF/LTAC Prior Approval Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Denial and Appeals Process

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

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

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

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

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

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

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

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

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

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

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

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

Group Health Incorporated Members

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

EmblemHealth

Provider Manual

Chapter 16: Medical Transportation Procedures

This chapter includes information on Medicaid policies for transporting and reimbursing Medicaid, Medicare Advantage and Managed Long Term Care members.

General Information and Contacts

This chapter contains our plan policies related to medically necessary transportation services for Medicaid members to and from health care appointments (including Child/Teen Health Program [C/THP] appointments for all children under age 21), whether services are covered by EmblemHealth or by Medicaid fee-for-service (FFS). It also includes plan policies related to medically necessary transportation services for members enrolled in our Medicaid Advantage and Managed Long Term Care (MLTC) benefit plans. In counties where transportation services are covered by Medicaid FFS, information on how to access services through the local department of social services or other Medicaid FFS transportation vendor is provided.

Emergency Transportation
Transportation in the event of a medical emergency does not require a prior approval for any of our members, including ASO and Commercial/CHPlus, as well as members in Medicare plans which are not otherwise covered in this chapter. All members are instructed to dial 911 to obtain immediate assistance.

Dual Eligible HMO SNP
These members, while "dual eligible" may only have very limited Medicaid coverage, e.g., Medicaid only covers payment of members' Medicare Part B, and may therefore not have transportation coverage through Medicaid FFS. Where members have both Medicare and Medicaid coverage for the same transportation service, the Medicare coverage is primary and considered part of their benefits through our plan.

Distance Travel Standards
Members are expected to select primary care physicians (PCPs) whose offices are within a reasonable proximity to their residence. Members are not entitled to transportation for distances less than 10 blocks unless there are special circumstances such as a physical disability.

Public Transportation

In New York City, members must use public transportation unless a specific medical condition contraindicates such use.

General Reimbursement When the Plan Covers Transportation

1. Health care providers (e.g., PCPs, OB/GYNs, physician group practices and dentists) are to reimburse members for round-trip public transportation to medical appointments and to appointments to which they refer members, including specialist appointments.
2. EmblemHealth, or the applicable Managing Entity financially responsible for transportation services, will:
   - Reimburse health care providers who dispense car fare to members upon submission of a properly completed Public Mass Transportation Reimbursement Ledger. Separate ledgers must be used to record transportation disbursements to members for whom a Managing Entity is financially responsible, and ledgers must be submitted to the Managing Entity.
   - Reimburse health care providers who submit FFS claims when they include the transportation expense on the claims for the visit using CPT codes (Livery/Taxi A0100, Ambulette A0130 and Ambulance A0425 Mileage, A0426 ALS Non ER, A0427 ALS ER, A0428 BLS Non ER and A0429 BLS ER).
   - Reimburse transportation costs for escorts of children and escorts for members of any age when medically necessary.
   - Reimburse contracted taxi, ambulette and ambulance providers directly.

Exception: The Plan does not reimburse members for use of private vehicles.

EmblemHealth Contact Information When Transportation Is Covered by the Plan

1. Members with HIP or HealthCare Partners (HCP) as their assigned Managing Entity: Call EmblemHealth Customer Service at 1-800-447-8255 to request transportation or fax the Medical Necessity Taxi Transportation Request Form to 1-631-719-0911.
2. If the Managing Entity is Montefiore (CMO): Call 1-877-447-6668 to request taxi transport, or fax request to 1-914-377-4798. Please note: This does not apply to Medicaid members because we do not cover non-emergency transportation in CMO's service area of New York City and Westchester.

LDSS' Vendor Contact Information When Transportation Is Covered by Medicaid FFS

1. Nassau County: EmblemHealth does not cover non-emergency rides for Medicaid members. Members should call Logisticare Solutions at 1-877-813-5602 to request transportation. Providers and members call1-516-227-8070 for reimbursement.
2. New York City: EmblemHealth does not cover non-emergency rides for Medicaid members. Members and providers should call Logisticare of New York City at 1-877-564-5922 to request transportation. For Dual Eligible (PPO) SNP, call Human Resources Administration (HRA) at 1-212-630-1810.
3. Suffolk County: EmblemHealth does not cover non-emergency rides for Medicaid members. Members should call Servisair at 1-866-952-1564 to register and request transportation. Providers call 1-866-952-1564 for reimbursement.
4. Westchester County: EmblemHealth does not cover non-emergency rides for Medicaid members. These members or their providers should call Medical Answering Services at 1-866-883-7865 to request transportation services.

Personal Vehicle Mileage

TABLE 1
PERSONAL VEHICLE (MILEAGE)

Service Area	Medicaid	Medicaid Advantage HMO	Dual Eligible (HMO SNP) MAP-MLTC & MLTC	Dual Eligible HMO/PPO SNP
New York City	Not Covered	Not Covered	Not Covered	Not Covered
Nassau	Covered by Medicaid FFS	Covered by Medicaid FFS	Not Covered	Covered by Medicaid FFS if member has benefit
Rockland	N/A	N/A	N/A	HMO SNP - N/A PPO SNP - Covered by Medicaid FFS if member has benefit
Suffolk	Covered by Medicaid FFS	Covered by Medicaid FFS	Not Covered	Covered by Medicaid FFS if member has benefit
Westchester	Covered by Medicaid FFS	Not Covered	Not Covered	Covered by Medicaid FFS if member has benefit

Criteria: When covered by Medicaid FFS, personal vehicle can be used to drive to any medical appointment or service.

Prior Approval: Required.

Who Arranges Services: Members call the LDSS' vendor to register.

Member Reimbursement: Contact the LDSS' vendor for reimbursement.

Public Transportation (Bus and Train)

TABLE 2
PUBLIC TRANSPORTATION (BUS AND TRAIN)

Service Area	Medicaid	Medicaid Advantage HMO	Dual Eligible (HMO SNP) MAP-MLTC & MLTC	Dual Eligible HMO/ PPO SNP
New York City	Covered by Medicaid FFS	Covered by the Plan	Covered by the Plan	Covered by Medicaid FFS if member has benefit

Nassau	Covered by Medicaid FFS	Covered by Medicaid FFS	Covered by the Plan	Covered by Medicaid FFS if member has benefit
Rockland	N/A	N/A	N/A	HMO SNP - N/A PPO SNP - Covered by Medicaid FFS if member has benefit
Suffolk	Covered by Medicaid FFS	Covered by Medicaid FFS	Covered by the Plan	Covered by Medicaid FFS if member has benefit
Westchester	Covered by Medicaid FFS	Covered by Medicaid FFS	Covered by the Plan	Covered by Medicaid FFS if member has benefit

Prior Approval: Not required.

Who Arranges Services: Members.

Member and Provider Reimbursement:

- When covered by the Plan, network physician group practices, dentists, individual practice PCPs and OB/GYNs reimburse members. Providers send the Public Mass Transportation Reimbursement Ledger to EmblemHealth for members assigned to the Managing Entity HIP or HCP or to Montefiore for MLTC members if CMO is the Managing Entity shown on the member's ID card. Providers submit logs to Coordinated Transportation Solutions (CTS) for reimbursement.
- When covered by Medicaid FFS, members contact the LDSS' vendor to arrange transportation and seek reimbursement.

Taxi and Van

TABLE 3
Taxi and Van

Service Area	Medicaid	Medicaid Advantage HMO	Dual Eligible (HMO SNP) MAP-MLTC & MLTC	Dual Eligible HMO/PPO SNP
New York City	Covered by Medicaid FFS	Covered by the Plan	Covered by the Plan	Covered by Medicaid FFS if member has benefit

Nassau	Covered by Medicaid FFS	Covered by Medicaid FFS	Covered by the Plan	Covered by Medicaid FFS if member has benefit
Rockland	N/A	N/A	N/A	HMO SNP - N/A PPO SNP - Covered by Medicaid FFS if member has benefit
Suffolk	Covered by Medicaid FFS	Covered by Medicaid FFS	Covered by the Plan	Covered by Medicaid FFS if member has benefit
Westchester	Covered by Medicaid FFS	Covered by Medicaid FFS	Covered by the Plan	Covered by Medicaid FFS if member has benefit

Prior Approval:

- When covered by the Plan, providers must fax the Medical Necessity Taxi Transportation Request Form to the Managing Entity shown on the member's ID card. The prior approval period is based on the expected duration of the member's condition. Prior approval extensions require submission of a new form. Providers must give the member the prior approval information to enable the member to arrange for services.
- For members with HIP or HealthCare Partners (HCP) as the Managing Entity: Call Customer Service at 1-800-447-8255 to request transportation and fax the Medical Necessity Taxi Transportation Request Formto 1-631-719-0911.
- For MLTC members: If the Managing Entity is Montefiore (CMO), call 1-877-447-6668 to request taxi transport, or fax request to 1-914-377-4798.
- When covered by Medicaid FFS, call the LDSS' vendor to arrange services.

Who Arranges Services:

- When covered by the Plan, the member must arrange services directly with the transportation provider at least 24 hours in advance of each trip for services to take place during the prior approval period. For MAP-MLTC, EmblemHealth case managers may assist members with transportation coordination.
- When covered by FFS Medicaid, the member calls the LDSS' vendor to arrange services.

Member and Provider Reimbursement:

- When covered by the Plan, network transportation providers submit claims to the address on the back of the member's ID card. For non-network taxi service, the member is expected to pay the driver, and then contact the Managing Entity on their member ID card for reimbursement. For Medicaid Advantage HMO NYC taxi/van: Transportation providers submit claims to CTS.
- When covered by Montefiore (CMO): Call Montefiore Provider Relations at 1-914-377-4477 for reimbursement.
- When covered by Medicaid FFS, contact the LDSS' vendor for instructions.

Criteria for Approving Taxi, Livery and Van Services

Transportation services are intended to ensure that members are able to access necessary medical care and services covered under their contract. Members who can get to medical care on their own should not have transportation services ordered for them. The transportation provided should be the least intensive mode required based on the member's current medical condition. Taxi, livery or van transportation should be ordered only when the below circumstances occur.

County	Criteria for Taxi, Livery and Van Transportation Services
New York City Because of its extensive public transportation network, New York City members must use public transportation to travel to and from medical appointments unless a specific medical condition contraindicates such use.	1. When members cannot use public transportation due to a debilitating physical or mental condition as determined by a physician.
All Other Counties	1. When members do not live within walking distance of the place of service and do not have access to a personal vehicle or public transportation. 2. When members are traveling to and from locations that are inaccessible by public transportation and do not have access to a personal vehicle. 3. When members cannot use public transportation or drive their personal vehicle due to a debilitating physical or mental condition as determined by a physician.

Medical Necessity Taxi Transportation Request Form

Medicaid Transportation Reimbursement Ledger: Taxi/Livery Transportation (TLT) General Instructions

- All uses of taxi/livery transportation require prior approval from an EmblemHealth network Medical Center and/or authorized provider. The Medical Center shall reimburse round-trip (where appropriate) for authorized taxi/livery transportation when:
  - There is documented medical justification, determined by an EmblemHealth network physician, on record with provider. Taxi/livery transportation is not to be utilized in lieu of public mass transportation.
  - The patient has confirmed with the medical center/provider the use of such transportation and the medical center/provider has checked eligibility status and justification.
- The patient is required to submit a receipt from the taxi/livery services. "Tips" are disallowed for purposes of reimbursement. The medical center/provider should retain receipt with the copy of this form.
- In cases of round-trip (when authorized), the medical center/provider should reimburse twice the amount of the one-way receipt.
- The medical center is responsible for reimbursement to specialists outside of the medical center. Such reimbursement shall be given to the patient at the next follow-up visit to the medical center after the specialist visit. Receipts (round trip) are required.

- Submit forms monthly to EmblemHealth.
  Attention: Accounts Payable, 55 Water Street, New York, NY 10041-8190.

Note: The transportation ledgers should not be used by the Managing Entities financially responsible for transportation services.

Ambulette and Non-Emergency Ambulance

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

TABLE 4
Ambulette and non-emergency ambulance

Service Area	Medicaid	Medicaid Advantage HMO	Dual Eligible (HMO SNP) MAP-MLTC & MLTC	Dual Eligible HMO/PPO SNP
New York City	Covered by Medicaid FFS	Covered by the Plan	Covered by the Plan	Covered by Medicaid FFS if member has benefit
Nassau	Covered by Medicaid FFS	Covered by Medicaid FFS	Covered by the Plan	Covered by Medicaid FFS if member has benefit
Rockland	N/A	N/A	N/A	HMO SNP - N/A PPO SNP - Covered by Medicaid FFS if member has benefit
Suffolk	Covered by Medicaid FFS	Covered by Medicaid FFS	Covered by the Plan	Covered by Medicaid FFS if member has benefit
Westchester	Covered by Medicaid FFS	Covered by Medicaid FFS	Covered by the Plan	Covered by Medicaid FFS if member has benefit

Prior Approval:

- When covered by the Plan, prior approval is required. To obtain prior approval, providers must call the prior approval number on the back of the member's ID card.
- When covered by Medicaid FFS, members or providers must call the LDSS' vendor.

Who Arranges Services:

- When covered by the Plan, the provider calls the prior approval number on the back of the member's ID card.
- When covered by Medicaid FFS, the provider calls the LDSS' vendor.

Provider Reimbursement:

- When covered by the Plan, network transportation providers submit claims for services to the address on the back of the member's ID card.
- When covered by Medicaid FFS, contact the LDSS' vendor for instructions.

Medically Necessary Criteria for Approving Ambulette Services

Ambulette Service - A special-purpose vehicle equipped to provide non-emergency care, which has either wheelchair-carrying capacity or the ability to transport disabled individuals to or from facilities that provide medical care. Ambulette services also provide personal assistance.

Personal Assistance - Provision of physical assistance by the ambulette service employee in walking, climbing or descending stairs, ramps, curbs or other obstacles; opening or closing doors; accessing an ambulette vehicle; moving wheelchairs or other items of medical equipment; removal of obstacles as necessary to ensure the safe movement of the patient; and to touch or guide the patient in such close proximity to be able to prevent any potential injury due to a sudden loss of steadiness or balance. A patient who can walk to and from a vehicle, his or her home, or a place of medical services without such assistance does not require personal assistance.

Prior Service Approval - Required.

Patient Needs	Service Provided	Medical Criteria For Ambulette Services
Stretcher	Transports patients in a recumbent position. Appropriate for patients not in need of any medical care or service en route to destination.	Patient needs to be transported in a recumbent position and the ambulette service is able to transport stretchers.

Ambulette or Invalid Coach	Has wheelchair-carrying capacity or the ability to transport disabled patients.	Ambulette transportation may be ordered when a patient: - Is wheelchair bound and is unable to use a taxi, livery service, bus, train or private vehicle (non-collapsible wheelchair or requires a specially configured vehicle). - Has a disabling physical condition that requires the use of a walker or crutches and is unable to use a taxi, livery service, bus or private vehicle. - Requires radiation therapy, chemotherapy or dialysis treatments that result in a disabling physical condition after treatment, making the patient unable to access transportation without personal assistance provided by an ambulette service. - Has a severe debilitating weakness or a disabling physical condition, other than the one described above, requiring the personal assistance provided by an ambulette service; and the ordering practitioner certifies that the patient cannot be transported by a taxi, livery service, bus or private vehicle. - Is mentally disoriented as a result of medical treatment, or has a mental impairment or a disabling mental condition, and requires the personal assistance of the ambulette driver; and the ordering practitioner certifies that the patient cannot be transported by a taxi, livery service, bus or private vehicle (disoriented to time/place/self; acute severity hallucination; delusions/inappropriate in public situations; threat/suicidal/homicidal with a plan; acute psychotic symptomatic manic episode; chemical dependency - acute withdrawal or acute intoxication). - Has a functional orthopedic impairment precluding unassisted ambulation (bilateral or unilateral amputee, lower extremities; cast on lower extremity or half body; fracture of pelvic, hip, femur or leg; severe arthritis of locomotor joint). - Has a neuromuscular impairment precluding unassisted ambulation (spinal injury). - Has cerebrovascular accident with resultant hemiplegia or hemiparesis (stroke). - Has peripheral vascular disease precluding unassisted ambulation (severe claudication, foot ulceration). - Has severe respiratory disease necessitating physical assistance on stairs (emphysema, chronic obstructive pulmonary disease, chronic bronchitis). - Has severe cardiac disease necessitating physical assistance on stairs. - Other (must be provided by the ordering practitioner).

Medically Necessary Criteria for Approving Ambulance Services

An ambulance is a motor vehicle, aircraft, boat or other form of transportation designed and equipped to provide emergency medical services during transit. All Medicaid members are entitled to emergency and non-emergency ambulance service based on medical necessity.

Emergency ambulance service - Transportation to a hospital emergency room generated by a dial 911 emergency system call or some other request for an immediate response to a medical emergency, including, but not limited to, trauma, burns, respiratory, circulatory and obstetrical emergencies. Emergency transportation is generally provided to an emergency facility. The mode of transportation for the return trip depends on the medical condition following care.

Non-emergency ambulance service - Transportation for the purpose of obtaining necessary medical care or services by a patient whose medical condition requires transportation in a recumbent position where the patient must be transported on a stretcher or requires the administration of life support equipment, such as oxygen, by trained medical personnel. Non-emergency transportation is of a pre-planned nature and is generally provided to and from medical treatment.

Prior Approval - Not required in emergencies; required in non-emergencies.

Patient Needs	Services	Medical Criteria For Ambulance Services
Advanced Life Support (ALS) Services	Provides invasive treatment that is inclusive and above the level of care provided by an NYS-certified EMT, including initiation of intravenous (IV) fluids, intubations/insertion of an airway tube, defibrillation of the patient's heart, cardiac monitoring (EKG) and administration of drugs, which includes oral and all other types of medications that are stored on an ALS ambulance.	Medical criteria for ambulance transportation includes but is not limited to the conditions below: - Medical or surgical disorder contraindicating active mobility and/or moderate exertion; intracranial lesion; - Functional orthopedic impairment precluding movement from prone positions; patient in full body cast; - Patient needs to be physically restrained; organic brain syndrome with acute psychosis and confusion; - Patient is unconscious; medically stabilized but comatose; - Patient must remain immobile because of fractured femur, fractured pelvis; - Severe respiratory disease necessitating administration of oxygen; emphysema, chronic obstructive pulmonary disease, chronic bronchitis; - Severe cardiac disease necessitating administration of oxygen; congestive
Basic Life Support (BLS) Services	Provides noninvasive treatment, including use of anti-shock trousers, cardiac (EKG) monitoring, monitoring of a patient's blood pressure, administration of oxygen, control of bleeding, splinting fractures, cardiopulmonary resuscitation, delivery of babies and monitoring of an already established intravenous solution.	

Advanced Life Support Assistive Services	Advanced life support response where an ALS-trained employee and ALS ambulance are dispatched to the emergency scene to assist the primary ambulance.	heart failure; - Hospitalized patients in need of diagnostic therapeutic service at another hospital; - Patient requires intravenous therapy; terminally ill, requires transport home.
Transport From An Emergency Room To A Psychiatric Center	Transportation of patient undergoing an acute episode of mental illness from an emergency room to a psychiatric hospital.	Emergency transportation of mentally ill patients: When dealing with a patient undergoing an acute episode of mental illness, hospital and law enforcement officials are required to use an ambulance vehicle to transport persons to acute psychiatric care. They may not use non-emergency modes of transportation such as ambulette or taxi.
Transportation Of Neonatal (Newborn) Infants To Regional Perinatal Centers	Transportation of critically ill newborn infants between community hospitals and regional perinatal centers.	When neonatal infants require intensive care at regional perinatal centers (RPCs): The RPC orders a hospital bed and arranges for the neonatal ambulance transportation.

Fixed Wing Air Ambulance And Helicopter Air Ambulance	Air transportation in life-threatening conditions as noted under medical criteria column.	Air ambulance transportation may be ordered when:
		- Rapid transport is necessary to minimize risk of death or deterioration of the patient's condition.
		- Ground transport is not appropriate and the patient:
		  - has a catastrophic, life-threatening illness;
		  - is at a hospital that is unable to properly manage the medical condition and needs to be transported to a uniquely qualified facility; and life support equipment and advanced medical care is necessary during transport.

Non-Emergency Ambulance	Transportation of a pre-planned nature by which the patient is transported on a stretcher or requires the administration of life support equipment, such as oxygen, by trained medical personnel.	May be ordered when the patient is in need of services that can only be administered by an ambulance service. The ordering physician must note in the patient's chart the patient's medical condition that qualifies the use of non-emergency ambulance service.

Emergency Ambulance

TABLE 5
EMERGENCY AMBULANCE

Service Area	Medicaid	Medicaid Advantage HMO	Dual Eligible (HMO) SNP MAP-MLTC & MLTC	Dual Eligible HMO/PPO SNP
New York City	Covered by Medicaid FFS	Covered by the Plan	Covered by the Plan	Covered by the Plan
Nassau	Covered by the Plan	Covered by the Plan	Covered by the Plan	Covered by the Plan
Rockland	N/A	Covered by the Plan	Covered by the Plan	Covered by the Plan
Suffolk	Covered by the Plan	Covered by the Plan	Covered by the Plan	Covered by the Plan
Westchester	Covered by Medicaid FFS	Covered by the Plan	Covered by the Plan	Covered by the Plan

Prior Approval: Emergency services are not subject to prior approval. Call 911.

Who Arranges Services: Anyone who can. Call 911.

Provider Reimbursement: Ambulance providers submit claims to the address on the back of the member's ID card. For Dual Eligible (PPO) SNP: Ambulance providers submit claims to: EmblemHealth Medicare PPO, PO Box 2830, New York, NY 10016-2830. When covered by Medicaid FFS, ambulance providers bill Medicaid FFS.

EmblemHealth

Provider Manual

Chapter 17: Care Management

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 Therapy and Occupational Therapy
- 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.

The table/s have been retired as of November 1, 2017. Retained for historical purposes only. Please follow the link to the current preauthorization list effective 01/01/2020.

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.

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.
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)
Em blemHealth 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)
Mon tefiore	R equests 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	
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:

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

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 Facility	Yes
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 substitution of benefits. No outpatient benefits are available under this benefit if no pre-certification is received.	Yes
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
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 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	Notification is required
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. Vew 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
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.

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	

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, pCO_2, pO_2 , CO_2, HCO_3	
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
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
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, pCO_2, pO_2 , CO_2, HCO_3	
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	
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)	
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.

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.

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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:

1. 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.
2. 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.
3. Contracted hospitals may notify Vytra by calling 1-888-288-9872.
4. 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 information on denial determinations.

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 chapters - Commercial/CHP, Medicaid, and 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. 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:

1. 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.

2. 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.
3. Contracted hospitals may notify Vytra by calling 1-888-288-9872.
4. 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/CHP, Medicaid, and 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/CHP, Medicaid or 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.

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. 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.

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.

EmblemHealth

Provider Manual

Chapter 18: Clinical Practice Guidelines

This chapter contains evidence-based recommendations to assist practitioners in providing medical care.

Overview

EmblemHealth encourages the use of Clinical Practice Guidelines (CPGs) for assistance in the treatment of acute, chronic and behavioral health issues. We've adopted these guidelines from professionally recognized sources and through consultation between board-certified specialists and our Health Status Improvement Subcommittee.

All CPGs are reviewed at a minimum of every two years and are updated as appropriate. (The HIV/AIDS CPGs are reviewed and updated annually.)

CPGs are not intended as a substitute for the professional assessment of the health care practitioner but to assist the practitioner in the management of certain types of preventive and clinical care. Individual patient treatment may vary from these guidelines based on the health care practitioner's clinical judgment.

The CPGs approved by EmblemHealth are listed below. Updates will be posted regularly to our Web site, so please check for updates on a monthly basis. If you are unable to access a specific CPG on the Web, please contact our Quality Management department at 1-888-447-5451 to request a mailed copy.

EmblemHealth-Adopted Clinical Practice Guidelines

Medical Management

(Please access these clinical practice guidelines.)

- Adult Preventive Services
- Appropriate Use of Antibiotics for Adults and Children
- Arthritis
- Asthma
- Cholesterol Management for Adults at Risk for Cardio/Vascular Disease
- Chronic Kidney Disease

- Chronic Obstructive Pulmonary Disease (COPD)
- Community-Acquired Pneumonia in Adults
- Congestive Heart Failure
- Coronary Artery Disease
- Diabetes Mellitus
- Helicobacter Pylori
- HIV/AIDS
- Hypertension
- Low Back Pain Diagnosis and Treatment
- Lyme Disease
- Obesity and Weight Management in Adults
- Obesity and Weight Management in Children and Adolescents
- Osteoporosis
- Pediatric and Adolescent Preventive Services
- Preconception Care
- Prenatal/Postpartum Care
- Sexually Transmitted Diseases (STDs)
- Smoking Cessation
- Stroke Prevention
- Tuberculosis
- Urinary Incontinence

Behavioral Health Services

Beacon Health Options manages behavioral health services for members served by Emblem Behavioral Health Services Program (for plans underwritten by HIP and HIPIC and administered by VHMS) and Behavioral Management Program (for plans underwritten by GHI).

Please access the Beacon Health Options Treatment Guidelines listed below at https://www.beaconhealthoptions.com/pcp-toolkit/.

Diagnosed Based

- Acute Stress Disorder and Post-Traumatic Stress Disorder (PDF)
  Adopted from APA 8/10/06 Reviewed 5/21/12
- Assessing and Treating Suicidal Behaviors (PDF)
  Adopted from APA 8/10/06 Reviewed 5/21/12
- ADHD Guidelines (Adults) (PDF)
  Adopted from Weiss and Weiss 5/11/09 Reviewed 3/13/13
- ADHD Guidelines (Child/Adolescent) (PDF)
  Adopted from AACAP Reviewed 3/13/13
- Autism Spectrum Disorders (PDF)

Reviewed 8/20/12

- Bi-Polar Disorder (PDF)
  Adopted from APA 6/2004 Reviewed 5/21/12
- Co-Occurring Mental Substance Related Problems (PDF)
  Reviewed 7/16/12
- Eating Disorders (PDF)
  Adopted from APA 5/12/05 Reviewed 3/18/13
- Generalized Anxiety Disorder (PDF)
  Adopted from Canadian Psychiatric Association Anxiety Guidelines 10/12/06 Reviewed 8/20/12
- Major Depression (PDF)
  Adopted from APA 5/12/05 Reviewed 3/18/13
- Tip 43 Medication Assisted Treatment for Opioid Addicition in Opioid Treatment Programs (PDF)
  Reviewed 4/18/11
- Suboxone (PDF)
  Reviewed 8/20/12
- Treating Schizophrenia (PDF)
  Adopted from APA Reviewed 3/18/13
- Schizophrenia Guideline Watch (PDF)
  Adopted 3/21/11 Reviewed 5/21/12
- Treating Panic Disorder (PDF)
  Adopted from APA 8/10/06 Reviewed 5/21/12
- Treating Substance Use Disorders (PDF)
  Adopted from APA 8/10/06 Reviewed 5/21/12

Program Based

- EAP Guidelines (PDF)
  Reviewed 3/18/13

Treatment Based

- Electroconvulsive Therapy (ECT) (PDF)

Medically Fragile Children

For the Medicaid children carve-in effective July 1, 2018, and the foster care children carve-in in 2019, EmblemHealth will incorporate the following into its guidance:

- OMH Clinic Standards of Care: https://www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html
- OASAS Clinical
  Guidance: https://www.health.ny.gov/health_care/medicaid/redesign/medically_fragile_children.htm
- OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April
  2013 https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf
- OCFS Working Together: Health Services for Children in Foster Care
  Manual httsp://ocfs.ny.gov/main/sppd/health_services/manual.asp
- Office of Health Insurance Programs Principles for Medically Fragile Children

Office of Health Insurance Programs Principles

A “medically fragile child” (MFC) is defined as an individual who is under 21 years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meets one or more of the following criteria:
(1) is technologically dependent for life or health-sustaining functions,
(2) requires a complex medication regimen or medical interventions to maintain or to improve their health status,
(3) is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health, or development at risk. Chronic debilitating conditions include, but are not limited to:

- bronchopulmonary dysplasia
- cerebral palsy
- congenital heart disease
- microcephaly
- pulmonary hypertension
- muscular dystrophy

With respect to medically fragile children, and children in foster care EmblemHealth:
A. Will, in accordance with the requirements of C/THP and EPSDT as described in Section 10.4 of the DOH Model Contract, cover all services that assist a medically fragile child in reaching their maximum functional capacity, taking into account the appropriate functional capacities of children of the same age. EmblemHealth will continue to cover services until that child achieves age-appropriate functional capacity.

B. Shall not base determinations solely based upon review standards applicable to (or designed for) adults to medically fragile children. Adult standards include, but are not limited to, Medicare rehabilitation standards and the “Medicare 3-hour rule.” Determinations have to take into consideration the specific needs of the child and the circumstances pertaining to their growth and development.

C. Will accommodate unusual stabilization and prolonged discharge plans for medically fragile children, as appropriate. Areas that plans must consider when developing and approving discharge plans include, but are not limited to:

-
  - sudden reversals of condition or progress, which may make discharge decisions uncertain or more prolonged than for other children or adults
  - necessary training of parents or other adults to care for a medically fragile child at home
  - unusual discharge delays encountered if parents or other responsible adults decline or are slow to assume full responsibility for caring for a medically fragile child
  - the need to await an appropriate home or home-like environment rather than discharge to a housing shelter or other inappropriate setting for a medically fragile child
  - the need to await construction adaptations to the home (such as the installation of generators or other equipment)
  - and lack of available suitable specialized care (such as unavailability of pediatric nursing home beds or pediatric ventilator units).

EmblemHealth will develop a person-centered discharge plan for the child, taking the above situations into consideration.

D. Will identify an available provider of needed covered services, as determined through a person-centered care plan, to effect safe discharge from a hospital or other facility. Payment will not be denied to a discharging hospital or other facility due to lack of an available post-discharge provider as long as they have worked with EmblemHealth to identify an appropriate provider. EmblemHealth will approve the use of out-of-network (OON) providers if we do not have a participating provider to address the child's needs.

E. EmblemHealth will ensure that a medically fragile child receives services from appropriate providers that have the expertise to effectively treat the child. EmblemHealth contracts with providers with demonstrated expertise in caring for medically fragile children. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek EmblemHealth's authorization for out-of-network providers when participating providers cannot meet the child's needs. EmblemHealth will authorize services as fast as the enrollee's condition requires and in accordance with established time frames in the Medicaid Managed Care Model Contract.

EmblemHealth expects those who treat medically frail and foster children to comply with this guidance.

EmblemHealth

Provider Manual

Chapter 19: Radiology Program

This chapter contains information about our diagnostic imaging management program for outpatient radiology services, including prior approval and radiology scheduling procedures, for all members.

Overview

The EmblemHealth Radiology Program, developed with eviCore, provides diagnostic imaging management for outpatient radiology services. Services targeted for utilization management depend on the EmblemHealth benefit plan. eviCore also conducts clinical standard and expedited appeals (excluding members with Medicare plans).

Assessment and Certification

All radiologists and non-radiologists participating in our radiology programs undergo a comprehensive site visit, as well as evaluation of equipment, technical staff credentials, continuing education, equipment maintenance records and operating policies. They may also be required to complete the appropriate assessment and certification forms. This process is based on nationally recognized requirements of the American Institute of Ultrasound in Medicine, the American College of Radiology and The Joint Commission.

Film Review

Practitioners' film images must comply with the high standards of the American College of Radiology. At least once every two years, practitioners may be required to provide EmblemHealth and/or eviCore with requested materials for an independent review and professional interpretation of films. For this review, we randomly select a sampling of patient studies. At least two board-certified radiologists then assess these studies for technical quality and diagnostic interpretation.

Members Exempt from the EmblemHealth Radiology Program

As of January 1, 2018, ACPNY members are no longer exempt from the EmblemHealth Radiology Program. eviCore now provides utilization management (prior approval) for ACPNY radiology services. The referring provider will need to contact eviCore to get the prior approval.

As of August 20, 2018, members assigned to a PCP affiliated with St. Barnabas Hospital are no longer exempt from the EmblemHealth Radiology Program. eviCore now provides utilization management (prior approval) for these members. The referring provider will need to contact eviCore to get the prior approval.

While most of our members' covered radiology services are managed by eviCore, the following exceptions apply:

- Members whose care is managed by Montefiore Medical Group (CMO) or HealthCare Partners (HCP) must contact the applicable organization for prior approval. Check the member's ID card or eligibility information on emblemhealth.com to determine whether HIP, CMO, or HCP is the managing entity responsible for managing a member's care; if HIP is the managing entity, then eviCore is the organization to contact for prior approval.
- Effective January 1, 2018, this exemption no longer applies for:
  - Members who selected a PCP assigned to ACPNY. The prior approval request must be entered on emblemhealth.com.
- Effective August 20, 2018, this exemption no longer applies for:
  - Members who selected a physician affiliated with the St. Barnabas Hospital System. The prior approval request must be entered on emblemhealth.com.

Prior Approval Procedures

Services Requiring Prior Approval

Please refer to the charts later in this chapter for a list of services (and CPT-4 codes) that require prior approval:

HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO and Vytra EmblemHealth EPO/PPO and EmblemHealth Medicare PPO
Each procedure requires a separate prior approval. Prior approvals are specific to the CPT-4 code and site location. They are valid for 45 days from the approval date.

Prior approval is required for services performed in the following places of service:

- Outpatient hospital facilities
- Freestanding radiology facilities
- Radiology office-based settings
- Non-radiology office-based settings

Neither prior approval nor referral is required for:

- Inpatient hospitalization
- Services rendered in hospital emergency departments
- Services provided when one of EmblemHealth's companies is the secondary insurer
- Pulmonary perfusion imaging

The following services do not require prior approval but may require a referral from the member's PCP:

- Basic X-rays
- Mammograms
- Bone density tests

Who Requests Prior Approval

It is the responsibility of the referring practitioner (i.e., the practitioner developing the patient's treatment plan) to obtain the prior approval before services are rendered. If the referring and rendering practitioners are different, the rendering practitioner is encouraged to confirm that a prior approval is on file before services are rendered. The rendering practitioner is ultimately responsible for ensuring that all applicable radiology imaging procedures at the applicable service location have received all necessary prior approvals.

How To Obtain Prior Approval

Before requesting prior approval from please have the patient's medical records on hand and complete the request form specific to the procedure being requested. These request forms are available at the links below and at evicore.com. They list all clinical questions the practitioner must answer during the initial prior approval review.

For MRI, General Use Clinical Certification Request Form
For CT Scan, CT/CTA Clinical Certification Request Form
For PET Scan, PET Scan Clinical Certification Request Form
For MR/MRAs, MR/MRA Clinical Certification Request Form

Once the form is complete, submit prior approval requests in one of three ways:

Online: Visit www.evicore.com. To submit online requests, the ordering physician must be a registered user. To register for a user ID and password, visit www.evicore.com and click the "Register" button.

By phone: Call 1-866-417-2345 for GHI HMO, HIP and EmblemHealth CompreHealth EPO (Retired August 1, 2018) and Vytra plan members. Call 1-800-835-7064 for EmblemHealth EPO/PPO and EmblemHealth Medicare PPO plan members. Representatives are available Monday through Friday, from 7 am to 7 pm, EST. The program is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving and Christmas Day.

By fax: Fax the completed request form to 1-800-540-2406.

Please have the following information available when you call:

- The completed form, as noted above
- The patient's full name, member ID number and insurance information
- The exam(s) requested for the patient
- The working diagnosis or rule-out
- The signs and symptoms that call for the exam, as well as their duration
- Any previous imaging studies performed, corresponding results or pertinent lab results
- History of prior treatment methods, drugs, surgery or other therapies, as well as duration of prior treatment

- Any other information indicating the need for the exam

Expedited Approval Requests

evicore.com cannot be used for expedited approval requests. These requests must be processed through the call center. Call 1-866-417-2345 for GHI HMO, HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO, and Vytra plan members. Call 1-800-835-7064 for EmblemHealth EPO/PPO and EmblemHealth Medicare PPO plan members. Utilization review staff is available 24 hours a day, 7 days a week. The program is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving and Christmas Day.

Urgent Requests

If the treatment is medically urgent and must be performed outside business hours, the physician may deliver treatment and must submit the prior approval request (with supporting clinical documentation) within two (2) business days. Urgent requests are reviewed against medical necessity criteria, and an approval is issued as long as the request meets these medical necessity criteria. Urgent requests will be completed within 24 hours of receiving the request. evicore.com cannot be used for urgent approval requests. These requests must be processed through the call center. Call 1-866-417-2345for GHI HMO, HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO and Vytra plan members. Call 1-800-835-7064 for EmblemHealth EPO/PPO and EmblemHealth Medicare PPO plan members. Utilization review staff is available 24 hours a day, 7 days a week. The program is closed New Year's Day, Memorial Day, Independence Day, Labor Day.

Non-Urgent Requests

Non-urgent requests will be completed within three (3) business days of receiving all necessary information, or within the time frames otherwise required by the member's benefit plan (see Standard Pre-Service Review in the Care Management chapter). In most cases, the staff will review and determine prior approvals during the initial phone call, as long as all the required information is provided. The review and determination processes may, however, take longer if member or practitioner eligibility verification is required, or if the request requires additional clinical review (see Standard Pre-Service Review in the Care Management chapter).

A physician with office hours later than the call center's may initiate a case through evicore.com which will be processed on the next business day.

Modifying a Prior Approval Request

If it becomes necessary to change or update the procedure after prior approval is obtained, the program must be contacted no later than 48 hours after the modified procedure is performed. If the prior approval for the treatment plan is not updated and the claim does not match the authorized procedures, the claim will be denied for payment, with no liability to the member.

Verifying the Prior Approval Status

To verify the status of a prior approval request, either call the applicable number below or visit the Authorization Lookup section at evicore.com.

Call 1-866-417-2345 for GHI HMO, HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO and Vytra plan members. Call 1-800-835-7064 for EmblemHealth EPO/PPO and EmblemHealth Medicare PPO plan members.

Note: While the program may approve or deny a prior approval request, this determination is based on medical necessity only. Always verify member eligibility, benefits and copayments with EmblemHealth directly at www.emblemhealth.com.

Determination Disagreement

If the referring physician disagrees with the determination, contact the Peer-to-Peer Consultation Line to discuss the case with a medical director. Call 1-866-417-2345 for GHI HMO, HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO and Vytra plans. Call 1-800-835-7064 for EmblemHealth EPO/PPO and EmblemHealth Medicare PPO plan members.

Claims will be denied and the member will not be liable for payment if:

- A prior approval was required but not obtained for the CPT-4 code performed.
- Procedures are performed at a service location other than the address on the prior approval issued.

Radiology Program Prior Approval Code List For HIP, EmblemHealth CompreHealth EPO and EmblemHealth Medicare HMO

Radiology Program Prior Approval Code List
For HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO and Vytra

Radiology CPT Code	Procedure Description
70336	MAGNETIC RESONANCE IMAGING TMJ
70450	COMPUTED TOMOGRAPHY HEAD/BRAIN WITHOUT CONTRAST
70460	COMPUTED TOMOGRAPHY HEAD/BRAIN WITH CONTRAST
70470	COMPUTED TOMOGRAPHY HEAD/BRAIN WITHOUT AND WITH CONTRAST
70480	COMPUTED TOMOGRAPHY ORBIT WITHOUT CONTRAST
70481	COMPUTED TOMOGRAPHY ORBIT WITH CONTRAST
70482	COMPUTED TOMOGRAPHY ORBIT WITHOUT AND WITH CONTRAST

70486	COMPUTED TOMOGRAPHY MAXILLOFACIAL WITHOUT CONTRAST
70487	COMPUTED TOMOGRAPHY MAXILLOFACIAL WITH CONTRAST
70488	COMPUTED TOMOGRAPHY MAXILLOFACIAL WITHOUT AND WITH CONTRAST
70490	COMPUTED TOMOGRAPHY SOFT TISSUE NECK WITHOUT CONTRAST
70491	COMPUTED TOMOGRAPHY SOFT TISSUE NECK WITH CONTRAST
70492	COMPUTED TOMOGRAPHY SOFT TISSUE NECK WITHOUT AND WITH CONTRAST
70496	COMPUTED TOMOGRAPHIC ANGIOGRAPHY HEAD
70498	COMPUTED TOMOGRAPHIC ANGIOGRAPHY NECK
70540	MAGNETIC RESONANCE IMAGING FACE, ORBIT, NECK WITHOUT CONTRAST
70542	MAGNETIC RESONANCE IMAGING FACE, ORBIT, NECK WITH CONTRAST
70543	MAGNETIC RESONANCE IMAGING FACE, ORBIT, NECK WITH AND WITHOUT CONTRAST
70544	MAGNETIC RESONANCE ANGIOGRAPHY HEAD WITHOUT CONTRAST
70545	MAGNETIC RESONANCE ANGIOGRAPHY HEAD WITH CONTRAST
70546	MAGNETIC RESONANCE ANGIOGRAPHY HEAD WITH AND WITHOUT CONTRAST
70547	MAGNETIC RESONANCE ANGIOGRAPHY NECK WITHOUT CONTRAST

70548	MAGNETIC RESONANCE ANGIOGRAPHY NECK WITH CONTRAST
70549	MAGNETIC RESONANCE ANGIOGRAPHY NECK WITH AND WITHOUT CONTRAST
70551	MAGNETIC RESONANCE IMAGING HEAD WITHOUT CONTRAST
70552	MAGNETIC RESONANCE IMAGING HEAD WITH CONTRAST
70553	MAGNETIC RESONANCE IMAGING HEAD WITH AND WITHOUT CONTRAST
70554	MAGNETIC RESONANCE IMAGING, BRAIN, FUNCTIONAL MAGNETIC RESONANCE IMAGING; INCLUDING TEST SELECTION AND ADMINISTRATION OF REPETITIVE BODY PART MOVEMENT AND/OR VISUAL STIMULATION, NOT REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION
70555	MAGNETIC RESONANCE IMAGING, BRAIN, FUNCTIONAL MAGNETIC RESONANCE IMAGING; REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION OF ENTIRE NEUROFUNCTIONAL TESTING
71250	COMPUTED TOMOGRAPHY THORAX WITHOUT CONTRAST
71260	COMPUTED TOMOGRAPHY THORAX WITH CONTRAST
71270	COMPUTED TOMOGRAPHY THORAX WITHOUT AND WITH CONTRAST
71275	COMPUTED TOMOGRAPHIC ANGIOGRAPHY CHEST, NON-CORONARY
71550	MAGNETIC RESONANCE IMAGING CHEST WITHOUT CONTRAST
71551	MAGNETIC RESONANCE IMAGING CHEST WITH CONTRAST
71552	MAGNETIC RESONANCE IMAGING CHEST WITH AND WITHOUT CONTRAST

71555	MAGNETIC RESONANCE ANGIOGRAPHY CHEST (EXC MYOCARDIUM) WITH OR WITHOUT CONTRAST
72125	COMPUTED TOMOGRAPHY CERVICAL SPINE WITHOUT CONTRAST
72126	COMPUTED TOMOGRAPHY CERVICAL SPINE WITH CONTRAST
72127	COMPUTED TOMOGRAPHY CERVICAL SPINE WITHOUT AND WITH CONTRAST
72128	COMPUTED TOMOGRAPHY THORACIC SPINE WITHOUT CONTRAST
72129	COMPUTED TOMOGRAPHY THORACIC SPINE WITH CONTRAST
72130	COMPUTED TOMOGRAPHY THORACIC SPINE WITHOUT AND WITH CONTRAST
72131	COMPUTED TOMOGRAPHY LUMBAR SPINE WITHOUT CONTRAST
72132	COMPUTED TOMOGRAPHY LUMBAR SPINE WITH CONTRAST
72133	COMPUTED TOMOGRAPHY LUMBAR SPINE WITHOUT AND WITH CONTRAST
72141	MAGNETIC RESONANCE IMAGING CERVICAL SPINE WITHOUT CONTRAST
72142	MAGNETIC RESONANCE IMAGING CERVICAL SPINE WITH CONTRAST
72146	MAGNETIC RESONANCE IMAGING THORACIC SPINE WITHOUT CONTRAST
72147	MAGNETIC RESONANCE IMAGING THORACIC SPINE WITH CONTRAST
72148	MAGNETIC RESONANCE IMAGING LUMBAR SPINE WITHOUT CONTRAST

72149	MAGNETIC RESONANCE IMAGING LUMBAR SPINE WITH CONTRAST
72156	MAGNETIC RESONANCE IMAGING C SPINE WITH AND WITHOUT CONTRAST
72157	MAGNETIC RESONANCE IMAGING T SPINE WITH AND WITHOUT CONTRAST
72158	MAGNETIC RESONANCE IMAGING L SPINE WITH AND WITHOUT CONTRAST
72159	MAGNETIC RESONANCE ANGIOGRAPHY SPINAL CANAL WITH OR WITHOUT CONTRAST
72191	COMPUTED TOMOGRAPHIC ANGIOGRAPHY PELVIS
72192	COMPUTED TOMOGRAPHY PELVIS WITHOUT CONTRAST
72193	COMPUTED TOMOGRAPHY PELVIS WITH CONTRAST
72194	COMPUTED TOMOGRAPHY PELVIS WITHOUT AND WITH CONTRAST
72195	MAGNETIC RESONANCE IMAGING PELVIS WITHOUT CONTRAST
72196	MAGNETIC RESONANCE IMAGING PELVIS WITH CONTRAST
72197	MAGNETIC RESONANCE IMAGING PELVIS WITH AND WITHOUT CONTRAST
72198	MAGNETIC RESONANCE ANGIOGRAPHY PELVIS WITH OR WITHOUT CONTRAST
73200	COMPUTED TOMOGRAPHY UPPER EXTREMITY WITHOUT CONTRAST
73201	COMPUTED TOMOGRAPHY UPPER EXTREMITY WITH CONTRAST

73202	COMPUTED TOMOGRAPHY UPPER EXTREMITY WITHOUT AND WITH CONTRAST
73206	COMPUTED TOMOGRAPHIC ANGIOGRAPHY UPPER EXTREMITY
73218	MAGNETIC RESONANCE IMAGING UPPER EXTREMITY WITHOUT CONTRAST
73219	MAGNETIC RESONANCE IMAGING UPPER EXTREMITY WITH CONTRAST
73220	MAGNETIC RESONANCE IMAGING UPPER EXTREMITY WITH AND WITHOUT CONTRAST
73221	MAGNETIC RESONANCE IMAGING UPPER EXTREMITY JOINT WITHOUT CONTRAST
73222	MAGNETIC RESONANCE IMAGING UPPER EXTREMITY JOINT WITH CONTRAST
73223	MAGNETIC RESONANCE IMAGING UPPER EXTREMITY JOINT WITH AND WITHOUT CONTRAST
73225	MAGNETIC RESONANCE ANGIOGRAPHY UPPER EXTREMITY WITH OR WITHOUT CONTRAST
73700	COMPUTED TOMOGRAPHY LOWER EXTREMITY WITHOUT CONTRAST
73701	COMPUTED TOMOGRAPHY LOWER EXTREMITY WITH CONTRAST
73702	COMPUTED TOMOGRAPHY LOWER EXTREMITY WITHOUT AND WITH CONTRAST
73706	COMPUTED TOMOGRAPHIC ANGIOGRAPHY LOWER EXTREMITY
73718	MAGNETIC RESONANCE IMAGING LOWER EXTREMITY WITHOUT CONTRAST
73719	MAGNETIC RESONANCE IMAGING LOWER EXTREMITY WITH CONTRAST

73720	MAGNETIC RESONANCE IMAGING LOWER EXTREMITY WITH AND WITHOUT CONTRAST
73721	MAGNETIC RESONANCE IMAGING LOWER EXTREMITY JOINT WITHOUT CONTRAST
73722	MAGNETIC RESONANCE IMAGING LOWER EXTREMITY JOINT WITH CONTRAST
73723	MAGNETIC RESONANCE IMAGING LOWER EXTREMITY JOINT WITH AND WITHOUT CONTRAST
73725	MAGNETIC RESONANCE ANGIOGRAPHY LOWER EXTREMITY WITH OR WITHOUT CONTRAST
74150	COMPUTED TOMOGRAPHY ABDOMEN WITHOUT CONTRAST
74160	COMPUTED TOMOGRAPHY ABDOMEN WITH CONTRAST
74170	COMPUTED TOMOGRAPHY ABDOMEN WITHOUT AND WITH CONTRAST
74174	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING
74175	COMPUTED TOMOGRAPHIC ANGIOGRAPHY ABDOMEN
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL
74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL(S)
74178	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS IN ONE OR BOTH BODY REGIONS
74181	MAGNETIC RESONANCE IMAGING ABDOMEN WITHOUT CONTRAST
74182	MAGNETIC RESONANCE IMAGING ABDOMEN WITH CONTRAST

74183	MAGNETIC RESONANCE IMAGING ABDOMEN WITH AND WITHOUT CONTRAST
74185	MAGNETIC RESONANCE ANGIOGRAPHY ABDOMEN WITH OR WITHOUT CONTRAST
74261	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITHOUT CONTRAST MATERIAL
74262	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITH CONTRAST MATERIAL(S) INCLUDING NON-CONTRAST IMAGES, IF PERFORMED
74263	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, SCREENING, INCLUDING IMAGE POSTPROCESSING
75635	COMPUTED TOMOGRAPHIC ANGIOGRAPHY ABDOMINAL AORTA
76376	3D RENDERING WITH INTERPRETATION AND REPORTING OF COMPUTED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, ULTRASOUND OR OTHER TOMOGRAPHIC MODALITY; NOT REQUIRING IMAGE POSTPROCESSING ON AN INDEPENDENT WORKSTATION
76377	3D RENDERING WITH INTERPRETATION AND REPORTING OF COMPUTED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, ULTRASOUND OR OTHER TOMOGRAPHIC MODALITY; REQUIRING IMAGE POSTPROCESSING ON AN INDEPENDENT WORKSTATION
76380	COMPUTED TOMOGRAPHY LIMITED OR LOCALIZED FOLLOW-UP STUDY
76390	MAGNETIC RESONANCE IMAGING SPECTROSCOPY
76801	ULTRASOUND OBSTETRICAL PELVIS, PREGNANT UTERUS, FIRST TRIMESTER <14 WEEKS SINGLE OR FIRST GESTATION
76802	ULTRASOUND OBSTETRICAL PELVIS, PREGNANT UTERUS, FIRST TRIMESTER <14 WEEKS EACH ADDITIONAL GESTATION
76805	ULTRASOUND OBSTETRICAL PELVIS, PREGNANT UTERUS, B-SCAN (ALLOWED ONCE PER GESTATION)

76810	ULTRASOUND OBSTETRICAL PELVIS COMPLETE, MULTIPLE GESTATION AFTER 1ST TRIMESTER (ALLOWED ONCE FOR EACH ADDITIONAL FETUS PER GESTATION; MUST BE BILLED WITH 76805)
76811	ULTRASOUND PREGNANT UTERUS FETAL AND MATERNAL EVAL PLUS ULTRASOUND FETAL ANATOMIC EVAL TRANSABDOMINAL SINGLE OR FIRST GESTATION (ALLOWED ONCE PER GESTATION; SECOND STUDY ALLOWED IF PERFORMED BY A DIFFERENT PHYSICIAN)
76812	ULTRASOUND PREGNANT UTERUS FETAL AND MATERNAL EVAL PLUS ULTRASOUND FETAL ANATOMIC EVAL TRANSABDOMINAL EACH ADDITIONAL GESTATION (ALLOWED ONCE FOR EACH ADDITIONAL FETUS ULTRASOUND PER GESTATION; MUST BE BILLED WITH 76811; SECOND STUDY ALLOWED IF PERFORMED BY A DIFFERENT PHYSICIAN)
76813	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FIRST TRIMESTER FETAL NUCHAL TRANSLUCENCY MEASUREMENT, TRANSABDOMINAL OR TRANSVAGINAL APPROACH; SINGLE OR FIRST GESTATION (ALLOWED ONCE PER GESTATION)
76814	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FIRST TRIMESTER FETAL NUCHAL TRANSLUCENCY MEASUREMENT, TRANSABDOMINAL OR TRANSVAGINAL APPROACH; EACH ADDITIONAL GESTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) (ALLOWED ONCE FOR EACH ADDITIONAL FETUS PER GESTATION)
76815	ULTRASOUND PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, LIMITED (E.G., FETAL HEART BEAT, PLACENTAL LOCATION, FETAL POSITION AND/OR QUALITATIVE AMNIOTIC FLUID VOLUME), 1 OR MORE FETUSES
76816	ULTRASOUND OBSTETRICAL PELVIS FOLLOW-UP OR REPEAT
76817	ULTRASOUND PREGNANT UTERUS TRANSVAGINAL
76818	FETAL BIOPHYSICAL PROFILE
76819	FETAL BIOPHYSICAL PROFILE WITHOUT STRESS NON STRESS
76820	DOPPLER VELOCIMETRY, FETAL; UMBILICAL ARTERY
76821	DOPPLER VELOCIMETRY, FETAL; MIDDLE CEREBRAL ARTERY

76825	ULTRASOUND OBSTETRICAL ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM
76826	FOLLOW-UP OR REPEAT STUDY
76827	DOPPLER ECHOCARDIOGRAPHY FETAL COMPLETE
76828	FOLLOW-UP OR REPEAT STUDY
76975	ULTRASOUND GASTROINTESTINAL, ENDOSCOPIC
77021	MAGNETIC RESONANCE IMAGING GUIDANCE FOR NEEDLE PLACEMENT
77022	MAGNETIC RESONANCE IMAGING GUIDANCE FOR AND MONITORING OF TISSUE ABLATION
77058	MAGNETIC RESONANCE IMAGING BREAST WITH AND/OR WITHOUT CONTRAST; UNILATERAL
77059	MAGNETIC RESONANCE IMAGING BREAST BILATERAL
77084	MAGNETIC RESONANCE IMAGING BONE MARROW BLOOD SUPPLY
78000	THYROID RAI UPTAKE
78001	THYROID MULTIPLE UPTAKE
78003	THYROID SUPPRESS OR STIMULATION
78006	THYROID UPTAKE AND SCAN
78007	THYROID IMAGE, MULTIPLE UPTAKES
78010	THYROID SCAN ONLY

78011	THYROID IMAGING WITH FLOW
78015	THYROID MET IMAGING
78016	THYROID MET IMAGING WITH ADDITIONAL STUDIES
78018	THYROID SCAN WHOLE BODY
78020	THYROID CARCINOMA METASTASES UPTAKE
78070	PARATHYROID NUCLEAR IMAGING
78075	ADRENAL NUCLEAR IMAGING
78102	BONE MARROW IMAGING, LIMITED
78103	BONE MARROW IMAGING, MULTIPLE
78104	BONE MARROW IMAGING, WHOLE BODY
78185	SPLEEN IMAGING WITH OR WITHOUT VASCULAR FLOW
78195	LYMPH SYSTEM IMAGING
78201	LIVER IMAGING
78202	LIVER IMAGING WITH FLOW
78205	LIVER IMAGING SPECT

78206	LIVER IMAGING SPECT WITH VASCULAR FLOW
78215	LIVER AND SPLEEN IMAGING
78216	LIVER AND SPLEEN IMAGING WITH FLOW
78226	LIVER FUNCTION STUDY
78227	HIDA SCAN
78230	SALIVARY GLAND IMAGING
78231	SERIAL SALIVARY GLAND
78232	SALIVARY GLAND FUNCTION TEST
78258	ESOPHAGUS MOTILITY STUDY
78261	GASTRIC MUCOSA IMAGING
78262	GASTROESOPHAGEAL REFLUX EXAM
78264	GASTRIC EMPTYING STUDY
78278	GI BLEEDER SCAN
78282	GI PROTEIN LOSS EXAM
78290	MECKEL'S DIVERTICULUM IMAGING

78291	LEVEEN SHUNT PATENCY EXAM
78300	BONE OR JOINT IMAGING LIMITED
78305	BONE OR JOINT IMAGING MULTIPLE
78306	BONE SCAN WHOLE BODY
78315	BONE AND/OR JOINT IMAGING; 3 PHASE STUDY
78320	BONE JOINT IMAGING TOMO TEST SPECT
78414	NON-IMAGING HEART FUNCTION
78428	CARDIAC SHUNT IMAGING
78445	RADIONUCLIDE VENOGRAM NON-CARDIAC
78456	ACUTE VENOUS THROMBOSIS IMAGING
78457	VENOUS THROMBOSIS IMAGING UNILATERAL
78458	VENOUS THROMBOSIS IMAGING BILATERAL
78466	MYOCARDIAL INFARCTION SCAN
78468	HEART INFARCT IMAGE EF
78469	HEART INFARCT IMAGE SPECT

78472	GATED HEART, REST OR STRESS
78473	CARDIAC BLOOD POOL MUGA SCAN
78481	HEART FIRST PASS SINGLE
78483	CARDIAC BLOOD POOL IMAGING, MULTIPLE
78494	CARDIAC BLOOD POOL IMAGING, SPECT
78496	CARDIAC BLOOD POOL IMAGING, SINGLE AT REST
78579	PULMONARY VENTILATION IMAGING (E.G., AEROSOL OR GAS)
78580	PULMONARY PERFUSION IMAGING
78582	PULMONARY VENTILATION (E.G., AEROSOL OR GAS) AND PERFUSION IMAGING
78597	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION, INCLUDING IMAGING, WHEN PERFORMED
78598	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION AND VENTILATION (E.G., AEROSOL OR GAS), INCLUDING IMAGING, WHEN PERFORMED
78600	BRAIN IMAGING LIMITED STATIC
78601	BRAIN LIMITED IMAGING AND FLOW
78605	BRAIN IMAGING COMPLETE
78606	BRAIN IMAGING COMPLETE WITH FLOW

78607	BRAIN IMAGING SPECT
78608	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC EVALUATION
78609	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION EVALUATION
78610	BRAIN FLOW IMAGING ONLY
78630	CISTERNOGRAM (CEREBROSPINAL FLUID FLOW)
78635	CEREBROSPINAL VENTRICULOGRAPHY
78645	CEREBROSPINAL FLUID FLOW SHUNT EVALUATION
78647	CEREBROSPINAL FLUID SCAN SPECT
78650	CEREBROSPINAL FLUID FLOW LEAKAGE DETECTION AND LOCALIZATION
78660	RADIOPHARMACEUTICAL DACRYOCYSTORGRAPHY
78700	KIDNEY IMAGING MORPHOLOGY
78701	KIDNEY IMAGING MORPHOLOGY WITH VASCULAR FLOW
78707	KIDNEY IMAGING MORPHOLOGY WITH VASCULAR FLOW AND FUNCTION STUDY
78708	KIDNEY IMAGING MORPHOLOGY WITH VASCULAR FLOW AND FUNCTION, SINGLE WITH PHARM INTERVENTION
78709	KIDNEY IMAGING MORPHOLOGY WITH VASCULAR FLOW, MULTIPLE, WITHOUT AND WITH PHARM INTERVENTION

78710	KIDNEY IMAGING, SPECT
78725	KIDNEY FUNCTION STUDY, NON-IMAGE RADIOISOTROPIC
78730	URINARY BLADDER RESIDUAL STUDY
78740	URETERAL REFLUX STUDY
78761	TESTICULAR IMAGING WITH VASCULAR FLOW
78800	RADIOPHARM LOCALIZATION OF TUMOR, LIMITED AREA
78801	RADIOPHARM LOCALIZATION OF TUMOR, MULTIPLE AREAS
78802	RADIOPHARM LOCALIZATION OF TUMOR, WHOLE BODY
78803	RADIOPHARM LOCALIZATION OF TUMOR, SPECT
78804	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR OR DISTRIBUTION OF RADIOPHARMACEUTICAL AGENT(S); WHOLE BODY, REQUIRING 2 OR MORE DAYS IMAGING
78805	RADIOPHARM LOCALIZATION OF ABSCESS, LIMITED AREA
78806	RADIOPHARM LOCALIZATION OF ABSCESS, WHOLE BODY
78807	RADIOPHARM LOCALIZATION OF ABSCESS, SPECT
78811	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; LIMITED AREA (E.G., CHEST, HEAD/NECK)
78812	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; SKULL BASE TO MID-THIGH

78813	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; WHOLE BODY
78814	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; LIMITED AREA (E.G., CHEST, HEAD/NECK)
78815	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; SKULL BASE TO MID-THIGH
78816	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; WHOLE BODY
C8900	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, ABDOMEN
C8901	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, ABDOMEN
C8902	MAGNETIC RESONANCE ANGIOGRAPHY WITH AND WITHOUT CONTRAST, ABDOMEN
C8903	MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST; UNILATERAL
C8904	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST; UNILATERAL
C8905	MAGNETIC RESONANCE IMAGING WITH AND WITHOUT CONTRAST, BREAST; UNILATERAL
C8906	MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST; BILATERAL
C8907	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST; BILATERAL
C8908	MAGNETIC RESONANCE IMAGING WITH AND WITHOUT CONTRAST, BREAST; BILATERAL

C8909	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, CHEST (EXCLUDING MYOCARDIUM)
C8910	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, CHEST (EXCLUDING MYOCARDIUM)
C8911	MAGNETIC RESONANCE ANGIOGRAPHY WITH AND WITHOUT CONTRAST, CHEST (EXCLUDING MYOCARDIUM)
C8912	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, LOWER EXTREMITY
C8913	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, LOWER EXTREMITY
C8914	MAGNETIC RESONANCE ANGIOGRAPHY WITH AND WITHOUT CONTRAST, LOWER EXTREMITY
C8918	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, PELVIS
C8919	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, PELVIS
C8920	MAGNETIC RESONANCE ANGIOGRAPHY WITH AND WITHOUT CONTRAST, PELVIS
C8931	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, SPINAL CANAL AND CONTENTS
C8932	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, SPINAL CANAL AND CONTENTS
C8933	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, SPINAL CANAL AND CONTENTS
C8934	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, UPPER EXTREMITY
C8935	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, UPPER EXTREMITY

C8936	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, UPPER EXTREMITY

Note: This program does not change members' benefits, nor does it change claim submission procedures for providers with a current direct contract with one of EmblemHealth's companies. Radiologists directly contracted with eviCore are now required to submit claims to eviCore.

Radiology Program Prior Approval Code List For EmblemHealth EPO/PPO and EmblemHealth Medicare PPO

Radiology Program Prior Approval Code List For GHI EPO/PPO, EmblemHealth EPO/PPO and EmblemHealth Medicare PPO
Effective October 1, 2012

Radiology CPT Code	Procedure Description
C8936	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, UPPER EXTREMITY (crosswalked to 73225)
C8935	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, UPPER EXTREMITY (crosswalked to 73225)
C8934	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, UPPER EXTREMITY (crosswalked to 73225)
C8933	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, SPINAL CANAL AND CONTENTS (crosswalked to 72159)
C8932	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, SPINAL CANAL AND CONTENTS (crosswalked to 72159)
C8931	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, SPINAL CANAL AND CONTENTS (crosswalked to 72159)
C8920	MRA WITH AND WITHOUT CONTRAST, PELVIS (crosswalked to 72198)
C8919	MRA WITHOUT CONTRAST, PELVIS (crosswalked to 72198)
C8918	MRA WITH CONTRAST, PELVIS (crosswalked to 72198)

C8914	MRA WITH AND WITHOUT CONTRAST, LOWER EXTREMITY (crosswalked to 73725)
C8913	MRA WITHOUT CONTRAST, LOWER EXTREMITY (crosswalked to 73725)
C8912	MRA WITH CONTRAST, LOWER EXTREMITY (crosswalked to 73725)
C8911	MRA WITH AND WITHOUT CONTRAST, CHEST (EXCLUDING MYOCARDIUM) (crosswalked to 71555)
C8910	MRA WITHOUT CONTRAST, CHEST (EXCLUDING MYOCARDIUM) (crosswalked to 71555)
C8909	MRA WITH CONTRAST, CHEST (EXCLUDING MYOCARDIUM) (crosswalked to 71555)
C8908	MRI WITH AND WITHOUT CONTRAST, BREAST; BILATERAL (crosswalked to 77059)
C8907	MRI WITHOUT CONTRAST, BREAST; BILATERAL (crosswalked to 77059)
C8906	MRI WITH CONTRAST, BREAST; BILATERAL (crosswalked to 77059)
C8905	MRI WITH AND WITHOUT CONTRAST, BREAST; UNILATERAL (crosswalked to 77058)
C8904	MRI WITHOUT CONTRAST, BREAST; UNILATERAL (crosswalked to 77058)
C8903	MRI WITH CONTRAST, BREAST; UNILATERAL (crosswalked to 77058)
C8902	MRA WITH AND WITHOUT CONTRAST, ABDOMEN (crosswalked to 74185)
C8901	MRA WITHOUT CONTRAST, ABDOMEN (crosswalked to 74185)
C8900	MRA WITH CONTRAST, ABDOMEN (crosswalked to 74185)

0175T	COMPUTER-AIDED DETECTION (CAD), INCLUDING COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION, WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION AND REPORT, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S) PERFORMED REMOTE FROM PRIMARY INTERPRETATION
0174T	COMPUTER-AIDED DETECTION (CAD), INCLUDING COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION, WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION AND REPORT, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S) PERFORMED CONCURRENT WITH PRIMARY INTERPRETATION
78816	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; WHOLE BODY
78815	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; SKULL BASE TO MID-THIGH
78814	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; LIMITED AREA (E.G., CHEST, HEAD/NECK)
78813	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; WHOLE BODY
78812	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; SKULL BASE TO MID-THIGH
78811	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; LIMITED AREA (E.G., CHEST, HEAD/NECK)
78807	RADIOPHARM LOCALIZATION OF ABSCESS, SPECT
78806	RADIOPHARM LOCALIZATION OF ABSCESS, WHOLE BODY
78805	RADIOPHARM LOCALIZATION OF ABSCESS, LIMITED AREA
78804	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR OR DISTRIBUTION OF RADIOPHARMACEUTICAL AGENT(S); WHOLE BODY, REQUIRING 2 OR MORE DAYS IMAGING

78803	RADIOPHARM LOCALIZATION OF TUMOR, SPECT
78802	RADIOPHARM LOCALIZATION OF TUMOR, WHOLE BODY
78801	RADIOPHARM LOCALIZATION OF TUMOR, MULTI AREAS
78800	RADIOPHARM LOCALIZATION OF TUMOR, LIMITED AREA
78761	TESTICULAR IMAGING W/ VASCULAR FLOW
78740	URETERAL REFLUX STUDY
78730	URINARY BLADDER RESIDUAL STUDY
78725	KIDNEY FUNCTION STUDY, NON-IMAGE RADIOISOTROPIC
78710	KIDNEY IMAGING, SPECT
78709	KIDNEY IMAGING MORPHOLOGY W/ VASCULAR FLOW, MULTI, W/O AND W/ PHARM INTERVENTION
78708	KIDNEY IMAGING MORPHOLOGY W/ VASCULAR FLOW AND FUNCTION, SINGLE W/ PHARM INTERVENTION
78707	KIDNEY IMAGING MORPHOLOGY W/ VASCULAR FLOW AND FUNCTION STUDY
78701	KIDNEY IMAGING MORPHOLOGY W/ VASCULAR FLOW
78700	KIDNEY IMAGING MORPHOLOGY
78660	RADIOPHARMACEUTICAL DACRYOCYSTORGRAPHY

78650	CSF LEAKAGE DETECTION AND LOCALIZATION
78647	CEREBROSPINAL FLUID SCAN SPECT
78645	CSF SHUNT EVALUATION
78635	CEREBROSPINAL VENTRICULOGRAPHY
78630	CISTERNOGRAM (Cerebrospinal fluid flow)
78610	BRAIN FLOW IMAGING ONLY
78609	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION EVALUATION
78608	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC EVALUATION
78607	BRAIN IMAGING SPECT
78606	BRAIN IMAGING COMPLETE W/ FLOW
78605	BRAIN IMAGING COMPLETE
78601	BRAIN LTD IMAGING AND FLOW
78600	BRAIN IMAGING LTD STATIC
78598	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION AND VENTILATION (E.G., AEROSOL OR GAS), INCLUDING IMAGING WHEN PERFORMED
78597	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION, INCLUDING IMAGING WHEN PERFORMED

78582	PULMONARY VENTILATION (E.G., AEROSOL OR GAS) AND PERFUSION IMAGING
78579	PULMONARY VENTILATION IMAGING (E.G., AEROSOL OR GAS)
78496	CARDIAC BLOOD POOL IMAGING, SINGLE AT REST (Use with 78472)
78494	CARDIAC BLOOD POOL IMAGING, SPECT
78492	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION; MULTIPLE STUDIES AT REST OR STRESS
78491	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION; SINGLE STUDY AT REST OR STRESS
78483	CARDIAC BLOOD POOL IMAGING, MULTI
78481	HEART FIRST PASS SINGLE
78473	CARDIAC BLOOD POOL MUGA SCAN
78472	GATED HEART, REST OR STRESS
78469	HEART INFARCT IMAGE SPECT
78468	HEART INFARCT IMAGE EF
78466	MYOCARDIAL INFARCTION SCAN
78459	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) METABOLIC EVAL
78458	VENOUS THROMBOSIS IMAGING BILATERAL

78457	VENOUS THROMBOSIS IMAGING UNILATERAL
78456	ACUTE VENOUS THROMBOSIS IMAGING
78454	MPI, PLANAR, MULTIPLE, REST OR STRESS
78453	MPI, PLANAR, SINGLE REST OR STRESS
78452	MPI, SPECT, MULTIPLE, REST OR STRESS
78451	MPI, SPECT, SINGLE REST OR STRESS
78445	RADIONUCLIDE VENOGRAM NON-CARDIAC
78428	CARDIAC SHUNT IMAGING
78414	NON-IMAGING HEART FUNCTION
78320	BONE JOINT IMAGING TOMO TEST SPECT
78315	BONE AND/OR JOINT IMAGING; 3 PHASE STUDY
78306	BONE SCAN WHOLE BODY
78305	BONE OR JOINT IMAGING MULTIPLE
78300	BONE OR JOINT IMAGING LTD
78291	LEVEEN SHUNT PATENCY EXAM

78290	MECKEL'S DIVERTICULUM IMAGING
78282	GI PROTEIN LOSS EXAM
78278	GI BLEEDER SCAN
78264	GASTRIC EMPTYING STUDY
78262	GASTROESOPHAGEAL REFLUX EXAM
78261	GASTRIC MUCOSA IMAGING
78258	ESOPHAGUS MOTILITY STUDY
78232	SALIVARY GLAND FUNCTION TEST
78231	SERIAL SALIVARY GLAND
78230	SALIVARY GLAND IMAGING
78227	HIDA SCAN
78226	LIVER FUNCTION STUDY
78223	HIDA SCAN
78220	LIVER FUNCTION STUDY
78216	LIVER AND SPLEEN IMAGING W/ FLOW

78215	LIVER AND SPLEEN IMAGING
78206	LIVER IMAGING SPECT W/ VASCULAR FLOW
78205	LIVER IMAGING SPECT
78202	LIVER IMAGING W/ FLOW
78201	LIVER IMAGING
78195	LYMPH SYSTEM IMAGING
78191	PLATELET SURVIVAL
78190	PLATELET SURVIVAL, KINETICS
78185	SPLEEN IMAGING W/ OR W/O VASCULAR FLOW
78140	LABELED RED CELL SEQUESTRATION
78104	BONE MARROW IMAGING, WHOLE BODY
78103	BONE MARROW IMAGING, MULTIPLE
78102	BONE MARROW IMAGING, LIMITED
78075	ADRENAL NUCLEAR IMAGING
78070	PARATHYROID NUCLEAR IMAGING

78020	THYROID CARCINOMA METASTASES UPTAKE (add on code - use w/ code 78018 only)
78018	THYROID SCAN WHOLE BODY
78016	THYROID MET IMAGING WITH ADDITIONAL STUDIES
78015	THYROID MET IMAGING
78011	THYROID IMAGING W/ FLOW
78010	THYROID SCAN ONLY
78007	THYROID IMAGE, MULTIPLE UPTAKES
78006	THYROID UPTAKE AND SCAN
78003	THYROID SUPPRESS OR STIMULATION
78001	THYROID MULTIPLE UPTAKE
78000	THYROID RAI UPTAKE
77084	MRI BONE MARROW BLOOD SUPPLY
77059	MRI BREAST BILATERAL
77058	MRI BREAST W/ AND/OR W/O CONTRAST; UNILATERAL
77021	MRI GUIDANCE FOR NEEDLE PLACEMENT

76390	MRI SPECTROSCOPY
76380	CT LIMITED OR LOCALIZED FOLLOW-UP STUDY
76377	3D RENDERING WITH INTERPRETATION AND REPORTING OF COMPUTED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, ULTRASOUND, OR OTHER TOMOGRAPHIC MODALITY; REQUIRING IMAGE POSTPROCESSING ON AN INDEPENDENT WORKSTATION
76376	3D RENDERING WITH INTERPRETATION AND REPORTING OF COMPUTED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, ULTRASOUND, OR OTHER TOMOGRAPHIC MODALITY; NOT REQUIRING IMAGE POSTPROCESSING ON AN INDEPENDENT WORKSTATION
75635	CT ANGIOGRAPHY ABDOMINAL AORTA
75574	CORONARY CTA
75573	CARDIAC CT FOR CONGENITAL HD
75572	CARDIAC CT FOR MORPHOLOGY
75563	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; WITH STRESS IMAGING
75561	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES
75559	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH STRESS IMAGING
75557	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL
74263	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, SCREENING, INCLUDING IMAGE POSTPROCESSING

74262	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED
74261	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITHOUT CONTRAST MATERIAL
74185	MRA ABDOMEN W/ OR W/O CONTRAST
74183	MRI ABDOMEN W/ & W/O CONTRAST
74182	MRI ABDOMEN W/ CONTRAST
74181	MRI ABDOMEN W/O CONTRAST
74178	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS IN ONE OR BOTH BODY REGIONS
74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL(S)
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL
74175	CT ANGIOGRAPHY ABDOMEN
74174	CT ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING
74170	CT ABDOMEN W/O & W/ CONTRAST
74160	CT ABDOMEN W/ CONTRAST
74150	CT ABDOMEN W/O CONTRAST

73725	MRA LOWER EXTREMITY W/ OR W/O CONTRAST
73723	MRI LOWER EXTREMITY JOINT W/ & W/O CONTRAST
73722	MRI LOWER EXTREMITY JOINT W/ CONTRAST
73721	MRI LOWER EXTREMITY JOINT W/O CONTRAST
73720	MRI LOWER EXTREMITY W/ & W/O CONTRAST
73719	MRI LOWER EXTREMITY W/ CONTRAST
73718	MRI LOWER EXTREMITY W/O CONTRAST
73706	CT ANGIOGRAPHY LOWER EXTREMITY
73702	CT LOWER EXTREMITY W/O & W/ CONTRAST
73701	CT LOWER EXTREMITY W/ CONTRAST
73700	CT LOWER EXTREMITY W/O CONTRAST
73225	MRA UPPER EXTREMITY W/ OR W/O CONTRAST
73223	MRI UPPER EXTREMITY JOINT W/ & W/O CONTRAST
73222	MRI UPPER EXTREMITY JOINT W/ CONTRAST
73221	MRI UPPER EXTREMITY JOINT W/O CONTRAST

73220	MRI UPPER EXTREMITY W/ & W/O CONTRAST
73219	MRI UPPER EXTREMITY W/ CONTRAST
73218	MRI UPPER EXTREMITY W/O CONTRAST
73206	CT ANGIOGRAPHY UPPER EXTREMITY
73202	CT UPPER EXTREMITY W/O & W/ CONTRAST
73201	CT UPPER EXTREMITY W/ CONTRAST
73200	CT UPPER EXTREMITY W/O CONTRAST
72198	MRA PELVIS W/ OR W/O CONTRAST
72197	MRI PELVIS W/ & W/O CONTRAST
72196	MRI PELVIS W/ CONTRAST
72195	MRI PELVIS W/O CONTRAST
72194	CT PELVIS W/O & W/ CONTRAST
72193	CT PELVIS W/ CONTRAST
72192	CT PELVIS W/O CONTRAST
72191	CT ANGIOGRAPHY PELVIS

72159	MRA SPINAL CANAL W/ OR W/O CONTRAST
72158	MRI L SPINE W/ & W/O CONTRAST
72157	MRI T SPINE W/ & W/O CONTRAST
72156	MRI C SPINE W/ & W/O CONTRAST
72149	MRI LUMBAR SPINE W/ CONTRAST
72148	MRI LUMBAR SPINE W/O CONTRAST
72147	MRI THORACIC SPINE W/ CONTRAST
72146	MRI THORACIC SPINE W/O CONTRAST
72142	MRI CERVICAL SPINE W/ CONTRAST
72141	MRI CERVICAL SPINE W/O CONTRAST
72133	CT L SPINE W/O & W/ CONTRAST
72132	CT L SPINE W/ CONTRAST
72131	CT L SPINE W/O CONTRAST
72130	CT T SPINE W/O & W/ CONTRAST
72129	CT T SPINE W/ CONTRAST
72128	CT T SPINE W/O CONTRAST

72127	CT C SPINE W/O & W/ CONTRAST
72126	CT C SPINE W/ CONTRAST
72125	CT C SPINE W/O CONTRAST
71555	MRA CHEST (EXC MYOCARDIUM) W/ OR W/O CONTRAST
71552	MRI CHEST W/ & W/O CONTRAST
71551	MRI CHEST W/ CONTRAST
71550	MRI CHEST W/O CONTRAST
71275	CT ANGIOGRAPHY CHEST, NON-CORONARY
71270	CT THORAX W/O & W/ CONTRAST
71260	CT THORAX W/ CONTRAST
71250	CT THORAX W/O CONTRAST
70555	MRI, BRAIN, FUNCTIONAL MRI; REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION OF ENTIRE NEUROFUNCTIONAL TESTING
70554	MRI, BRAIN, FUNCTIONAL MRI; INCLUDING TEST SELECTION AND ADMINISTRATION OF REPETITIVE BODY PART MOVEMENT AND/OR VISUAL STIMULATION, NOT REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION
70553	MRI HEAD W/ & W/O CONTRAST

70552	MRI HEAD W/ CONTRAST
70551	MRI HEAD W/O CONTRAST
70549	MRA NECK W/ & W/O CONTRAST
70548	MRA NECK W/ CONTRAST
70547	MRA NECK W/O CONTRAST
70546	MRA HEAD W/ & W/O CONTRAST
70545	MRA HEAD W/ CONTRAST
70544	MRA HEAD W/O CONTRAST
70543	MRI FACE, ORBIT, NECK W/ & W/O CONTRAST
70542	MRI FACE, ORBIT, NECK W/ CONTRAST
70540	MRI FACE, ORBIT, NECK W/O CONTRAST
70498	CT ANGIOGRAPHY NECK
70496	CT ANGIOGRAPHY HEAD
70492	CT SOFT TISSUE NECK W/O & W/ CONTRAST
70491	CT SOFT TISSUE NECK W/ CONTRAST

70490	CT SOFT TISSUE NECK W/O CONTRAST
70488	CT MAXLLFCL W/O & W/ CONTRAST
70487	CT MAXLLFCL W/ CONTRAST
70486	CT MAXLLFCL W/O CONTRAST
70482	CT ORBIT W/O & W/ CONTRAST
70481	CT ORBIT W/ CONTRAST
70480	CT ORBIT W/O CONTRAST
70470	CT HEAD/BRAIN W/O & W/ CONTRAST
70460	CT HEAD/BRAIN W/ CONTRAST
70450	CT HEAD/BRAIN W/O CONTRAST
70336	MRI TMJ

Deleted EmblemHealth Radiology Program Codes

The following codes may no longer be billed for services rendered in 2011 and 2012. Please reference these codes for older claims.

Deleted EmblemHealth Radiology Program Codes

Applicable to All Plans in Program Procedures That Required Prior Approval, CPT-4 List

For Reference for Claims With Dates of Service From 1/1/2011 to 12/31/2011

Please do not use for your current (2012) claims billing.

Nuclear Medicine

CPT-4 Code	Procedure Description	Note
78596	LUNG DIFFERENTIAL FUNCTION	Code deleted 1/1/12 - use 78598
78220	LIVER FUNCTION STUDY	Code deleted 1/1/12 - use new code 78226
78223	HIDA SCAN	Code deleted 1/1/12 - use new code 78227
78586	PULMONARY VENTILATION IMAGING	Code deleted 1/1/12, use 78579
78587	PULMONARY VENTILATION MULTI	Code deleted 1/1/12, use 78579
78591	VENT IMAGE 1 BREATH, 1 PROJECTION	Code deleted 1/1/12, use 78579
78593	VENT IMAGE 1 PROJECTION, GAS	Code deleted 1/1/12, use 78579
78594	VENT IMAGE MULTI PROJECTION, GAS	Code deleted 1/1/12, use 78579

78584	PULMONARY PERFUSION WITH VENT SINGLE BREATH	Code deleted 1/1/12, use 78582
78585	PULMONARY PERFUSION W/ WASHOUT OR W/O SINGLE BREATH	Code deleted 1/1/12, use 78582
78588	PULMONARY PERFUSION IMAGING, PARTICULATE, WITH VENTILATION IMAGING, AEROSOL, 1 OR MULTIPLE PROJECTIONS	Code deleted 1/1/12, use 78582

Radiology Program Prior Approval Code List For GHI HMO - RETIRED

Radiology Program Prior Approval Code List For GHI HMO - RETIRED

Effective October 1, 2012 until December 31, 2015

Radiology CPT Code	Procedure Description
70336	MRI TMJ
70450	CT HEAD/BRAIN W/O CONTRAST
70460	CT HEAD/BRAIN W/ CONTRAST
70470	CT HEAD/BRAIN W/O & W/ CONTRAST
70480	CT ORBIT W/O CONTRAST
70481	CT ORBIT W/ CONTRAST
70482	CT ORBIT W/O & W/ CONTRAST
70486	CT MAXLLFCL W/O CONTRAST
70487	CT MAXLLFCL W/ CONTRAST

70488	CT MAXLLFCL W/O & W/ CONTRAST
70490	CT SOFT TISSUE NECK W/O CONTRAST
70491	CT SOFT TISSUE NECK W/ CONTRAST
70492	CT SOFT TISSUE NECK W/O & W/ CONTRAST
70496	CT ANGIOGRAPHY HEAD
70498	CT ANGIOGRAPHY NECK
70540	MRI FACE, ORBIT, NECK W/O CONTRAST
70542	MRI FACE, ORBIT, NECK W/ CONTRAST
70543	MRI FACE, ORBIT, NECK W/ & W/O CONTRAST
70544	MRA HEAD W/O CONTRAST
70545	MRA HEAD W/ CONTRAST
70546	MRA HEAD W/ & W/O CONTRAST
70547	MRA NECK W/O CONTRAST
70548	MRA NECK W/ CONTRAST
70549	MRA NECK W/ & W/O CONTRAST

70551	MRI HEAD W/O CONTRAST
70552	MRI HEAD W/ CONTRAST
70553	MRI HEAD W/ & W/O CONTRAST
70554	MRI, BRAIN, FUNCTIONAL MRI; INCLUDING TEST SELECTION AND ADMINISTRATION OF REPETITIVE BODY PART MOVEMENT AND/OR VISUAL STIMULATION, NOT REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION
70555	MRI, BRAIN, FUNCTIONAL MRI; REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION OF ENTIRE NEUROFUNCTIONAL TESTING
71250	CT THORAX W/O CONTRAST
71260	CT THORAX W/ CONTRAST
71270	CT THORAX W/O & W/ CONTRAST
71275	CT ANGIOGRAPHY CHEST, NON-CORONARY
71550	MRI CHEST W/O CONTRAST
71551	MRI CHEST W/ CONTRAST
71552	MRI CHEST W/ & W/O CONTRAST
71555	MRA CHEST (EXC MYOCARDIUM) W/ OR W/O CONTRAST
72125	CT C SPINE W/O CONTRAST
72126	CT C SPINE W/ CONTRAST

72127	CT C SPINE W/O & W/ CONTRAST
72128	CT T SPINE W/O CONTRAST
72129	CT T SPINE W/ CONTRAST
72130	CT T SPINE W/O & W/ CONTRAST
72131	CT L SPINE W/O CONTRAST
72132	CT L SPINE W/ CONTRAST
72133	CT L SPINE W/O & W/ CONTRAST
72141	MRI CERVICAL SPINE W/O CONTRAST
72142	MRI CERVICAL SPINE W/ CONTRAST
72146	MRI THORACIC SPINE W/O CONTRAST
72147	MRI THORACIC SPINE W/ CONTRAST
72148	MRI LUMBAR SPINE W/O CONTRAST
72149	MRI LUMBAR SPINE W/ CONTRAST
72156	MRI C SPINE W/ & W/O CONTRAST
72157	MRI T SPINE W/ & W/O CONTRAST

72158	MRI L SPINE W/ & W/O CONTRAST
72159	MRA SPINAL CANAL W/ OR W/O CONTRAST
72191	CT ANGIOGRAPHY PELVIS
72192	CT PELVIS W/O CONTRAST
72193	CT PELVIS W/ CONTRAST
72194	CT PELVIS W/O & W/ CONTRAST
72195	MRI PELVIS W/O CONTRAST
72196	MRI PELVIS W/ CONTRAST
72197	MRI PELVIS W/ & W/O CONTRAST
72198	MRA PELVIS W/ OR W/O CONTRAST
73200	CT UPPER EXTREMITY W/O CONTRAST
73201	CT UPPER EXTREMITY W/ CONTRAST
73202	CT UPPER EXTREMITY W/O & W/ CONTRAST
73206	CT ANGIOGRAPHY UPPER EXTREMITY
73218	MRI UPPER EXTREMITY W/O CONTRAST

73219	MRI UPPER EXTREMITY W/ CONTRAST
73220	MRI UPPER EXTREMITY W/ & W/O CONTRAST
73221	MRI UPPER EXTREMITY JOINT W/O CONTRAST
73222	MRI UPPER EXTREMITY JOINT W/ CONTRAST
73223	MRI UPPER EXTREMITY JOINT W/ & W/O CONTRAST
73225	MRA UPPER EXTREMITY W/ OR W/O CONTRAST
73700	CT LOWER EXTREMITY W/O CONTRAST
73701	CT LOWER EXTREMITY W/ CONTRAST
73702	CT LOWER EXTREMITY W/O & W/ CONTRAST
73706	CT ANGIOGRAPHY LOWER EXTREMITY
73718	MRI LOWER EXTREMITY W/O CONTRAST
73719	MRI LOWER EXTREMITY W/ CONTRAST
73720	MRI LOWER EXTREMITY W/ & W/O CONTRAST
73721	MRI LOWER EXTREMITY JOINT W/O CONTRAST
73722	MRI LOWER EXTREMITY JOINT W/ CONTRAST

73723	MRI LOWER EXTREMITY JOINT W/ & W/O CONTRAST
73725	MRA LOWER EXTREMITY W/ OR W/O CONTRAST
74150	CT ABDOMEN W/O CONTRAST
74160	CT ABDOMEN W/ CONTRAST
74170	CT ABDOMEN W/O & W/ CONTRAST
74174	CT ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING
74175	CT ANGIOGRAPHY ABDOMEN
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL
74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL(S)
74178	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS IN ONE OR BOTH BODY REGIONS
74181	MRI ABDOMEN W/O CONTRAST
74182	MRI ABDOMEN W/ CONTRAST
74183	MRI ABDOMEN W/ & W/O CONTRAST
74185	MRA ABDOMEN W/ OR W/O CONTRAST

74261	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITHOUT CONTRAST MATERIAL
74262	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITH CONTRAST MATERIAL(S) INCLUDING NON-CONTRAST IMAGES, IF PERFORMED
74263	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, SCREENING, INCLUDING IMAGE POSTPROCESSING
75557	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL
75559	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH STRESS IMAGING
75561	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES
75563	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; WITH STRESS IMAGING
75572	CARDIAC CT FOR MORPHOLOGY
75573	CARDIAC CT FOR CONGENITAL HD
75574	CORONARY CTA
75635	CT ANGIOGRAPHY ABDOMINAL AORTA
76376	3D RENDERING WITH INTERPRETATION AND REPORTING OF COMPUTED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, ULTRASOUND OR OTHER TOMOGRAPHIC MODALITY; NOT REQUIRING IMAGE POSTPROCESSING ON AN INDEPENDENT WORKSTATION

76377	3D RENDERING WITH INTERPRETATION AND REPORTING OF COMPUTED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, ULTRASOUND OR OTHER TOMOGRAPHIC MODALITY; REQUIRING IMAGE POSTPROCESSING ON AN INDEPENDENT WORKSTATION
76380	CT LIMITED OR LOCALIZED FOLLOW-UP STUDY
76390	MRI SPECTROSCOPY
76801	U/S OB PELVIS, PREGNANT UTERUS, FIRST TRIMESTER <14 WEEKS SINGLE OR FIRST GESTATION
76802	U/S OB PELVIS, PREGNANT UTERUS, FIRST TRIMESTER <14 WEEKS EACH ADDITIONAL GESTATION
76805	U/S OB PELVIS, PREGNANT UTERUS, B-SCAN (Allowed once per gestation)
76810	U/S OB PELVIS COMPLETE, MULTIPLE GESTATION AFTER 1ST TRIMESTER (Allowed once for each additional fetus per gestation; must be billed with 76805)
76811	U/S PREGNANT UTERUS FETAL & MATERNAL EVAL PLUS FETAL ANATOMIC EVAL TRANSABDOMINAL SINGLE OR FIRST GESTATION (Allowed once per gestation; second study allowed if performed by a different physician)
76812	U/S PREGNANT UTERUS FETAL & MATERNAL EVAL PLUS FETAL ANATOMIC EVAL TRANSABDOMINAL EACH ADDITIONAL GESTATION (Allowed once for each additional fetus per gestation; must be billed with 76811; second study allowed if performed by a different physician)
76813	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FIRST TRIMESTER FETAL NUCHAL TRANSLUCENCY MEASUREMENT, TRANSABDOMINAL OR TRANSVAGINAL APPROACH; SINGLE OR FIRST GESTATION (Allowed once per gestation)
76814	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FIRST TRIMESTER FETAL NUCHAL TRANSLUCENCY MEASUREMENT, TRANSABDOMINAL OR TRANSVAGINAL APPROACH; EACH ADDITIONAL GESTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) (Allowed once for each additional fetus per gestation)
76815	U/S PREGNANT UTERUS, REAL TIME W/ IMAGE DOCUMENTATION, LIMITED (E.G., FETAL HEART BEAT, PLACENTAL LOCATION, FETAL POSITION AND/OR QUALITATIVE AMNIOTIC FLUID VOLUME), 1 OR MORE FETUSES

76816	U/S OB PELVIS FOLLOW-UP OR REPEAT
76817	U/S PREGNANT UTERUS TRANSVAGINAL
76818	FETAL BIOPHYSICAL PROFILE
76819	FETAL BIOPHYSICAL PROFILE W/O STRESS NON STRESS
76820	DOPPLER VELOCIMETRY, FETAL; UMBILICAL ARTERY
76821	DOPPLER VELOCIMETRY, FETAL; MIDDLE CEREBRAL ARTERY
76825	U/S OB ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM
76826	FOLLOW-UP OR REPEAT STUDY
76827	DOPPLER ECHOCARDIOGRAPHY FETAL COMPLETE
76828	FOLLOW-UP OR REPEAT STUDY
77021	MRI GUIDANCE FOR NEEDLE PLACEMENT
77058	MRI BREAST W/ AND/OR W/O CONTRAST; UNILATERAL
77059	MRI BREAST BILATERAL
77084	MRI BONE MARROW BLOOD SUPPLY
78000	THYROID RAI UPTAKE

78001	THYROID MULTIPLE UPTAKE
78003	THYROID SUPPRESS OR STIMULATION
78006	THYROID UPTAKE AND SCAN
78007	THYROID IMAGE, MULTIPLE UPTAKES
78010	THYROID SCAN ONLY
78011	THYROID IMAGING W/ FLOW
78015	THYROID MET IMAGING
78016	THYROID MET IMAGING WITH ADDITIONAL STUDIES
78018	THYROID SCAN WHOLE BODY
78020	THYROID CARCINOMA METASTASES UPTAKE (add on code - use w/ code 78018 only)
78070	PARATHYROID NUCLEAR IMAGING
78075	ADRENAL NUCLEAR IMAGING
78102	BONE MARROW IMAGING, LIMITED
78103	BONE MARROW IMAGING, MULTIPLE
78104	BONE MARROW IMAGING, WHOLE BODY

78140	LABELED RED CELL SEQUESTRATION
78185	SPLEEN IMAGING W/ OR W/O VASCULAR FLOW
78190	PLATELET SURVIVAL, KINETICS
78191	PLATELET SURVIVAL
78195	LYMPH SYSTEM IMAGING
78201	LIVER IMAGING
78202	LIVER IMAGING W/ FLOW
78205	LIVER IMAGING SPECT
78206	LIVER IMAGING SPECT W/ VASCULAR FLOW
78215	LIVER AND SPLEEN IMAGING
78216	LIVER AND SPLEEN IMAGING W/ FLOW
78220	LIVER FUNCTION STUDY
78223	HIDA SCAN
78226	LIVER FUNCTION STUDY
78227	HIDA SCAN

78230	SALIVARY GLAND IMAGING
78231	SERIAL SALIVARY GLAND
78232	SALIVARY GLAND FUNCTION TEST
78258	ESOPHAGUS MOTILITY STUDY
78261	GASTRIC MUCOSA IMAGING
78262	GASTROESOPHAGEAL REFLUX EXAM
78264	GASTRIC EMPTYING STUDY
78278	GI BLEEDER SCAN
78282	GI PROTEIN LOSS EXAM
78290	MECKEL'S DIVERTICULUM IMAGING
78291	LEVEEN SHUNT PATENCY EXAM
78300	BONE OR JOINT IMAGING LTD
78305	BONE OR JOINT IMAGING MULTIPLE
78306	BONE SCAN WHOLE BODY
78315	BONE AND/OR JOINT IMAGING; 3 PHASE STUDY

78320	BONE JOINT IMAGING TOMO TEST SPECT
78414	NON-IMAGING HEART FUNCTION
78428	CARDIAC SHUNT IMAGING
78445	RADIONUCLIDE VENOGRAM NON-CARDIAC
78451	MPI, SPECT, SINGLE REST OR STRESS
78452	MPI, SPECT, MULTIPLE, REST OR STRESS
78453	MPI, PLANAR, SINGLE REST OR STRESS
78454	MPI, PLANAR, MULTIPLE, REST OR STRESS
78456	ACUTE VENOUS THROMBOSIS IMAGING
78457	VENOUS THROMBOSIS IMAGING UNILATERAL
78458	VENOUS THROMBOSIS IMAGING BILATERAL
78459	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) METABOLIC EVAL
78466	MYOCARDIAL INFARCTION SCAN
78468	HEART INFARCT IMAGE EF
78469	HEART INFARCT IMAGE SPECT

78472	GATED HEART, REST OR STRESS
78473	CARDIAC BLOOD POOL MUGA SCAN
78481	HEART FIRST PASS SINGLE
78483	CARDIAC BLOOD POOL IMAGING, MULTI
78491	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION; SINGLE STUDY AT REST OR STRESS
78492	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION; MULTIPLE STUDIES AT REST OR STRESS
78494	CARDIAC BLOOD POOL IMAGING, SPECT
78496	CARDIAC BLOOD POOL IMAGING, SINGLE AT REST (Use with 78472)
78579	PULMONARY VENTILATION IMAGING (E.G., AEROSOL OR GAS)
78582	PULMONARY VENTILATION (E.G., AEROSOL OR GAS) AND PERFUSION IMAGING
78597	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION, INCLUDING IMAGING WHEN PERFORMED
78598	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION AND VENTILATION (E.G., AEROSOL OR GAS), INCLUDING IMAGING WHEN PERFORMED
78600	BRAIN IMAGING LTD STATIC
78601	BRAIN LTD IMAGING AND FLOW

78605	BRAIN IMAGING COMPLETE
78606	BRAIN IMAGING COMPLETE W/ FLOW
78607	BRAIN IMAGING SPECT
78608	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC EVALUATION
78609	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION EVALUATION
78610	BRAIN FLOW IMAGING ONLY
78630	CISTERNOGRAM (Cerebrospinal fluid flow)
78635	CEREBROSPINAL VENTRICULOGRAPHY
78645	CSF SHUNT EVALUATION
78647	CEREBROSPINAL FLUID SCAN SPECT
78650	CSF LEAKAGE DETECTION AND LOCALIZATION
78660	RADIOPHARMACEUTICAL DACRYOCYSTORGRAPHY
78700	KIDNEY IMAGING MORPHOLOGY
78701	KIDNEY IMAGING MORPHOLOGY W/ VASCULAR FLOW
78707	KIDNEY IMAGING MORPHOLOGY W/ VASCULAR FLOW AND FUNCTION STUDY

78708	KIDNEY IMAGING MORPHOLOGY W/ VASCULAR FLOW AND FUNCTION, SINGLE W/ PHARM INTERVENTION
78709	KIDNEY IMAGING MORPHOLOGY W/ VASCULAR FLOW, MULTI, W/O AND W/ PHARM INTERVENTION
78710	KIDNEY IMAGING, SPECT
78725	KIDNEY FUNCTION STUDY, NON-IMAGE RADIOISOTROPIC
78730	URINARY BLADDER RESIDUAL STUDY
78740	URETERAL REFLUX STUDY
78761	TESTICULAR IMAGING W/ VASCULAR FLOW
78800	RADIOPHARM LOCALIZATION OF TUMOR, LIMITED AREA
78801	RADIOPHARM LOCALIZATION OF TUMOR, MULTI AREAS
78802	RADIOPHARM LOCALIZATION OF TUMOR, WHOLE BODY
78803	RADIOPHARM LOCALIZATION OF TUMOR, SPECT
78804	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR OR DISTRIBUTION OF RADIOPHARMACEUTICAL AGENT(S); WHOLE BODY, REQUIRING 2 OR MORE DAYS IMAGING
78805	RADIOPHARM LOCALIZATION OF ABSCESS, LIMITED AREA
78806	RADIOPHARM LOCALIZATION OF ABSCESS, WHOLE BODY
78807	RADIOPHARM LOCALIZATION OF ABSCESS, SPECT

78811	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; LIMITED AREA (E.G., CHEST, HEAD/NECK)
78812	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; SKULL BASE TO MID-THIGH
78813	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; WHOLE BODY
78814	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; LIMITED AREA (E.G., CHEST, HEAD/NECK)
78815	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; SKULL BASE TO MID-THIGH
78816	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTER TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; WHOLE BODY
0174T	COMPUTER-AIDED DETECTION (CAD) INCLUDING COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION, WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION AND REPORT, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S) PERFORMED CONCURRENT WITH PRIMARY INTERPRETATION
0175T	COMPUTER-AIDED DETECTION (CAD), INCLUDING COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION, WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION AND REPORT, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S) PERFORMED REMOTE FROM PRIMARY INTERPRETATION
C8900	MRA WITH CONTRAST, ABDOMEN (crosswalked to 74185)
C8901	MRA WITHOUT CONTRAST, ABDOMEN (crosswalked to 74185)
C8902	MRA WITH AND WITHOUT CONTRAST, ABDOMEN (crosswalked to 74185)
C8903	MRI WITH CONTRAST, BREAST; UNILATERAL (crosswalked to 77058)

C8904	MRI WITHOUT CONTRAST, BREAST; UNILATERAL (crosswalked to 77058)
C8905	MRI WITH AND WITHOUT CONTRAST, BREAST; UNILATERAL (crosswalked to 77058)
C8906	MRI WITH CONTRAST, BREAST; BILATERAL (crosswalked to 77059)
C8907	MRI WITHOUT CONTRAST, BREAST; BILATERAL (crosswalked to 77059)
C8908	MRI WITH AND WITHOUT CONTRAST, BREAST; BILATERAL (crosswalked to 77059)
C8909	MRA WITH CONTRAST, CHEST (EXCLUDING MYOCARDIUM) (crosswalked to 71555)
C8910	MRA WITHOUT CONTRAST, CHEST (EXCLUDING MYOCARDIUM) (crosswalked to 71555)
C8911	MRA WITH AND WITHOUT CONTRAST, CHEST (EXCLUDING MYOCARDIUM) (crosswalked to 71555)
C8912	MRA WITH CONTRAST, LOWER EXTREMITY (crosswalked to 73725)
C8913	MRA WITHOUT CONTRAST, LOWER EXTREMITY (crosswalked to 73725)
C8914	MRA WITH AND WITHOUT CONTRAST, LOWER EXTREMITY (crosswalked to 73725)
C8918	MRA WITH CONTRAST, PELVIS (crosswalked to 72198)
C8919	MRA WITHOUT CONTRAST, PELVIS (crosswalked to 72198)
C8920	MRA WITH AND WITHOUT CONTRAST, PELVIS (crosswalked to 72198)
C8931	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, SPINAL CANAL AND CONTENTS (crosswalked to 72159)

C8932	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, SPINAL CANAL AND CONTENTS (crosswalked to 72159)
C8933	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, SPINAL CANAL AND CONTENTS (crosswalked to 72159)
C8934	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, UPPER EXTREMITY (crosswalked to 73225)
C8935	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, UPPER EXTREMITY (crosswalked to 73225)
C8936	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, UPPER EXTREMITY (crosswalked to 73225)

Formal Dispute Resolution

Please submit to EmblemHealth:

Appeals for Medicare members. Please follow EmblemHealth's standard processes for Medicare members, described in the Dispute Resolution Medicare chapter.

Complaints and grievances. Please refer to the Dispute Resolution chapters for Commercial/CHP and Medicaid/HARP, as applicable.

Please submit to eviCore:

Expedited and standard clinical appeals for Commercial/CHP members and expedited and standard action appeals for Medicaid/HARP members. Appeals may be filed by the member, the member's delegate (including the practitioner acting as the member's delegate) or by practitioners on their own behalf. For a full description of member and practitioner rights regarding clinical and action appeals, see the Dispute Resolution chapters for Commercial/CHP and Medicaid/HARP, as applicable.

GHI HMO, HIP and Vytra Radiology Scheduling Procedure

Plan Participation

Members with HIP as their managing entity (see the member's ID card or eligibility information on emblemhealth.com follow the Radiology Scheduling Procedure.

Scheduling Procedure

When a prior approval request is made, utilization review staff evaluates the requested procedure against the existing criteria and determines its medical necessity.

If the prior approval request is approved, a scheduling representative contacts the member to schedule the procedure at a participating location. Once the location is selected, the medical necessity determination is amended to include an authorization number.

Program staff attempts to contact the member for a 48-hour period. If at the end of that period the scheduling representative is unable to speak with the member, they select a participating imaging facility close to the member's home and send a letter to both the member and the referring practitioner with the contact information for the site selected.

Members may contact the scheduling department at 1-866-699-8131, Monday through Friday, from 7 am to 7 pm, EST, to schedule a procedure or change the procedure site before the appointment date.

Vytra Plans Radiology Program for Dates of Service Prior to January 1, 2016

Overview

Vytra HMO contracted with various groups to provide radiology services for its members. All participating Vytra PCPs designated a radiology center that their Vytra patients used exclusively. The designated radiology center appeared on the ID card of each Vytra member on the PCP's panel.

Designated Radiology Centers

For radiology services to be covered, Vytra plan members used the designated radiology center specified on their Vytra ID card. If no radiology center appeared on the ID card, the member was able to go to any Vytra network radiologist. Participating practitioners sent members directly, without a referral, to the designated radiologist by writing a prescription detailing the test required.

PCPs with more than one office location were able to select a different radiology center for each of their offices.

In the rare instance that the designated radiology center could not meet the member's needs, the practitioner contacted Vytra's Care Management department at 1-888-288-9872 for prior approval to send the member to another facility.

Guarantee Waiver Agreement for Radiology Groups

Radiology centers treating a member outside their designation called Vytra's Provider Service Line at 1-888-288-9872before rendering services. During this call, the center ensured prior approval was secured and use Vytra's Guarantee Waiver Agreement.

Each member seeking service outside their designated facility signed Vytra's Guarantee Waiver Agreement. This was

the only waiver recognized by Vytra. At time of signing, members were advised that they would be responsible for payment of all services performed. Practitioners had the right to withhold service to any member who chose not to sign this waiver.

If the radiology facility rendered services without having a signed waiver, the member was reimbursed for any up-front payment and could not be balance billed. Vytra reserves the right to withhold future payment to the facility until the member was reimbursed.

Changing Designated Radiology Groups

PCPs were able to change their designated radiologist under the following circumstances:

- PCP requested a change and Vytra's Provider Relations department deemed the change to be in the best interest of the PCP's patients (e.g., quality of care related, PCP location change)
- A corporate decision allowed all PCPs to change their designated radiologist
- Administrative purposes (e.g., correction of database)

Quality Issues

All quality-related issues had to be reported to Vytra at 1-888-288-9877 promptly for immediate resolution.

Copies of X-Rays

Copies of X-rays were not reimbursed unless the member received a second opinion for a cancer diagnosis and the practitioner received proper approval. Eligible copies were reimbursed at the then current fee schedule.

Radiation Therapy

Radiation therapy required the hematologist/oncologist to obtain prior approval.

If appropriate, a Care Management representative authorized an initial series of three visits for radiation therapy. Upon completing the initial evaluation, the radiation oncologist contacted Vytra's Care Management department with the findings.

The radiologist then forwarded a copy of the proposed treatment plan to the referring hematologist/oncologist. Specialists were required to communicate with the member's PCP regarding all treatment and follow-up care provided.

DEXA Scans

Vytra reimbursed only radiologists for dual energy X-ray absorptiometry (DEXA) scans. PCPs and specialists other than radiologists were not reimbursed for DEXA scans, regardless of any prior arrangements with or payments from Vytra.

If the member's designated radiologist did not perform DEXAs, the referring physician called Vytra's Care Management department to authorize services at another network radiologist.

EmblemHealth

Provider Manual

Chapter 20: Radiology Privileging

In this chapter you will find radiology privileging protocols to improve quality of care and make imaging services available when rendered by physicians other than radiologists.

Radiology Privileging Program Overview

There are many clinical reasons physicians other than radiologists must perform in-office imaging as part of their diagnostic and treatment plans. We have radiology privileging protocols to make imaging services available when rendered by physicians other than radiologists.

This chapter includes the lists of procedures and associated CPT-4 codes that network physicians other than radiologists can perform for specific benefit plans based on their specialty and network participation.

This program applies to members with the following benefit plans and to practitioners who service these members:

- EmblemHealth EPO/PPO
- GHI
- Vytra

Note: GHI HMO members and practitioners are not eligible for this program. Protocols for HIP, EmblemHealth CompreHealth EPO and EmblemHealth Medicare HMO appear in the HIP Outpatient Diagnostic Imaging Self-Referral Payment Policy chapter.

For physicians to perform radiological procedures within their specialty, they must have the appropriate certifications or accreditations, as noted in the Radiology Privileging by Specialty charts in this chapter. Certain procedures require prior approval. When radiological procedures are performed outside the physician's specialty or when appropriate prior approval is not obtained, claims for such services will be denied, with no liability to the member.

The charts below detail the inpatient, outpatient and office-based radiology services for which reimbursement will be made when performed by physicians other than radiologists.

- GHI and EmblemHealth EPO/PPO Practitioners
- Vytra Practitioners

GHI and EmblemHealth EPO/PPO Radiology Privileging By Specialty

PHYSICIAN TYPE	CPT-4 CODE	CPT-4 DESCRIPTION
Primary Care Physicians (includes Internal Medicine, Family Practice, General Practice MD, General Practice DO, Geriatrics, Preventive Medicine, Screening Center)	71010-71023	Chest Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	74000-74022	Abdomen Imaging
Allergists	74000-74022	Abdomen Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
Chiropractors	72010, 72040, 72069, 72070, 72080, 72100	Spine Imaging
Dermatologists	77401	Radiation Treatment Delivery
Emergency Medicine	74000-74022	Abdomen Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	77080, 77081	DEXA Studies, Bone Densitometry

Endocrinologists	76942	Ultrasonic Guidance
	76536	Thyroid Ultrasound
	71010-71023	Chest Imaging
	74000-74022	Abdomen Imaging
Gastroenterologists	76975	Endoscopic Ultrasound
	71010-71023	Chest Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	74000-74022	Abdomen Imaging
Gynecological Oncology	71010-71023	Chest Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	74000-74022	Abdomen Imaging
	77057	Screening Mammography
	77014	CT Guidance
	76830, 76856, 76857	Nonobstetrical Ultrasounds, Pelvis
	76873	Ultrasound, Transrectal

	76930, 76941, 76945, 76946, 76950	Ultrasonic Guidance
	71010-71023	Chest Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	74000-74022	Abdomen Imaging
Gynecology	77057	Screening Mammography
	77014	CT Guidance
	76830, 76856, 76857	Non-Obstetrical Ultrasounds, Pelvis
	76930, 76941, 76945, 76946	Ultrasonic Guidance
	73090-73140	Upper Extremity Imaging
	76000-76010	Fluoroscopy
Hand Surgeons	77073	Bone Length Study
	77077	Joint Survey
	77080, 77081	DEXA Studies, Bone Densitometry
	71010-71023	Chest Imaging

Hematology	77080, 77081	DEXA Studies, Bone Densitometry
	74000-74022	Abdomen Imaging
Infectious Disease	71010-71023	Chest Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	74000-74022	Abdomen Imaging
Neonatology/Perinatology	71010-71023	Chest Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	74000-74022	Abdomen Imaging
	76506, 76511-76529	Echoencephalography
	76604, 76645	Chest Ultrasound
	76801-76812, 76815-76819, 76825-76828	Obstetrical Ultrasounds, Pelvis
	76830-76857	Nonobstetrical Ultrasounds, Pelvis
	76930-76946	Ultrasonic Guidance
	71010-71023	Chest Imaging

Nephrology	77080, 77081	DEXA Studies, Bone Densitometry
	74000-74022	Abdomen Imaging
	76770, 76775	Retroperitoneal Ultrasound
	71010-71030	Chest Imaging
Neurology	74000-74022	Abdomen Imaging
	70010-70553, 70557-70559	Head/Neck Imaging
	72010-72120	Spine Imaging
	71010-71023	Chest Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	74000-74022	Abdomen Imaging
Obstetrics and Gynecology	77057	Screening Mammography
	76801-76812, 76815-76819, 76825-76828	Obstetrical Ultrasounds, Pelvis
	76830, 76856, 76857	Nonobstetrical Ultrasounds, Pelvis
	76930, 76941, 76945, 76946	Ultrasonic Guidance

Oncology	71010-71023	Chest Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	74000-74022	Abdomen Imaging
	77014	CT Guidance
	76873	Ultrasound, Transrectal
	76950	Ultrasonic Guidance
Ophthalmologists and Optometrists	77014	CT Guidance
	76506, 76511-76529	Ophthalmic Ultrasound
Oral Surgeons	70100, 70110, 70140, 70150	Mandible/Facial Bone Imaging
	70300, 70310, 70320	Teeth Imaging
	70350	Cephalogram
	70355	Orthopantogram
Otolaryngologists	70010, 70015, 70030-70220, 70140, 70250-70320, 70332, 70336*, 70350, 70355, 70360, 70370, 70371, 70373, 70380, 70390, 70496*	Head/Neck Imaging
Pediatrics	71010-71023	Chest Imaging

Perinatology	74000-74022	Abdomen Imaging
	74000-74022	Abdomen Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	77057	Screening Mammography
	76604, 76645	Chest Ultrasound
	76801-76812, 76815-76819, 76825-76828	Obstetrical Ultrasounds, Pelvis
	76830, 76831, 76856, 76857	Nonobstetrical Ultrasounds, Pelvis
	76930, 76932, 76936, 76937, 76940, 76941, 76945, 76946	Ultrasonic Guidance
Physical Medicine and Rehabilitation	70360-70390	Head/Neck Imaging
	72010-72120, 72170, 72190, 72200-72220	Spine/Pelvis Imaging
	73000-73140	Upper Extremities Imaging
	73500-73660	Lower Extremities Imaging
	74000-74022	Abdomen Imaging
Podiatrists, Podiatric Surgeons, Podiatric Orthopedists	73600, 73610, 73620, 73630, 73650, 73660	Lower Extremities Imaging

Pulmonologists	71010-71023	Chest Imaging
	74000-74022	Abdomen Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	76700-76775	Ultrasound Abdomen/Retroperitoneum
Reproductive Endocrinologists	71010-71023	Chest Imaging
	74000-74022	Abdomen Imaging
	77080, 77081	DEXA Studies, Bone Densitometry
	76801-76812, 76818, 76819, 76825-76828	Obstetrical Ultrasounds, Pelvis
	76830-76857	Nonobstetrical Ultrasounds, Pelvis
	76930-76941, 76945-76948	Ultrasonic Guidance
Rheumatologists	71010-71030	Chest Imaging
	72010-72120, 72170, 72190, 72200-72285, 72291	Spine/Pelvis Imaging
	73000-73140	Upper Extremities Imaging
	73500-73660	Lower Extremities Imaging

	74000-74022	Abdomen Imaging
	76000, 76001, 76010, 77002, 77003	Fluoroscopic Guidance
	77071, 77072, 77073	Bone/Joint Studies
	77077	Joint Survey
	74000-74022	Abdomen Imaging
	74400, 74425, 74430, 74450, 74455	Ultrasound, Urinary Tract
Urologists	76000	Fluoroscopy
	76870, 76872, 76873	Ultrasound Genitalia
	76942	Ultrasonic Guidance

*These procedures require prior approval.

Vytra Radiology Privileging By Specialty

PHYSICIAN TYPE	CPT-4 CODE	CPT-4 DESCRIPTION
Cardiology	78414-78499	Cardiac Nuclear Medicine Studies
General Surgery	76942	Echo Guide for Biopsy
	76942	Ultrasonic Guidance

Gynecology	76830	Transvaginal Ultrasound
	76998	Ultrasonic Guidance
	74740	Hysterosalpingography
Hand Surgery (practitioner must be certified in Hand Surgery by the American Board of Medical Specialties)	Those radiology procedures within the scope of the specialty area	
Obstetrics and Gynecology	76805-76831	Pregnancy-Related Sonograms
	76856	Pelvic Ultrasound, Nonobstetrical
	76941-76946	Needle Guidance Sonograms Used for Amniocentesis
	76998	Ultrasonic Guidance
Oncology	71010, 71020	Chest X-rays
Orthopedics	Those radiology procedures within the scope of the specialty area	
Pulmonology	71010, 71020	Chest X-rays
Rheumatology	Those radiology procedures within the scope of the specialty area	
Urology	76942, 76872, 76950, 77778, 78730	Ultrasound Guidance for Needle Biopsy

Vytra reviews this list on an ongoing basis and revises it as appropriate.

EmblemHealth

2015 HIP Outpatient Diagnostic Imaging Self-Referral Payment Policy

This policy now also applies to GHI PPO members with a member identification number beginning with the letter K.

2015 HIP Outpatient Diagnostic Imaging Self-Referral Payment Policy Effective January 1, 2015			
Provider Specialty	CPT Codes	Description	Accreditation Requirement(s)
Primary Care Physicians (includes Internal Medicine, Family Practice)	71010 -71030	Chest imaging	No additional requirements
	77080, 77081, 77085[3]	DEXA studies, bone densitometry	
	93303[1], 93304[1], 93306[1]-93308[1]	Transthoracic echocardiography	1. National Board of Echocardiography (NBE) certification 2. Laboratories accredited by the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (IAC Echocardiography) [3]
	93350[1], 93351[1]	Doppler echocardiography, add on codes	
Cardiologists (includes Cardiovascular Disease, Interventional Cardiologists, Cardiac Electrophysiologists)	71010 - 71030	Chest imaging	No additional requirements
	76930	Ultrasonic guidance for pericardiocentesis	
	76932	Ultrasonic guidance for endomyocardial biopsy	
	93303[1], 93304[1], 93306[1]–93308[1]	Transthoracic echocardiography	1. Cardiology certification by the American Board of Internal Medicine (ABIM) or American Osteopathic Board of Internal Medicine(AOBIM) 2. Laboratories accredited by the Intersocietal Commission for the Accreditation of Echocardiography
	93320, 93321, 93325	Doppler echocardiography, add on codes	

	93350[1], 93351[1]	Stress echocardiography	Laboratories (IAC Echocardiography) [3]
Cardiologists, Nuclear	78451[1], 78452[1], 78453[1], 78454[1]	Myocardial perfusion imaging	1. Certification by the American Board of Radiology (ABR), American Board of Nuclear Medicine(ABNM) or Certification Board of Nuclear Cardiology (CBNC) 2. Laboratories accredited by the Intersocietal Commission for the Accreditation of Nuclear Laboratories (IAC Nuclear/PET)[3] or American College of Radiology (ACR)
	78466[1], 78468[1], 78469[1]	Myocardial infarction scans	
	78472[1], 78473[1], 78481[1], 78483[1], 78494[1]	Cardiac blood pool imaging	
	76930	Ultrasonic guidance for pericardiocentesis	
	76932	Ultrasonic guidance for endomyocardial biopsy	
Pediatric Cardiologists	76825[2] - 76828[2]	Echocardiography, fetal	1. Certification in pediatric cardiology by the American Board of Pediatrics 2. Laboratories accredited by the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (IAC Echocardiography) [3]
	71555[1]	MRA chest	
	75557[1] - 75563[1]	Cardiac MRI	
	71010 - 71030	Chest imaging	
	76930	Ultrasonic guidance for pericardiocentesis	
	76932	Ultrasonic guidance for endomyocardial biopsy	
	93303[1], 93304[1], 93306[1] to 93308[1]	Stress echocardiography	
	93350[1] , 93351	Transesophageal echocardiography	
	93320, 93321, 93325	Doppler echocardiography, add on codes	
Chiropractors	72010, 72040, 72069, 72070, 72080, 72100	Spine imaging	No additional requirements
Colon and Rectal Surgeons	76872	Ultrasound, transrectal	Must be board certified by the American Board of Colon and Rectal Surgery(ABCRS) to perform this ultrasound
	76942	Ultrasonic guidance for biopsy only	

Endocrinologists	77080,77081, 77085[3]	DEXA studies, bone densitometry	No additional requirements
	76536	Thyroid ultrasound	Endocrine Certification in Neck Ultrasound (ECNU) from the American Association of Clinical Endocrinologist (AACE) [5] Effective 1/1/16: American Institute of Ultrasound in Medicine(AIUM) accreditation in thyroid/ parathyroid ultrasound
	76942	Ultrasonic guidance for biopsy	
Gastroenterologists	76975	Endoscopic ultrasound	No additional requirements
General Surgeons	75962	Transluminal balloon angioplasty	No additional requirements
Breast Surgeons	76942	Ultrasonic guidance for biopsy	[4] Effective 9/1/15: For breast ultrasound and ultrasound guided breast biopsy: Physicians must be certified in breast ultrasound by the American Society of Breast Surgeons(ASBS) and: Facilities must have accreditation from the ASBS for breast ultrasound and ultrasound guided breast biopsy; or Accredited by the Am. College of Radiology in breast ultrasound and ultrasound guided biopsy; or Accredited by AIUM in interventional breast ultrasound
	76641[3]	Breast ultrasound, complete	
	76642[3]	Breast ultrasound, limited	
Geriatricians	71010 - 71030	Chest imaging	No additional requirements
	93303[1], 93304[1], 93306[1] to 93308[1]	Transthoracic echocardiography	Non-cardiologists: 1. National Board of Echocardiography (NBE) certification 2. Laboratories accredited by the Intersocietal Commission for the Accreditation of

	93320, 93321, 93325	Doppler echocardiography, add on codes	Echocardiography Laboratories (IAC Echocardiography) [3]
Hand Surgeons	76000	Fluoroscopy	No additional requirements
	73100 - 73140	Upper extremity imaging	
Head and Neck Surgeons (includes ENT, Otolaryngologists)	76942, 76536	Ultrasonic guidance for biopsy only	No additional requirements [5] Effective 9/1/15: AIUM accreditation in head and neck ultrasound
Hematologist/Oncologists Medical Oncologists Oncologists	71010 - 71030	Chest imaging	No additional requirements
Maternal and Fetal Medicine	77052	Computer-aided detection of radiographic images	Must be fully compliant with Mammography Quality Standards Act(MQSA) requirements to perform screening mammography
	77057, G0202	Screening mammography	
	77063[3]	Screening tomosynthesis	
	74740	Hysterosalpingography	No additional requirements
	77080, 77081, 77085[3]	DEXA studies, bone densitometry	
	76815[2], 76816[2], 76817[2], 76820[2], 76821[2], 76830 – 76857, 76930, 76941, 76942, 76945, 76946, 76948	Ultrasound: obstetrical, pelvic, guidance	
	76801[2], 76802[2], 76805[2], 76810[2], 76811[2], 76812[2], 76813[2], 76814[2], 76818[2], 76819[2], 76820[2], 76821[2], 76825[2], 76826[2], 76827[2], 76828[2]	Ultrasound: obstetrical/pelvic guidance	AIUM/ACR Accreditation
	76970	Ultrasound study, follow-up	

	93325	Doppler echocardiography, add on	
Nephrologists	75791	Angiography arteriovenous shunt, radiological supervision and interpretation	No additional requirements
	75978	Venous angioplasty, radiological supervision and interpretation	
	77021	MR guidance for needle placement	
	77012	CT scan for needle biopsy	
	77002	Needle localization by x-ray	
	76942	Ultrasonic guidance for biopsy	
	75962[3]	Transluminal balloon angioplasty	

Nuclear Medicine	78012[1], 78013[1], 78014[1], 78015[1], 78016[1], 78018[1], 78020[1], 78070[1], 78071[1], 78072[1], 78075[1], 78102[1], 78103[1], 78104[1], 78110, 78111, 78120, 78121, 78122, 78130, 78135, 78140, 78185[1], 78190, 78191, 78195[1], 78201[1], 78202[1], 78205[1], 78206[1], 78215[1], 78216[1], 78226[1], 78227[1], 78230[1], 78231[1], 78232[1], 78258[1], 78261[1], 78262[1], 78264[1], 78270, 78271, 78272, 78278[1], 78282[1], 78290[1], 78291[1], 78300[1], 78305[1], 78306[1], 78315[1], 78320[1], 78579[1], 78580[1], 78582 [1], 78597[1],78598[1], 78600[1], 78601[1], 78605[1], 78606[1], 78607[1], 78610[1], 78630[1], 78635[1], 78645[1], 78647[1], 78650[1], 78660[1], 78700[1], 78701[1], 78707[1], 78708[1], 78709[1], 78710[1], 78725[1], 78730[1], 78740[1], 78761[1], 78800[1], 78801[1], 78802[1], 78803[1], 78804[1], 78805[1], 78806[1], 78807[1], 78808, 78811[1], 78812[1], 78813[1], 78814[1], 78815[1], 78816[1]	Nuclear medicine studies	Physicians certified by the American Board of Radiology (ABR) or the American Board of Nuclear Medicine (ABNM)
Obstetrics and	77052	Computer aided detection of radiographic images	No additional requirements
	77057, G0202	Screening Mammography	
	77063[3]	Screening tomosynthesis	
	77080, 77081, 77085[3]	DEXA studies, bone densitometry	
	74740	Hysterosalpingography	
	76830 to 76857, 76815[2], 76816[2], 76817[2]	Ultrasound : obstetrical, pelvic	
	76930	Ultrasound study, follow-up Guidance	
	76941	Ultrasonic guidance for fetal transfusion or cordocentesis	

Gynecology	76945	Ultrasonic guidance for chorionic villus sampling	
	76946	Ultrasonic guidance for amniocentesis	
	76948	Ultrasonic guidance for aspiration of ova	
	76970	Ultrasound study, follow-up	
	76801[2], 76802[2], 76805[2], 76810[2], 76811[2], 76812[2], 76813[2], 76814[2], 76818[2], 76819[2], 76820[2], 76821[2], 76825[2], 76826[2], 76827[2], 76828[2]	Ultrasound: obstetrical, pelvic	
	93325	Doppler echocardiography	
Oral Surgeons	70100, 70110, 70140, 70150	Mandible and facial bone imaging	No additional requirements
	70300, 70310, 70320	Teeth imaging	
	70328, 70330	TMJ imaging	
	70350	Cephalogram, orthodontic	
	70355	Orthopantogram	
Orthopedists (includes Pediatric Orthopedists, Orthopedic Surgeons and Pediatric Orthopedic Surgeons)	71100 - 71111	Radiologic examination, ribs	No additional requirements
	71120 - 71130	Radiologic examination, sternum	
	72010 - 72120,72170, 72190 72200 - 72220	Spine and Pelvis imaging	
	73000 - 73140, 73500 - 73660	Imaging to Upper and lower extremities	
	76000, 77002, 77003	Fluoroscopy	
	77071	Radiologic examination, any joint	
	77073	Bone length studies	

	77077	Joint survey	
	76881	Ultrasound, extremity	AIUM accreditation in musculoskeletal ultrasound
	76882	Ultrasound, extremity, limited	
	76885	Ultrasound, infant hips	
	76886 76942[3]	Ultrasound, infant hips, limited Ultrasonic guidance for needle placement	
Pain Specialists (includes Physiatrists, Anesthesiologists, Neurologists, Neurosurgeons, Physical Medicine and Rehabilitation)	72275	Epidurography, radiological supervision and interpretation	No additional requirements
	76000, 77002, 77003	Fluoroscopy	
Pediatricians	71010–71030	Chest imaging	No additional requirements
Podiatrists	73600, 73610, 73620, 73630, 73650, 73660	Lower extremity imaging	No additional requirements
	76942[4]	Ultrasonic guidance for needle placement	
	76881[4]	Ultrasound, extremity	
	76882[4]	Ultrasound, extremity, limited	
Pulmonologists	71010–71030	Chest imaging	No additional requirements
Radiation Oncologists	77012	Computed tomography guidance for needle placement	No additional requirements
	77014	Computed tomography guidance for placement of radiation therapy fields	
	76873	Prostate volume study for brachytherapy treatment planning	

	76950	Ultrasonic guidance for placement of radiation therapy fields	
	76965	Ultrasonic guidance for interstitial radioelement application	
	76942	Ultrasonic guidance for biopsy only	
Reproductive Endocrinologists	77052	Computer aided detection of radiographic images	Must be fully compliant with MQSA requirements to perform screening mammography
	77057, G0202	Screening Mammography	
	77063[3]	Screening tomosynthesis	
	77080, 77081, 77085[3]	DEXA studies, bone densitometry	No additional requirements
	76815[2], 76816[2], 76817[2], 76830 to 76857	Ultrasound – obstetrical, pelvic	
	76948	Ultrasonic guidance for aspiration of ova	
	76970	Ultrasound study, follow-up	
	74740	Hysterosalpingography	
	76801[2], 76802[2], 76805[2], 76810[2], 76811[2], 76812[2], 76813[2], 76814[2], 76818[2], 76819[2], 76820[2], 76821[2], 76825[2], 76826[2], 76827[2], 76828[2]	Ultrasound: obstetrical, pelvic, guidance	AIUM/ACR Accreditation
	76941	Ultrasonic guidance for fetal transfusion or cordocentesis	
	76942	Ultrasonic guidance for biopsy	
	76945	Ultrasonic guidance for chorionic villus sampling	
	76946	Ultrasonic guidance for amniocentesis	

	93325	Doppler echocardiography, add on	
Rheumatologists	72010 - 72120,72170, 72190 72200 - 72220	Spine and pelvis imaging	No additional requirements
	73000 - 73140, 73500 - 73660	Imaging- Upper and lower extremities	
	76000, 77002	Fluoroscopy	
	77073, 77077	Bone length studies, joint survey	
	77080, 77081, 77085[3]	DEXA studies, bone densitometry	
	76881	Ultrasound, extremity	AIUM accreditation in musculoskeletal ultrasound
	76882	Ultrasound, extremity, limited	
	76885	Ultrasound, infant hips	
	76886	Ultrasound, infant hips, limited	
	76942 [3]	Ultrasonic guidance for needle placement	
Sports Medicine	71100 - 71111	Radiologic examination, ribs	Board certification in sports medicine and combined fellowship, residency and training in sports medicine of at least four years
	71120 - 71130	Radiologic examination, sternum	
	72010 - 72120, 72170, 72190, 72200 - 72220	Spine and pelvis imaging	
	73000 - 73140, 73500 - 73660	Imaging to upper and lower extremities	
	76881	Ultrasound, extremity	AIUM accreditation in dedicated musculoskeletal ultrasound
	76882	Ultrasound, extremity, limited	
	76942[3]	Ultrasonic guidance for needle placement	

Urologists	74455	Urethrocystography	No additional requirements
	76775	Ultrasound, limited	[4] Effective 9/1/15: AIUM accreditation in urologic ultrasound
	76870, 76872, 76873	Ultrasounds - scrotum, Transrectal Prostate volume study for brachytherapy treatment planning	
	76942	Ultrasonic guidance for biopsy only	
	76857	Ultrasound pelvic limited or follow up	
Vascular Neurology	76125	Cineradiography/video radiography	ABMS Certification in Vascular Neurology
	75898	Angiography through existing catheter	
	75896	Transcatheter therapy, infusion	
	75894	Transcatheter therapy, embolization	
	75685	Angiography, vertebral, cervical and/or intracranial	
	75680	Angiography, carotid, cervical, bilateral	
	75676	Angiography, carotid, cervical, unilateral	
	75671	Angiography, carotid, cerebral, bilateral	
	75665	Angiography, carotid, cerebral, unilateral	
	75662	Angiography, external carotid, bilateral, selective	
	75660	Angiography, external carotid, unilateral, selective	
	75600	Aortography, thoracic, without serialography	

Vascular Surgeons	77001	Fluoroscopic guidance for central venous access device	No additional requirements
	76937	US guidance for vascular access	

Note: This policy does not apply to IPA services rendered in Putnam and Ulster Counties

[1] These procedures require pre-certification; call 1-866-417-2345

[2] Any studies beyond three require pre-certification; call 1-866-417-2345

[3] Procedure Code Changes effective 1/1/15

[4] Changes effective 9/1/15:

- General Surgeons must have individual ASBS certification; facilities must have accreditation from ASBS, or ACR or AIUM
- Head and Neck Surgeons must have accreditation in Head and Neck Ultrasound from AIUM
- Podiatrist must have accreditation in Dedicated Musculoskeletal Ultrasound from AIUM
- Urologist must have accreditation in Urologic Ultrasound from AIUM

[5] Changes Effective: 1/1/16:

- Endocrinologist must have accreditation in Dedicated Thyroid/Parathyroid Ultrasound from AIUM

EmblemHealth

Provider Manual

Chapter 21: HIP Outpatient Diagnostic Imaging Referral Payment Policy

Our diagnostic imaging payment policy as it applies to services performed in an office setting (POS 11). The policy designates which imaging procedures will be reimbursed (subject to the member's benefit plan) according to practitioner specialty.

Overview

There are many clinical reasons practitioners other than radiologists perform in-office imaging as part of their diagnostic and treatment plans. We have radiology and cardiology imaging privileging protocols for HIP/HIPIC-underwritten Benefit Plans that are administered by EmblemHealth, which include Commercial (including GHI HMO, Vytra branded plans), state-sponsored and Medicare plans. These privileging protocols make up the Diagnostic Imaging Self-Referral Payment Policy. They are designed to promote the appropriate use of diagnostic imaging by clinicians in office settings.

The payment policy applies to services performed in an office setting (POS 11). It is based on a careful review of the literature and standards of the American Society of Echocardiography (ASE), Intersocietal Accreditation Commission (IAC), American College of Cardiology (ACC) and American Board of Radiology (ABR). The policy designates which imaging procedures will be reimbursed (subject to the member's benefit plan) according to practitioner specialty. It also describes the minimum accreditation and certification requirements.

For providers to perform imaging procedures within their specialty, they must meet and maintain the minimum certification requirements. These requirements are listed in the Outpatient Imaging Self-Referral Payment Policy chart in this chapter. When imaging procedures are performed outside the practitioner's specialty or when the practitioner fails to maintain the minimum certification requirements or obtain Prior Approval when required, claims for such services will be denied, with no liability to the member.

Members Exempt From Payment Rules

Excluded from this payment policy are HIP/HIPIC-underwritten Benefit Plans members assigned to a Montefiore, HealthCare Partners (HCP) or AdvantageCare Physicians (ACPNY) PCP. These members can be identified by their member ID card or through member eligibility information on our secure website. Protocols for GHI-underwritten plans are contained within the Radiology Privileging chapter.

Requirements for Echocardiography and Nuclear Studies

EmblemHealth will reimburse cardiologists for approved echocardiography studies (CPT codes 93303, 93304, 93306, 93307, 93308, 93350 and 93351) and nuclear studies (CPT codes 78451, 78452, 78453, 78454, 78466, 78468, 78469, 78472, 78473, 78481, 78483 and 78494), but only if they are performed at accredited locations. Prior approval rules continue to apply where applicable.

Accreditation for echocardiography studies requires both:

1. Cardiology board certification of the physician by the American Board of Internal Medicine (ABIM) or American Osteopathic Board of Internal Medicine (AOBIM) and
2. That services are rendered in laboratories accredited by the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL)

Accreditation for nuclear studies requires both:

1. Certification of the physician by the American Board of Radiology (ABR), American Board of Nuclear Medicine (ABNM) or Certification Board of Nuclear Cardiology (CBNC) and
2. That services are rendered in laboratories accredited by the Intersocietal Commission for the Accreditation of Nuclear Laboratories (ICANL) or American College of Radiology (ACR)

Accreditation Status and Submissions

Participating practitioners will be reviewed for active accreditation. For echocardiography services, the review will appear in the national databases of ICAEL and ICANL. For nuclear medicine/nuclear cardiology services, the review will appear in the national database of ACR. All other specialties must email their certification(s) directly to provideraccreditations@evicore.com. For more information about accreditation status or certificate submissions,a email provideraccreditations@evicore.com or call 1-800-918-8924, ext. 27901.

For information on accreditation requirements and instructions for submitting an application for accreditation, refer to the websites of the accrediting organizations below:

- American Association of Clinical Endocrinologists (AACE), Endocrine Certification in Neck Ultrasound (ECNU)
- American Board of Radiology (ABR): https://www.theabr.org/

  American College of Cardiology (ACC): https://www.acc.org

- American College of Nuclear Medicine (ACNM): http://www.acnmonline.org/
- American College of Radiology (ACR): https://www.acr.org
- American Osteopathic Board of Radiology (AOBR): https://www.aocr.org
- American Registry for Diagnostic Medical Sonography (ARDMS): https://www.ardms.org/
- American Registry of MRI Technologists (ARMRIT): https://www.armrit.org/index.shtml
- American Registry of Radiologic Technologists (ARRT): https://www.arrt.org/
- American Society of Nuclear Cardiology (ASNC): https://www.asnc.org/
- American Institute of Ultrasound in Medicine (AIUM): https://www.aium.org/
- Canadian Association of Medical Radiation Technologists (CAMRT): https://www.camrt.ca/
- Federal Drug Administration (FDA):, Radiation Emitting Products https://www.fda.gov/Radiation-EmittingProducts/default.htm
- International Society of Bone Densitometry (ISCD): https://www.iscd.org/
- Intersocietal Accreditation Commission (IAC): https://www.intersocietal.org/intersocietal.htm
- Intersocietal Commission for the Accreditation of Computed Tomographic Laboratories (ICACTL): https://www.intersocietal.org/ct/
- Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL): https://www.intersocietal.org/echo/
- Intersocietal Commission for the Accreditation of Magnetic Resonance Laboratories (ICAMRL): https://www.intersocietal.org/mri/
- Intersocietal Commission for the Accreditation of Nuclear Medicine Laboratories (ICANL): https://www.intersocietal.org/nuclear/
- Intersocietal Commission for the Accreditation of Vascular Testing (ICAVL): https://www.intersocietal.org/vascular/
- Mammography Quality Standards Act (MQSA): https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/ucm110823.htm

HIP Outpatient Diagnostic Imaging Self Referral Payment Policy

HIP Outpatient Diagnostic Imaging Self-Referral Payment Policy

The Outpatient Imaging Self-Referral payment policies are designed to promote appropriate use of diagnostic imaging by primary care physicians, specialty physicians and other health care professionals in office settings. The HIP payment policies below designate which imaging procedures shall be payable by HIP (subject to member benefits) in primary care physicians', specialty physicians' and other health care professionals' offices by provider practice specialty. In addition, these payment policies describe the minimum accreditation and certification requirements for ultrasound, echocardiography and nuclear medicine. This payment policy assumes board certification (by an ABMS recognized board) in the provider specialties listed below. All specialty payment policies apply to the related pediatric specialties as well.

View 2015 HIP Outpatient Diagnostic Imaging Self-Referral Payment Policy page here

EmblemHealth

Provider Manual

Chapter 22: Cardiology Imaging Program

This chapter describes our diagnostic imaging management program for outpatient cardiology for selected HIP members, including:

- Prior approval procedures
- Cardiology imaging scheduling procedures

Overview

The EmblemHealth Cardiology Imaging Program provides cardiology imaging management for outpatient cardiology imaging services. Services targeted for utilization management depend on the EmblemHealth benefit plan.

The Program also covers clinical standard and expedited appeals (excluding members with Medicare plans).

Members Exempt From the EmblemHealth Cardiology Imaging Program

While most of our members' covered cardiology imaging services are managed through this program, the following exceptions apply:

- Members whose care is managed by Montefiore Medical Group (CMO) or HealthCare Partners (HCP) must contact the applicable organization for prior approval. Check the member's ID card or eligibility information on emblemhealth.com to determine whether HIP, CMO, or HCP is the managing entity responsible for managing a member's care; if HIP is the managing entity, then eviCore is the organization to contact for prior approval.
- Members who selected a PCP affiliated with St. Barnabas Hospital or with ACPNY are excluded from this program. Effective August 20, 2018, St. Barnabas is part of the EmblemHealth Cardiology Imaging Program.
- PCPs must enter a prior approval request at emblemhealth.com.

Prior Approval Procedures

Services Requiring Prior Approval

Please refer to the charts later in this chapter for a list of services (and CPT-4 codes) that require prior approval. Note: All echocardiography exams require a prior approval regardless of the number of exams the member has had previously.

Each procedure requires a separate prior approval. Prior approvals are specific to the CPT-4 code and site location. They are valid for 45 days from the approval date.

Claims will be denied for procedures that require but did not receive prior approval through this program. In such cases, the member will not be liable for billing or payment.

Prior approval is required for services performed in the following places of service:

- Outpatient hospital facilities
- Freestanding radiology facilities
- Radiology office-based settings
- Non-radiology office-based settings

Prior approval is required for the following types of services:

- Services with the CPT-4 codes later in this chapter
- All coronary computed tomographic angiography (CCTA) services
- Services performed in ambulatory surgery centers (cardiac catheterization procedures only)

Prior approval is not required for services performed in the following places of service:

- Inpatient hospital facilities
- Hospital emergency departments
- Services provided when one of EmblemHealth's companies is the secondary insurer

Who Requests Prior Approval

We encourage PCPs or specialists to initiate the prior approval request. But requests will be accepted from the physician's office staff.

PCPs referring patients to a cardiologist for testing are responsible for initiating the prior approval request according to the instructions in this chapter. In cases where a cardiologist is already treating the patient, that cardiologist should initiate the request. The treating practitioner is ultimately responsible for ensuring that all applicable cardiology imaging procedures at the applicable service location have received prior approval.

How To Obtain Prior Approval

You may submit prior approval requests in one of three ways:

- Online: Visit www.evicore.com. To submit online prior approval requests, the ordering physician must be a registered user. To register for a user ID and password, visit www.evicore.com and click the "Register" button.
- By phone: Call 1-866-417-2345 for HIP, EmblemHealth CompreHealth EPO EPO (Retired August 1, 2018) , EmblemHealth Medicare HMO, GHI HMO and Vytra plan members. Call 1-800-835-7064 for EmblemHealth Medicare PPO plan members. Program representatives are available Monday through Friday, from 7 am to 7 pm. The Program is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving and Christmas Day. Multiple requests may be handled with one call.
- By fax: The fax option applies only to prior approval requests for cardiac imaging codes. You may fax these requests to 1-888-622-7369. With your fax submission, please include an EmblemHealth-specific cardiac imaging clinical request form. This form is available at www.evicore.com.

Please have the following information available when you call:

- The patient's full name, member ID number and insurance information
- The exam(s) requested for the patient
- The working diagnosis or rule-out
- The signs and symptoms that call for the exam, as well as their duration
- Any previous imaging studies performed, corresponding results or pertinent lab results
- History of prior treatment methods, drugs, surgery or other therapies, as well as duration of prior treatment
- Any other information indicating the need for the exam

Expedited Approval Requests

The website cannot be used for expedited approval requests. These requests must be processed through the call center. Call 1-866-417-2345 for HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), GHI HMO, Vytra and EmblemHealth Medicare HMO plan members. Call 1-800-835-7064 for EmblemHealth Medicare PPO plan members. Program representatives are available 24 hours a day, 7 days a week. The program is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving and Christmas Day.

Urgent Requests

If the cardiology treatment is medically urgent and must be performed outside the Program’s business hours, the physician may deliver treatment and must submit the prior approval request (with supporting clinical documentation) within two business days. Urgent requests are reviewed against medical necessity criteria, and an approval is issued as long as the request meets these medical necessity criteria. Urgent requests will be completed within 24 hours of receiving the request.

The website cannot be used for urgent approval requests. These requests must be processed through the call center. Call 1-866-417-2345 for HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), GHI HMO, Vytra and EmblemHealth Medicare HMO plan members. Call 1-800-835-7064 for EmblemHealth Medicare PPO plan members. Program representatives are available 24 hours a day, 7 days a week. The program is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving and Christmas Day.

Non-Urgent Requests

Non-urgent requests will be completed within three business days of receiving all necessary information, or within

the time frames otherwise required by the member's benefit plan (see Standard Pre-Service Review in the Care Management chapter). In most cases, we will review and determine prior approvals during the initial phone call, as long as all the required information is provided. The review and determination processes may, however, take longer if member or practitioner eligibility verification is required, or if the request requires additional clinical review (see Standard Pre-Service Review in the Care Management chapter).

A physician with office hours later than the Program's call center may initiate a case through the Program's website. We will process the request on the next business day.

Modifying a Prior Approval Request

If it becomes necessary to change or update the procedure after prior approval is obtained, we must be contacted no later than 48 hours after the modified procedure is performed. If the prior approval for the treatment plan is not updated and the claim does not match the authorized procedures, the claim will be denied for payment, with no liability to the member.

Verifying the Prior Approval Status

To verify the status of a prior approval request, either call the numbers that follow or visit the Authorization Lookup section of the website at www.evicore.com. Call 1-866-417-2345 for HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), GHI HMO, Vytra and EmblemHealth Medicare HMO plan members. Call 1-800-835-7064 for EmblemHealth Medicare PPO plan members.

Note: While we may approve or deny a prior approval request, this determination is based on medical necessity only. Always verify member eligibility, benefits and copayments directly with EmblemHealth at www.emblemhealth.com.

Determination Disagreement

If a physician disagrees with the determination, contact the Program's Peer-to-Peer Consultation Line to discuss the case with a medical director. Call 1-866-417-2345 for HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), GHI HMO, Vytra and EmblemHealth Medicare HMO plans. Call 1-800-835-7064 for EmblemHealth Medicare PPO plan members.

CPT-4 Codes Requiring Prior Approval

The following CPT-4 codes require prior approval for all plans covered by the EmblemHealth Cardiology Imaging Program:

Cardiology Imaging Prior Approval Code List For EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO/PPO, GHI HMO and HIP Benefit Plans Effective October 1, 2012 (Vytra EFFECTIVE JANUARY 1, 2016)

Cardiology Imaging CPT Code	Procedure Description
75557	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL

75559	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH STRESS IMAGING
75561	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES
75563	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; WITH STRESS IMAGING
75571*	COMPUTED TOMOGRAPHY, HEART, WITHOUT CONTRAST MATERIAL, WITH QUANTITIVE EVALUATION OF CORONARY CALCIUM
75572	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)
75573	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY IN THE SETTING OF CONGENITAL HEART DISEASE (INCLUDING 3D IMAGE POSTPROCESSING,ASSESSMENT OF LV CARDIAC FUNCTION, RV STRUCTURE AND FUNCTION AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)
75574	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEART, CORONARY ARTERIES AND BYPASS GRAFTS (WHEN PRESENT), WITH CONTRAST MATERIAL, INCLUDING 3D IMAGE POSTPROCESSING (INCLUDING EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)
78451	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)
78452	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION
78453	MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)

78454	MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION
78459	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET) METABOLIC EVALUATION
78491	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION; SINGLE STUDY AT REST OR STRESS
78492	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION; MULTIPLE STUDIES AT REST AND/OR STRESS
93303	TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; COMPLETE
93304	TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; FOLLOW-UP OR LIMITED STUDY
93306	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITH SPECTRAL DOPPLER ECHOCARDIOGRAPHY, AND WITH COLOR FLOW DOPPLER ECHOCARDIOGRAPHY
93307	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITHOUT SPECTRAL OR COLOR DOPPLER ECHOCARDIOGRAPHY
93308	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D) INCLUDES M-MODE RECORDING, WHEN PERFORMED, FOLLOW-UP OR LIMITED STUDY
93350	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, DURING REST AND CARDIOVASCULAR STRESS TEST USING TREADMILL, BICYCLE EXERCISE AND/OR PHARMACOLOGICALLY INDUCED STRESS, WITH INTERPRETATION AND REPORT

93351	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, DURING REST AND CARDIOVASCULAR STRESS TEST USING TREADMILL, BICYCLE EXERCISE AND/OR PHARMACOLOGICALLY INDUCED STRESS, WITH INTERPRETATION AND REPORT; INCLUDING PERFORMANCE OF CONTINUOUS ELECTROCARDIOGRAPHIC MONITORING, WITH SUPERVISION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL.
93452	LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED
93453	COMBINED RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED
93454	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION
93455	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL VENOUS GRAFTS) INCLUDING INTRAPROCEDURAL INJECTION(S) FOR BYPASS GRAFT ANGIOGRAPHY
93456	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT HEART CATHETERIZATION
93457	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS), INCLUDING INTRAPROCEDURAL INJECTION(S) FOR BYPASS GRAFT ANGIOGRAPHY AND RIGHT HEART CATHETERIZATION
93458	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED

93459	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH LEFT HEART CATHETERIZATION, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED, CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) WITH BYPASS GRAFT ANGIOGRAPHY
93460	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED
93461	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT AND LEFT HEART CATHETERIZATION, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED, CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) WITH BYPASS GRAFT ANGIOGRAPHY
93462	LEFT HEART CATHETERIZATION BY TRANSSEPTAL PUNCTURE THROUGH INTACT SEPTUM OR BY TRANSAPICAL PUNCTURE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
C8921	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, FOR CONGENITAL CARDIAC ANOMALIES; COMPLETE
C8922	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, FOR CONGENITAL CARDIAC ANOMALIES; FOLLOW-UP OR LIMITED STUDY
C8923	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITHOUT SPECTRAL OR COLOR DOPPLER ECHOCARDIOGRAPHY
C8924	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, FOLLOW-UP OR LIMITED STUDY
C8928	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, DURING REST AND CARDIOVASCULAR STRESS TEST USING TREADMILL, BICYCLE EXERCISE AND/OR PHARMACOLOGICALLY INDUCED STRESS, WITH INTERPRETATION AND REPORT

C8929	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, OR WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITH SPECTRAL DOPPLER ECHOCARDIOGRAPHY, AND WITH COLOR FLOW DOPPLER ECHOCARDIOGRAPHY
C8930	TRANSTHORACIC ECHOCARDIOGRAPHY, WITH CONTRAST, OR WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, DURING REST AND CARDIOVASCULAR STRESS TEST USING TREADMILL, BICYCLE EXERCISE AND/OR PHARMACOLOGICALLY INDUCED STRESS, WITH INTERPRETATION AND REPORT; INCLUDING PERFORMANCE OF CONTINUOUS ELECTROCARDIOGRAPHIC MONITORING, WITH PHYSICIAN SUPERVISION

*GHI HMO exception: 75571 is not a GHI HMO contracted code.

The following codes may no longer be billed. Please reference these codes for older claims (claims for dates of service prior to 1/1/2011).

Cardiology Imaging Procedures Requiring Prior Approval
CPT-4 Code List

Effective 1/1/2011 to 12/31/11
For Reference Only - Do Not Use

CPT-4 Code	Procedure Description
75557	Cardiac magnetic resonance imaging (MRI) for morphology and function without contrast material
75559	Cardiac MRI for morphology and function without contrast material; with stress imaging
75561	Cardiac MRI for morphology and function without contrast material(s), followed by contrast material(s) and further sequences
75563	Cardiac MRI for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium

75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts, with contrast material, including 3D image postprocessing
78451	Myocardial perfusion imaging, tomographic (SPECT), single study, at rest or stress
78452	Myocardial perfusion imaging, tomographic (SPECT), multiple studies, at rest and/or stress and/or redistribution and/or rest reinjection
78453	Myocardial perfusion imaging, planar, single study, at rest or stress
78454	Myocardial perfusion imaging, planar, multiple studies, at rest or stress and/or redistribution and/or rest reinjection
78456	Acute venous thrombosis imaging, peptide
78457	Venous thrombosis imaging, venogram, unilateral
78458	Venous thrombosis imaging, venogram, bilateral
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
93303	Transthoracic echocardiography for congenital cardiac anomalies, complete
93304	Transthoracic echocardiography for congenital cardiac anomalies, follow-up or limited study
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography

93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test
93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress, including performance of continuous electrocardiographic monitoring, with physician supervision
93451	Right heart catheterization, including measurement(s) of oxygen saturation and cardiac output, when performed
93452	Left heart catheterization, including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
93453	Combined right and left heart catheterization, including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
93454 (replaces 93508)	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation
93455 (replaces 93508)	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts), including intraprocedural injection(s) for bypass graft angiography
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization

93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts), including intraprocedural injection(s) for bypass graft angiography and right heart catheterization
93458 (replaces 93510)	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization, including intraprocedural injection(s) for left ventriculography, when performed
93459 (replaces 93510)	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization, including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
93460 (replaces 93526)	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization, including intraprocedural injection(s) for left ventriculography, when performed
93461 (replaces 93526)	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization, including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
93462 (replaces 93524)	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)

Formal Dispute Resolution

Please submit to EmblemHealth:

- Appeals for Medicare members. Please follow EmblemHealth's standard processes for Medicare members, described in the Dispute Resolution for Medicare Plans chapter.
- Complaints and grievances. Please refer to the Dispute Resolution chapters for Commercial/CHP and Medicaid, as applicable.

Please submit to the Program:

- Expedited and standard clinical appeals for Commercial/CHP members and expedited and standard action appeals for Medicaid members. Appeals may be filed by the member, the member's delegate (including the practitioner acting as the member's delegate) or by practitioners on their own behalf. For a full description of

member and practitioner rights regarding clinical and action appeals, see the Dispute Resolution chapters for Commercial/CHP and Medicaid, as applicable.

EmblemHealth

Provider Manual

Chapter 23: Radiation Therapy Program

This chapter contains policies and procedures for the EmblemHealth Radiation Therapy Program:

- Cancer Clinical Pathways
- Place of service for select outpatient radiation therapy services
- Prior approval procedures
- Urgent requests/non-urgent requests
- Formal dispute resolution
- CPT code list

Overview

On October 1, 2012, EmblemHealth instituted the EmblemHealth Radiation Therapy program. eviCore administers the program by conducting medical necessity reviews and authorizations, where applicable, for select outpatient radiation therapy services. eviCore also conducts clinical standard and expedited appeals (excluding members with Medicare plans).

Program Exclusions

Members in the following benefit plans are excluded from the program managed by eviCore. A prior approval request must be submitted to EmblemHealth at www.emblemhealth.com for radiation therapy services:

- EmblemHealth Medicare Supplemental (Medicare Cost)
- GHI CBP Program for City of New York Employees and Retirees
- DC37 Med Team Program
- EmblemHealth Medicare ASO (underwritten by GHI)
- EmblemHealth EPO/PPO (underwritten by GHI)
- HIP Prime® HMO and POS Plans for City of New York Employees

  HIP and GHI FEHB plans

- Vytra ASO accounts (underwritten by Vytra Health Plans Managed Systems)
- Vytra HMO (underwritten by HIP)

Also excluded from this program are HIP members assigned to a Montefiore (CMO) or HealthCare Partners (HCP) PCP and members assigned to a PCP affiliated with AdvantageCare Physicians, as listed below.

AdvantageCare Physicians:

- Manhattan's Physician Group
- Preferred Health Partners
- Queens-Long Island Medical Group
- Staten Island Physician Practice

For applicable benefit plans, these members can be identified by their member ID card.

For members excluded from the Radiation Therapy program managed by eviCore, please refer to the Care Management chapter for information on how to obtain prior approval.

Prior approval must be obtained from eviCore for radiation therapy services performed on or after October 1, 2012. To submit prior approval requests, visit www.evicore.com or call eviCore at 1-866-417-2345 for plans underwritten by HIP or 1-800-835-7064 for GHI HMO and EmblemHealth Medicare PPO plans. Representatives are available Monday through Friday, from 7 am to 7 pm. Multiple requests can be handled with one call.

Prior Approval Procedures

Services Requiring Prior Approval

All outpatient radiation therapy services require prior approval. eviCore has specific cancer clinical pathways, indicated below. For cancers less commonly treated with radiation therapy, the prior authorization follows an "Other Cancer Types" clinical pathway.

- Bone Metastases
- Brain Metastases
- Breast Cancer
- Cervical Cancer
- Endometrial Cancer
- Gastric Cancer
- Head/Neck Cancer
- Non-Cancerous Indications
- Non-Small Cell Lung Cancer
- Other Cancer Types

- Pancreatic Cancer
- Primary Central Nervous System Lymphoma
- Primary Central Nervous System Neoplasms
- Prostate Cancer
- Rectal Cancer
- Small Cell Lung Cancer

Each particular radiation treatment plan requires prior approval. Prior approvals are specific to the cancer type being treated. They have an expiration date based on the cancer diagnosis, treatment modality and the number of phases and fractions being requested. Prior approval must be obtained for radiation therapy treatment used to treat both malignant and benign indications.

Prior approval is required for services performed in the following places of service:

- Ambulatory surgery centers (POS 24)
- Freestanding radiology facilities (POS 11)
- Outpatient facilities (POS 22)
- Practitioner offices (POS 11)

Claims will be denied for procedures that require but did not receive prior approval or appropriate authorization through eviCore. In such cases, the member will not be held liable for billing or payment.

Who Requests Prior Approval

It is the responsibility of the referring practitioner (i.e., the practitioner developing the patient's treatment plan) to obtain the prior approval before services are rendered. If the referring practitioner and rendering practitioner are different, the rendering practitioner is encouraged to confirm that a prior approval is on file before services are rendered.

How To Request Prior Approval

Before requesting prior approval from eviCore, please have the medical records on hand and complete the form specific to the type of cancer being treated and the procedure being requested. These forms are available at the links below and at www.evicore.com. evieCore lists all clinical questions the practitioner must answer during the initial prior approval review.

- Bone Metastases
- Brain Metastases
- Breast Cancer
- Cervical Cancer
- Endometrial Cancer
- Gastric Cancer
- Head/Neck Cancer
- Non-Cancerous Indications

- Non-Small Cell Lung Cancer
- Other Cancer Types
- Pancreatic Cancer
- Primary Central Nervous System Lymphoma
- Primary Central Nervous System Neoplasms
- Prostate Cancer
- Rectal Cancer
- Small Cell Lung Cancer

Once the form is completed, submit prior approval requests in one of two ways:

- Online: Visit www.evicore.com. To submit online requests, the ordering physician must be a registered user. To register for a user ID and password, visit www.evicore.com and select "Register."
- By phone: Call 1-866-417-2345 for plans underwritten by HIP or 1-800-835-7064 for GHI HMO and EmblemHealth Medicare PPO plans. Representatives are available Monday through Friday, from 7 am to 7 pm. eviCore is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving, and Christmas Day.

Expedited Prior Approval Requests

The eviCore website cannot be used for expedited approval requests. These requests must be processed through the eviCore call center. Call 1-866-417-2345 for plans underwritten by HIP or 1-800-835-7064 for GHI HMO and EmblemHealth Medicare PPO plans. eviCore utilization review staff is available 24 hours a day, 7 days a week. eviCore is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving, and Christmas Day.

To expedite prior approvals, please have the following information on hand (please see forms at links above or at www.evicore.com:

- Cancer type being treated with radiation therapy
- Patient information
- Ordering practitioner information
- Rendering site information
- Patient history
  - Recent test results
  - Work up
  - Current clinical condition
- Treatment plan specifics, which may include:
  - Immobilization techniques
  - Treatment plan
  - Treatment technique
  - Fields/angles
  - Fractions

    Boost

-

Urgent Requests

If the radiation treatment is medically urgent and must be performed outside eviCore's business hours, the physician may deliver treatment and must submit the prior approval request (with supporting clinical documentation) within two business days. Urgent requests are reviewed against medical necessity criteria, and an approval is issued as long as the request meets this criteria. Urgent requests will be completed within 24 hours of receiving the request.

The eviCore website cannot be used for urgent approval requests. These requests must be processed through the eviCore call center. Call 1-866-417-2345 for plans underwritten by HIP or 1-800-835-7064 for GHI HMO and EmblemHealth Medicare PPO plans. eviCore utilization review staff is available 24 hours a day, 7 days a week. eviCore is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving, and Christmas Day.

Non-Urgent Requests

Non-urgent requests will be completed within three business days of receiving all necessary information. In most cases, eviCore will review and determine prior approvals during the initial phone call, as long as all the required information is provided. The review and determination processes may take longer if member or practitioner eligibility verification is required or if the request requires additional clinical review.

A physician with office hours later than eviCore's call center may initiate a case through eviCore's website. eviCore will process the request on the next business day.

Modifying Prior Approval Requests

If during a course of treatment the rendering physician opts to modify an approved treatment plan, the referring or rendering physician should call eviCore to discuss the new treatment plan. This allows eviCore to adjust the existing prior approval or create a new prior approval as needed. The referring or rendering physician must submit the supporting clinical history to determine medical necessity. The referring or rendering physician will then be notified as to whether the proposed changes to the treatment plan are deemed medically necessary. If the prior approval for the treatment plan is not updated and the claim does not match the authorized procedures, the claim will be denied for payment, with no liability to the member.

Prior Approval for Additional Treatment

The prior approval is valid for the approved treatment plan (an "episode of care"). If the member is provided with an additional episode of care, the referring and rendering physicians must communicate with eviCore about the member's care because a new prior approval will be required.

Verifying the Prior Approval Status

The practitioner who renders the services (e.g., the practitioner rendering the service at the outpatient hospital or ambulatory care center) is responsible for ensuring that the appropriate approval is on file. The appropriate staff at the location where services are rendered should verify the status of a prior approval request by calling 1-866-417-2345 for plans underwritten by HIP or 1-800-835-7064 for GHI HMO and EmblemHealth Medicare PPO plans.

You can also verify the prior approval request on the Authorization Lookup section of www.evicore.com. eviCore's prior approval determinations do not display at www.emblemhealth.com.

Please note that while eviCore may approve or deny a prior approval request, this determination is based on medical necessity only. Always verify member eligibility, benefits and copayments directly with EmblemHealth at www.emblemhealth.com.

Prior Approval Authorized Treatment

One prior approval is assigned per treatment plan. It includes the time frame for the treatment plan and any approved scans and simulations. Also, one prior approval number is assigned per course of treatment. This number applies to all services/CPT codes that are part of the approved treatment plan.

The prior approval letter includes the prior approval number, time frame the treatment is valid for, type of technique, number of phases, number of gantry angles, number of fractions, select CPT codes and claim instructions. If you have any questions about what is authorized, please call eviCore at 1-866-417-2345 for plans underwritten by HIP or 1-800-835-7064 for GHI HMO and EmblemHealth Medicare PPO plans.

Prior Approval Duration

The duration, or validity period, of a prior approval is communicated once the treatment plan is approved. If additional time is needed, the referring or rendering physician must contact eviCore to request an extension. The physician may contact eviCore's Clinical Review Department at 1-866-417-2345 for plans underwritten by HIP or 1-800-835-7064 for GHI HMO and EmblemHealth Medicare PPO plans. Claims will be denied for services performed without prior approval.

Determination Disagreement

If a referring or rendering physician disagrees with the eviCore determination, contact eviCore's Peer-to-Peer Consultation Line to discuss the case with a eviCore medical director. Call 1-866-417-2345 for plans underwritten by HIP or 1-800-835-7064 for GHI HMO and EmblemHealth Medicare PPO plans.

CPT Codes Requiring Prior Approval

The following CPT codes require prior approval for all plans covered by the EmblemHealth Radiation Therapy Program:

EmblemHealth Radiation Therapy Code List Effective October 1, 2012

CPT Code	Procedure Description	CPT Code	Procedure Description
00330*	RADIOLOGY/THERAPEUTIC – GENERAL CLASSIFICATION	77417	THERAPEUTIC RADIOLOGY PORT FILMS
00333*	RADIOLOGY/THERAPEUTIC – RADIATION THERAPY	77418	IMRT TREATMENT DELIVERY; SINGLE OR MULTIPLE FIELDS/ ARCS, VIA NARROW SPATIALLY AND TEMPORARILY MODULATED BEAMS, BINARY, DYNAMIC MLC, PER TREATMENT SESSION

00339*	RADIOLOGY/THERAPEUTIC – OTHER	77421	STEREOSCOPIC X–RAY GUIDANCE FOR LOCALIZATION OF TARGET VOLUME
00344*	THERAPEUTIC RADIOPHARMACEUTICALS	77422	HIGH ENERGY NEUTRON RADIATION TREATMENT DELIVERY; SINGLE TREATMENT AREA USING A SINGLE PORT OR PARALLEL-OPPOSED PORTS WITH NO BLOCKS OR SIMPLE BLOCKING
00973*	RADIOLOGY/THERAPEUTIC – PROFESSIONAL FEES	77423	HIGH ENERGY NEUTRON RADIATION TREATMENT DELIVERY; 1 OR MORE ISOCENTER(S) WITH COPLANAR OR NON-COPLANAR GEOMETRY WITH BLOCKING AND/OR WEDGE, AND/OR COMPENSATOR(S)
19296*	PLACEMENT OF RADIATION THERAPY AFTERLOADING EXPANDABLE CATHETER INTO THE BREAST FOR INTERSTITIAL RADIOELEMENT APPLICATION FOLLOWING PARTIAL MASTECTOMY, ON DATE SEPARATE FROM PARTIAL MASTECTOMY	77427	RADIATION TREATMENT MANAGEMENT, FIVE TREATMENTS
19297*	PLACEMENT OF RADIATION THERAPY AFTERLOADING EXPANDABLE CATHETER INTO THE BREAST FOR INTERSTITIAL RADIOELEMENT APPLICATION FOLLOWING PARTIAL MASTECTOMY, CONCURRENT WITH PARTIAL MASTECTOMY	77431	RADIATION TREATMENT MANAGEMENT, WITH COMPLETE COURSE OF THERAPY CONSISTING OF 1 –2 FRACTIONS ONLY
19298	PLACEMENT OF RADIATION THERAPY AFTERLOADING BRACHYTHERAPY CATHETER INTO THE BREAST FOR INTERSTITIAL RADIOELEMENT APPLICATION FOLLOWING PARTIAL MASTECTOMY	77432	STEREOTACTIC RADIATION TREATMENT MANAGEMENT CEREBRAL LESION(S) COMPLETE COURSE OF TREATMENT CONSISTING OF 1 SESSION
32553	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (E.G., FIDUCIAL MARKERS, DOSIMETER), PERCUTANEOUS, INTRA–THORACIC, SINGLE OR MULTIPLE	77435	STEREOTACTIC BODY RADIATION TREATMENT MANAGEMENT PER TREATMENT COURSE; 1 OR MORE LESIONS, INCLUDING IMAGE GUIDANCE ENTIRE COURSE NOT TO EXCEED 5 FRACTIONS
55920	PLACEMENT OF NEEDLES OR CATHETERS INTO PELVIC ORGANS AND/OR GENITALIA (EXCEPT PROSTATE) FOR SUBSEQUENT INTERSTITIAL RADIOELEMENT APPLICATION	77523	PROTON TREATMENT DELIVERY, INTERMEDIATE
57155	INSERTION OF UTERINE TANDEM AND/OR VAGINAL OVOIDS FOR CLINICAL BRACHYTHERAPY	77525	PROTON TREATMENT DELIVERY, COMPLEX
57156	INSERTION OF A VAGINAL RADIATION AFTERLOADING APPARATUS FOR CLINICAL BRACHYTHERAPY	77600	HYPERTHERMIA, EXTERNALLY GENERATED; SUPERFICIAL (I.E., HEATING TO A DEPTH OF 4 CM OR LESS)
58346	INSERTION OF HEYMAN CAPSULES FOR CLINICAL BRACHYTHERAPY	77605	HYPERTHERMIA, EXTERNALLY GENERATED; DEEP (I.E., HEATING TO DEPTHS GREATER THAN 4 CM)

76950	ULTRASONIC GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS	77610	HYPERTHERMIA GENERATED BY INTERSTITIAL PROBE(S); 5 OR FEWER INTERSTITIAL APPLICATORS
76965	ULTRASOUND GUIDANCE FOR INTERSTITIAL RADIOELEMENT APPLICATION	77615	HYPERTHERMIA GENERATED BY INTERSTITIAL PROBE(S); MORE THAN 5 INTERSTITIAL APPLICATORS
77011	COMPUTED TOMOGRAPHY GUIDANCE FOR STEREOTACTIC LOCALIZATION	77620	HYPERTHERMIA GENERATED BY INTRACAVITARY PROBES
77014	COMPUTED TOMOGRAPHY GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS	77750	INFUSION OR INSTILLATION OF RADIOELEMENT SOLUTION (INCLUDES 3-MONTH FOLLOW-UP CARE)
77261	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; SIMPLE	77761	INTRACAVITARY RADIATION SOURCE APPLICATION; SIMPLE
77262	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; INTERMEDIATE	77762	INTRACAVITARY RADIATION SOURCE APPLICATION; INTERMEDIATE
77263	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; COMPLEX	77763	INTRACAVITARY RADIATION SOURCE APPLICATION; COMPLEX
77280	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; SIMPLE	77776	INTERSTITIAL RADIATION SOURCE; SIMPLE
77285	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; INTERMEDIATE	77777	INTERSTITIAL RADIATION SOURCE; INTERMEDIATE
77290	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; COMPLEX	77778	INTERSTITIAL RADIATION SOURCE; COMPLEX
77295	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; 3-DIMENSIONAL	77785	REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE BRACHYTHERAPY; 1 CHANNEL
77299	UNLISTED PROCEDURE; THERAPEUTIC RADIOLOGY CLINICAL TREATMENT PLANNING	77786	REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE BRACHYTHERAPY; 2–12 CHANNELS
77300	BASIC RADIATION DOSIMETRY CALCULATION, CENTRAL AXIS DEPTH DOSE CALCULATION, TDF, NSD, GAP CALCULATION, OFF AXIS FACTOR, TISSUE INHOMOGENEITY FACTORS, CALCULATION OF NON-IONIZING RADIATION SURFACE AND DEPTH DOSE, AS REQUIRED DURING COURSE OF TREATMENT, ONLY WHEN PRESCRIBED BY THE TREATING PHYSICIAN	77787	REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE BRACHYTHERAPY; OVER 12 CHANNELS
77301	INTENSITY MODULATED RADIOTHERAPY PLAN, INCLUDING DOSE-VOLUME HISTOGRAMS FOR TARGET AND CRITICAL STRUCTURE PARTIAL TOLERANCE SPECIFICATIONS	77789	SURFACE APPLICATION OF RADIATION SOURCE
77305	TELETHERAPY ISODOSE PLAN; SIMPLE	77790	SUPERVISION, HANDLING, LOADING OF RADIATION SOURCE

77310	TELETHERAPY ISODOSE PLAN; INTERMEDIATE	77799	UNLISTED PROCEDURE, CLINICAL BRACHYTHERAPY
77315	TELETHERAPY ISODOSE PLAN; COMPLEX	0073T	OMPENSATOR-BASED BEAM MODULATION TREATMENT DELIVERY OF INVERSE PLANNED TREATMENT USING 3 OR MORE HIGH RESOLUTION (MILLED OR CAST) COMPENSATOR CONVERGENT BEAM MODULATED FIELDS, PER TREATMENT SESSION
77321	SPECIAL TELETHERAPY PORT PLAN, PARTICLES, HEMIBODY, TOTAL BODY	0182T	HIGH DOSE RATE ELECTRONIC BRACHYTHERAPY, PER FRACTION
77326	BRACHYTHERAPY ISODOSE PLAN; SIMPLE	0197T	INTRA-FRACTION LOCALIZATION AND TRACKING OF TARGET OR PATIENT MOTION DURING DELIVERY OF RADIATION THERAPY (E.G., 3D POSITIONAL TRACKING, GATING, 3D SURFACE TRACKING), EACH FRACTION OF TREATMENT
77327	BRACHYTHERAPY ISODOSE PLAN; INTERMEDIATE	C1715	BRACHYTHERAPY NEEDLE
77328	BRACHYTHERAPY ISODOSE PLAN; COMPLEX	C1716	BRACHYTHERAPY SOURCE, NON-STRANDED, GOLD-198, PER SOURCE
77331	SPECIAL RADIATION DOSIMETRY	C1717	BRACHYTHERAPY SOURCE, NON-STRANDED, GOLD-198 PER SOURCE
77332	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; SIMPLE	C1719	BRACHYTHERAPY SOURCE, NON-STRANDED, NONHIGH DOSE RATE IRIDIUM-192, PER SOURCE
77333	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; INTERMEDIATE	C1728	CATHETER, BRACHYTHERAPY SEED ADMINISTRATION
77334	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; COMPLEX	C2634	BRACHYTHERAPY SOURCE, NON-STRANDED, HIGH ACTIVITY, IODINE-124, GREATER THAN 1.01 MCI
77336	CONTINUING MEDICAL PHYSICS CONSULTATION	C2635	BRACHYTHERAPY SOURCE, NON-STRANDED, HIGH ACTIVITY, PALLADIUM-103, GREATER THAN 2.2 MCI
77338	MULTI-LEAF COLLIMATOR (MLC) DEVICE(S) FOR INTENSITY MODULATED RADIATION THERAPY (IMRT), DESIGN AND CONSTRUCTION PER IMRT PLAN	C2636	BRACHYTHERAPY LINEAR SOURCE, NON-STRANDED, PALADIUM-103, PER 1MM
77370	SPECIAL MEDICAL RADIATION PHYSICS CONSULTATION	C2637	BRACHYTHERAPY SOURCE, NON-STRANDED, YTTERBIUM-169, PER SOURCE

77371	RADIATION TREATMENT DELIVERY, STEREOTACTIC RADIOSURGERY (SRS), COMPLETE COURSE OF TREATMENT OF CEREBRAL LESION(S) CONSISTING OF 1 SESSION, MULTI-SOURCE COBALT 60 BASED	C2638	BRACHYTHERAPY SOURCE, STRANDED, IODINE-125, PER SOURCE
77372	RADIATION TREATMENT DELIVERY, STEREOTACTIC RADIOSURGERY (SRS) COMPLETE COURSE OF TREATMENT OF CEREBRAL LESION(S) 1 CONSISTING OF SESSION, LINEAR ACCELERATOR BASED	C2639	BRACHYTHERAPY SOURCE, NON-STRANDED, IODINE-125, PER SOURCE
77373	STEREOTACTIC BODY RADIATION THERAPY DELIVERY PER FRACTION 1 OR MORE LESIONS; INCLUDING IMAGE GUIDANCE, ENTIRE COURSE NOT TO EXCEED 5 FRACTIONS	C2640	BRACHYTHERAPY SOURCE, STRANDED, PALLADIUM-103, PER SOURCE
77399	UNLISTED PROCEDURE, MEDICAL RADIATION PHYSICS, DOSIMETRY AND TREATMENT DEVICES, AND SPECIAL SERVICES	C2641	BRACHYTHERAPY SOURCE, NON-STRANDED, PALLADIUM-103, PER SOURCE
77401	RADIATION TREATMENT DELIVERY; SUPERFICIAL AND/OR ORTHO VOLTAGE	C2642	BRACHYTHERAPY SOURCE, STRANDED, CESIUM-131, PER SOURCE
77402	RADIATION TREATMENT DELIVERY; SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS UP TO 5 MEV	C2643	BRACHYTHERAPY SOURCE, NON-STRANDED, CESIUM -131, PER SOURCE
77403	RADIATION TREATMENT DELIVERY; SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; 11-19 MEV	C2698	BRACHYTHERAPY SOURCE, STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE
77404	RADIATION TREATMENT DELIVERY; SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; 6-10 MEV	C2699	BRACHYTHERAPY SOURCE, NON-STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE
77406	RADIATION TREATMENT DELIVERY; SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; 20 MEV AND GREATER	C9725	LACEMENT OF ENDORECTAL INTRACAVITARY APPLICATOR FOR HIGH INTENSITY BRACHYTHERAPY
77407	RADIATION TREATMENT DELIVERY; TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA USE OF MULTIPLE BLOCKS; UP TO 5 MEV	C9726	PLACEMENT AND REMOVAL (IF PERFORMED) OF APPLICATOR INTO BREAST FOR RADIATION THERAPY
77408	RADIATION TREATMENT DELIVERY; TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA USE OF MULTIPLE BLOCKS; 6-10 MEV	C9728	LACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY/ SURGERY GUIDANCE (E.G., FIDUCIAL MARKERS, DOSIMETER), OTHER THAN ABDOMEN, PELVIS, PROSTATE, RETROPERITONEUM, THORAX (ANY APPROACH), SINGLE OR MULTIPLE

77409	RADIATION TREATMENT DELIVERY; TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA USE OF MULTIPLE BLOCKS; 11-19 MEV	G0173	LINEAR ACCELERATOR BASED STEREOTACTIC RADIOSURGERY, COMPLETE COURSE OF THERAPY IN ONE SESSION
77411	RADIATION TREATMENT DELIVERY; TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA USE OF MULTIPLE BLOCKS; 20 MEV OR GREATER	G0251	LINEAR ACCELERATOR BASED STEREOTACTIC RADIOSURGERY, DELIVERY INCLUDING COLLIMATOR CHANGES AND CUSTOM PLUGGING, FRACTIONATED TREATMENT, ALL LESIONS, PER SESSION, MAXIMUM FIVE SESSIONS PER COURSE OF TREATMENT
77412	RADIATION TREATMENT DELIVERY; THREE OR MORE SEPARATE TREATMENT AREAS; CUSTOM BLOCKING, TANGENTIAL PORTS WEDGES, ROTATIONAL BEAM, COMPENSATORS, ELECTRON BEAM; UP TO 5 MEV	G0339	IMAGE-GUIDED ROBOTIC LINEAR ACCELERATORBASED STEREOTACTIC RADIOSURGERY, COMPLETE COURSE OF THERAPY IN ONE SESSION OR FIRST SESSION OF FRACTIONATED TREATMENT
77413	RADIATION TREATMENT DELIVERY; THREE OR MORE SEPARATE TREATMENT AREAS; CUSTOM BLOCKING, TANGENTIAL PORTS WEDGES, ROTATIONAL BEAM, COMPENSATORS, ELECTRON BEAM; 6-10 MV COMPLEX	G0340	IMAGE-GUIDED ROBOTIC LINEAR ACCELERATOR-BASED STEREOTACTIC RADIOSURGERY, DELIVERY INCLUDING COLLIMATOR CHANGES AND CUSTOm PLUGGING, FRACTIONATED TREATMENT, ALL LESIONS, PER SESSION, SECOND THROUGH FIFTH SESSIONS, MAXIMUM FIVE SESSIONS PER COURSE OF TREATMENT
77414	RADIATION TREATMENT DELIVERY; THREE OR MORE SEPARATE TREATMENT AREAS; CUSTOM BLOCKING, TANGENTIAL PORTS WEDGES, ROTATIONAL BEAM, COMPENSATORS, ELECTRON BEAM; 11-19 MV COMPLEX	Q3001	BRACHYTHERAPY RADIOELEMENTS
77416	RADIATION TREATMENT DELIVERY; THREE OR MORE SEPARATE TREATMENT AREAS; CUSTOM BLOCKING, TANGENTIAL PORTS WEDGES, ROTATIONAL BEAM, COMPENSATORS, ELECTRON BEAM; 20 MV OR GREATER	S8030	SCLERAL APPLICATION OF TANTALUM RING(S) FOR LOCALIZATION OF LESIONS FOR PROTON BEAM THERAPY

* Covered if billed with an appropriate CPT code.

Formal Dispute Resolution

Please submit to EmblemHealth:

- Appeals for Medicare members. Please follow EmblemHealth's standard processes for Medicare members, described in the Dispute Resolution for Medicare Plans chapter.

Please submit to eviCore:

- Expedited and standard clinical appeals for Commercial/Child Health Plus members and expedited and standard action appeals for Medicaid members. Appeals may be filed by the member, the member's delegate (including the practitioner acting as the member's delegate) or the practitioner on his or her own behalf. For a full description of

member and practitioner rights regarding clinical and action appeals, see the Dispute Resolution chapters for Commercial/CHP and Medicaid, as applicable.

EmblemHealth

Provider Manual

Chapter 24: Chiropractic Program

This chapter contains information about our network and utilization management program for chiropractic services provided to designated members.

Chiropractic Program Overview

EmblemHealth has partnered with Palladian Muscular Skeletal Health (Palladian), a specialty network and utilization management organization, to arrange chiropractic services for our members in the benefit plans listed below. Through this partnership, Palladian is responsible for the administration of prior approvals, claims payment, credentialing, recredentialing and appeals for denial determinations, as described in this chapter.

- GHI HMO
- GHI HMO - Point of Service
- GHI HMO - Senior Supplement (Commercial)
- GHI PPO
- HIP Access I and HIP Access II
- HIP Prime (HMO)
- HIP Prime (POS)
- EmblemHealth Medicare HMO
- EmblemHealth Medicare PPO
- Vytra HMO

Members and eligible dependents covered by these plans are allowed unlimited visits to a network chiropractor, based on medical necessity and the meeting of prior approval and referral requirements (according to the member's benefit).

All members excluded from the Chiropractic Program are medically managed in the same way as they are for all other services and are subject to consistent utilization review and utilization management standards and protocols.

Prior Approvals and Referrals

HIP and Vytra HMO Plans

The initial visit to a chiropractor does not require prior approval. Chiropractors must obtain prior approval from Palladian for the member's second treatment, and each continued treatment thereafter, by completing and submitting the medical necessity review forms online by signing in to www.palladianhealth.com or by faxing them to 1-716-712-2802 for HIP members or to 1-716-712-2803 for Vytra members.

GHI HMO Plans

The practitioner providing care or the ordering specialist must provide members with a referral for them to obtain chiropractic services. This initial referral is valid for the first six visits to the participating chiropractor. Within three business days of the initial evaluation, the referred chiropractor must complete and submit the Referral Certification Form online or via fax.

To complete and submit the form for the first six visits and any additional visits thereafter, referred chiropractors may complete and submit the Referral Certification Form online after logging into www.palladianhealth.com. They may also fax the completed form (found at the end of this chapter) to 1-716-712-2817. Palladian will then register the visits.

GHI PPO Plans

Members may access chiropractic care without a referral or prior approval for no less than the first eight visits, depending on the member's benefit. Chiropractors must obtain prior approval from Palladian for each continued treatment thereafter by submitting the medical necessity review forms online by logging onto www.palladianhealth.com or by faxing them to 1-716-712-2817.

NOTE: Failure to submit required forms for additional authorization may result in an administrative denial.

Submitting Requests For Medical Review

Medical necessity determinations for future care are based on the completion of three concise clinical intake forms:

- The Chiropractic Treatment Form - completed by the participating therapist
- The Chiropractic Intake Form - completed by the patient
- The Chiropractic Outcomes Form - completed by the patient; or the Pediatric Outcomes Form - completed by the parent or guardian of patients under the age of 18

These forms are on www.emblemhealth.com and on www.palladianhealth.com. The practitioner is responsible for submitting all forms to Palladian for review. Practitioners may submit the completed forms electronically by logging

onto www.palladianhealth.com or they may fax them to Palladian at 1-716-809-8324.

Following are examples of the forms required for different scenarios:

- For every new patient and when there is a change in the primary diagnosis, the following three forms need to be submitted within five business days of the initial evaluation.
  - The Chiropractic Treatment Form- completed by the therapist
  - The Chiropractic Intake Form - completed by the patient
  - The Chiropractic Outcomes Form - completed by the patient
- For any additional follow-up care after the initial authorization, the following two forms need to be submitted within five business days of the "Requested Start Date."
  - The Chiropractic Treatment Form - completed by the therapist
  - The Chiropractic Outcomes Form- completed by the patient

All requests for additional care may be submitted to www.palladianhealth.com.

Appeals

For Commercial members, appeals for denial determinations made by Palladian must be submitted to:

Palladian Muscular Skeletal Health
Attn: UM Department
2732 Transit Road
West Seneca, NY 14224

For Medicare members, appeals for denial determinations made by Palladian must be submitted to:

EmblemHealth
Grievance and Appeals Department
P.O. Box 2807
New York, NY 10116-2807

Customer Service

Eligible members may call the following numbers for customer service and more information:

- HIP: 1-877-774-7693
- GHI PPO: 1-212-501-4444 (in New York City) or 1-315-432-0826 (in all other areas)
- Medicare PPO: 1-866-557-7300
- GHI HMO: 1-866-284-2901
- Vytra: 1-866-883-0643

Credentialing

Palladian is responsible for the credentialing and recredentialing of participating chiropractors for GHI HMO and HIP. EmblemHealth EPO/PPO and GHI PPO providers contract directly with the plan. Please refer to the chart below:

Benefit Plan	Palladian	EmblemHealth
GHI HMO	Yes	
HIP	Yes	
Vytra	Yes	
EmblemHealth EPO/PPO		Yes
GHI PPO (Commercial)		Yes
Medicare Choice PPO		Yes

Claims

Claims must be submitted in the following manner:

Benefit Plan	Address	Form Required
HIP and Vytra HMO	Palladian Muscular Skeletal Health P.O. Box 368 Lancaster, NY 14086-0368 For electronic claims submission, Palladian's Payor ID is 37268.	CMS-1500

GHI HMO	Palladian Muscular Skeletal Health P.O. Box 307 Lancaster, NY 14086 For electronic claims submission, Palladian's Payor ID is 37268.	CMS-1500
GHI PPO (Commercial)	GHI Claims P.O. Box 2832 New York, NY 10116	CMS-1500
Medicare Choice PPO	EmblemHealth Medicare PPO P.O. Box 2830 New York, NY 10116-2830	CMS-1500

Forms

See the following pages for our Chiropractic Program forms:

- The Chiropractic Treatment Form
- The Chiropractic Intake Form
- The Chiropractic Outcomes Form
- Pediatric Outcomes Form

EmblemHealth

Provider Manual

Chapter 25: Physical and Occupational Therapy Program

This chapter contains information about our utilization management program for physical and occupational therapy provided in partnership with Palladian Muscular Skeletal Health.

Overview

The following members, services and benefit plans are not managed by Palladian:

- PT/OT services rendered by a podiatrist
- GHI underwritten benefit plans
- Members whose ID card indicates a primary care physician from one of the following entities:
  - HealthCare Partners (HCP) Cohort I
  - Montefiore (CMO) (except Medicare members starting Jan. 1, 2020)
- Members who have not been assigned to a PCP

These members are medically managed in the same way as they are for other services by the assigned Managing Entity. Referrals and pre-authorizations are managed by the Managing Entity listed on the back of the members' ID card. You should check member ID cards at every visit, regardless of service or reason for the visit.

Referral Requirements for an Initial Visit

For GHI HMO Members

The initial referral is valid for the first six visits to the participating PT/OT provider. Within three business days of the initial evaluation, the referred PT/OT practitioner must submit the Referral Certification Form through www.palladianhealth.com or via fax to 1-716-712-2817. Palladian will then register the initial six visits.

Prior Approvals

Palladian conducts a Medical Necessity Review Process for all PT/OT services to assess the patient's current medical condition, pain, and progression of treatment. Practitioners and patients will be able to complete and submit the required forms via Palladian's Web site at www.palladianhealth.com. The medical necessity review process is user-friendly and designed to gather concise information from you and your patient to help determine the appropriate course of care.

Outpatient Hospital Retrospective Utilization Reviews for HIP Claims

Retrospective Utilization Reviews (RURs) are clinical in nature and may be requested when HIP claims have been denied for a lack of medical necessity or in situations where there is no prior approval on file.

Should you receive a claim denial for hospital outpatient physical or occupational therapy from HIP, you must file a RUR with Palladian.

Time Frame for RUR Requests

All requests for RURs must be submitted within the time frames specified in your contract with HIP. If your contract does not contain language regarding a specific time frame, then regulatory timeframes (i.e., 45 calendar days from the date of remittance) will apply. A determination will be made and communicated within 30 days of the request.

Where to Submit Documentation

All RUR requests, along with medical records and other information related to the case, should be sent to the following address:

Palladian
Utilization Management Department
2732 Transit Road
West Seneca, NY 14224

Palladian will determine medical necessity and either grant the approval or uphold the denial. If you have any questions, you may contact Palladian's customer service department at 1-877-774-7693, Monday through Friday, from 8:30 am to 5 pm.

For services that receive RUR approval, HIP will reprocess the claims for the affected dates of service. We ask that you do not resubmit these claims as it may result in a duplicate claim submission and possibly delay payment.

Appeals

If your GHI HMO claims have been denied for a lack of medical necessity or because there is no prior approval on file and you would like to dispute the denial, you do not request a RUR. You will receive information from Palladian regarding your clinical appeal rights so that you may file an appeal.

If your request for RUR of a HIP claim is denied, you will receive information from Palladian regarding your clinical appeal rights. All appeals of RURs will be processed by HIP as indicated in the appropriate Dispute Resolution section of this Provider Manual: Medicaid; Commercial/CHP; or Medicare. All other appeals will follow Palladian's process which follows:

The appeals process for Palladian is the same for GHI HMO and HIP members.

If you do not agree with a decision regarding medical necessity, you may:

1. Request a peer-to-peer conversation if you have not already discussed the adverse determination with the clinical peer reviewer.
2. File a written or oral standard or expedited UR appeal or action appeal within 180 calendar days of receiving the original decision. Please note that appeals filed on behalf of Medicaid members must be filed within 90 calendar days of the date of the adverse determination letter. In addition, oral standard appeals must be followed up in writing, expedited appeals do not.

To initiate a UR or action appeal, call Palladian's customer service department toll-free at 1-877-774-7693, Monday through Friday, from 8:30 a.m. to 5 p.m. You may initiate a written request for an appeal by sending the request to:

Palladian Muscular Skeletal Health
Attn: Utilization Management Department
2732 Transit Road
West Seneca, New York 14224

You may submit written comments, documents, records and other information related to the case. A clinical peer reviewer who was not involved in the original decision will review the case. When Palladian does not change its original decision, you will receive information about your or your patient's further appeal rights. Once you have completed the first level of the internal appeals process, you are entitled to a New York State External Appeal. Medicaid members may also be entitled to request a New York State Fair Hearing.

Appeals for denial determinations made by Palladian must be submitted to:

HIP Commercial Plans	GHI HMO Plans
Palladian Muscular Skeletal Health PO Box 368 Lancaster, NY 14086-0368	Palladian Muscular Skeletal Health Attn: Utilization Management Department 2732 Transit Road West Seneca, NY 14224

For Medicare members, appeals for denial determinations made by Palladian must be submitted to:

EmblemHealth Grievance and Appeals Department
PO Box 2807

New York, NY 10116-2807

Customer Service

Eligible members may call the following numbers for customer service and more information:

- GHI HMO: 1-866-284-2901
- HIP: 1-877-774-7693 or 1-716-712-2808

Claims

For instructions on submitting claims, please see the chart below.

Benefit Plan	Address	Form Required
GHI HMO	GHI PO Box 2832 New York, NY 10116-2832	CMS-1500
HIP - Professional Providers	Palladian Muscular Skeletal Health PO Box 366 Lancaster, NY 14086 For electronic claims submission, Palladian's Payor ID is 37268.	CMS-1500
HIP - Outpatient Facility Providers	HIP Claims Department PO Box 2803 New York, NY 10116-2803	UB-04

GHI and EmblemHealth EPO/PPO Plans

PT/OT Benefits

EmblemHealth PPO/EPO and GHI plan members are not covered under the Palladian program. They have a capped,

limited benefit of 30 visits per calendar year. PPO members are allowed to go out of network. EPO members may only see network providers.

There are no referral or prior approval requirements for these initial base benefit visits. If more visits are needed in a calendar year, the provider may follow the member grievance process in the Dispute Resolution for Commercial/CHP Members chapter.

City of New York (Including Unions and Locals)

City of New York members (including all unions and locals) have a base benefit of 16 visits per calendar year for outpatient physical therapy (PT) only, both office-based and hospital-based. They do not have outpatient occupational therapy (OT) as a covered service. OT is only covered as part of home care services.

Benefit Extensions

The Benefit Extension process is implemented when additional visits above the base benefit are requested and are provided for under an EmblemHealth EPO/PPO or GHI EPO/PPO member's contract.

Where EmblemHealth EPO/PPO or GHI is listed as the primary insurer, you may submit a benefit extension request from our secure Provider Web site at www.emblemhealth.com. Once signed in, look for the option on the left-hand navigation bar. (The member's primary insurer may also be verified through our secure site.)

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

- EmblemHealth: 1-877-482-3625
- GHI: 1-800-223-9870

Forms

- EmblemHealth Benefit Extensions Treatment Plan
- EmblemHealth Extension Request for a Current Authorization
- PT/OT Appeals Form
- PT/OT Patient Intake Form
- PT/OT Patient Outcomes Form
- PT/OT Pediatric Outcomes Form
- PT/OT Treatment Form

EmblemHealth

Provider Manual

Chapter 26: Behavioral Health Services

In this chapter, you'll find our policies and procedures for mental health and substance abuse services, including:

- Prior approval procedures
- Post-discharge protocols
- Mental Health Parity Law
- Health Homes

Overview

EmblemHealth has engaged Beacon Health Options to administer behavioral health services for most of its members under two programs. Members of plans underwritten by HIP or HIPIC and ASO plans administered by Vytra Health Plans Managed Systems (VHMS) have their behavioral health services administered by Beacon Health Options under the Emblem Behavioral Health Services Program (EBHSP). GHI-underwritten plan members by have their behavioral health services administered by Beacon Health Options under the EmblemHealth Behavioral Management Program (BMP).

For information on accreditation, prior approvals, claims and more, please see the Beacon Health Options Provider Manual: beaconhealthoptions.com/providers/emblemhealth.

It is very important for our physical health network practitioners to be aware of their patients' mental health and substance use disorders. We ask our PCPs to screen their patients for depression and other potential issues and to take these diagnoses into consideration when developing treatment plans. Where possible, please identify and coordinate care with your patient's behavioral health providers. Care for FIDA members will be coordinated in their IDTs and Medicaid and HARP members through their Health Homes.

Emblem Behavioral Health Services Program

Behavioral health services for members in plans underwritten by HIP or in ASO plans administered by VHMS are

administered by Beacon Health Options under the Emblem Behavioral Health Services Program.

Provider Networks served by EBHSP include:

- Enhanced Care Prime Network
- NY Metro Network (Retired August 1, 2018)
- Premium Network
- Prime Network
- Select Care Network
- VIP Prime Network

Under EBHSP, Beacon Health Options administers covered inpatient, outpatient and ambulatory behavioral health services including provider network and care management services such as utilization management and case management. Beacon Health Options also manages credentialing, claims processing, claims payment and grievances and appeals (except for Medicare plans), as well as other provider service issues related to Behavioral health.

Members may call 1-888-447-2526 or use our online Find a Doctor tool to find a mental health or substance abuse practitioner.

Montefiore members can access behavioral health providers in the Montefiore network. They also may use the Beacon Health Options network if they choose. For providers who are not Montefiore network participants, claims for members who have the Montefiore logo on their ID card must be submitted to Beacon Health Options. Utilization management functions for behavioral health services for these members, including prior approvals, are performed by Montefiore. Please call 1-800-401-4822 for help finding a Montefiore network mental health or substance abuse practitioner.

Note: EmblemHealth administers disease management, including the Depression Disease Management program, for all members except for Medicare plans which will be administered by Beacon Health Options effective August 1, 2015. For more information on Serious and Persistent Mental Illness Disease Management Services , visit the Care Management Programs section of the Health Promotion and Disease Management chapter.

Health and Recovery Plan (HARP)

Our Health and Recovery Plan (HARP), Enhanced Care Plus, is designed to meet the unique needs of members living with serious mental illness and/or substance use disorder. For more information on HARP and other Medicaid services, please see the Medicaid section of the Provider Network and Member Benefit Plans chapter.

Medicaid Health Homes

All HARP members and qualifying Medicaid members will be assigned to Health Homes that will be responsible for

coordinating all of their care. It is especially important for there to be coordinated care between a member's medical and behavioral health care providers. The Health Home will facilitate the development of a plan of care that encompasses both aspects of the member's health.

A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home."

For information on MMC and HARP covered services, please see the Medicaid section of the Provider Network and Member Benefits Plans chapter.

Contracting with Beacon Health Options: Emblem Behavioral Health Services Program

To care for all members served by the EBHSP, providers are required to participate in both of the Beacon Health Options practitioner networks and must have a Beacon Health Options practitioner agreement and a CHCS IPA agreement (collectively referred to as "Beacon Health Options Agreements").

Providers who only have a CHCS IPA agreement will only be permitted to provide in-network care to Health Insurance Plan of New York (HIP) members.

Providers who only have a Beacon Health Options practitioner agreement will only be permitted to provide in-network care to HIPIC-underwritten members and members of ASO plans administered by VHMS.

For patients in an active course of treatment prior to January 1, 2012, please see Continuity of Care During Program Implementation.

EmblemHealth Behavioral Management Program

Members of EPO and PPO plans underwritten by GHI have their behavioral health services administered by Beacon Health Options under the Behavioral Management Program (BMP).

Provider Networks served by BMP include:

- CBP Network, National Network, Tristate Network
- Network Access Network
- Medicare Choice PPO Network

Under BMP, Beacon Health Options manages covered inpatient, outpatient and ambulatory behavioral health services, including provider network and care management services such as utilization management and case management. Provider claims should be submitted to EmblemHealth, except those for Medicare members; these claims should be submitted to Beacon Health Options. Appeals and grievances should be submitted to Beacon Health Options, except for those of Medicare members; these appeals and grievances should be submitted to EmblemHealth.

Contracting with Beacon Health Options: Emblem Behavioral Health Services Program

To care for GHI members served by the BMP, providers are only required to have a Beacon Health Options practitioner agreement.

For more information about contracting with Beacon Health Options, please call the Beacon Health Options National Provider Line at 1-800-397-1630 from 8 a.m. to 5 p.m. and ask to speak with the Credentialing department.

Referring Patients for Behavioral Health Services

Providers must be contracted in the Beacon Health Options network(s) to provide covered behavioral health care to members served by BMP and EBHSP.

You and your patients are able to find EBHSP and BMP practitioners and facilities by going to our online Find a Doctor tool and entering the patient's ID number at the beginning of the search. Since some of our benefit plans use different provider networks, entering the patient's ID number will ensure that the search locates a provider that participates in the patient's benefit plan.

network(s) to provide covered behavioral health care to members served by BMP and EBHSP.

You and your patients are able to find EBHSP and BMP practitioners and facilities by going to our online Find a Doctor tool and entering the patient's ID number at the beginning of the search. Since some of our benefit plans use different provider networks, entering the patient's ID number will ensure that the search locates a provider that participates in the patient's benefit plan.

Prior Approval Requirements

In some cases, coverage of behavioral health services to a member served by EBHSP or BMP requires a prior approval before the service can be rendered. Members may be subject to a copay and/or deductible depending on their benefit plan.

Routine Outpatient Services - No Prior Approval

Prior approval is not required for routine outpatient services. These services include initial consultation and individual, group, family, couple and collateral treatment. Beacon Health Options will, however, reach out to practitioners when there are questions regarding the member's clinical treatment.

Services Requiring Prior Approval

Prior approval is always required for the following services:

- Inpatient behavioral health treatment
- Ambulatory detoxification treatment
- Outpatient ECT (electro-convulsive treatment)
- Partial hospitalization
- Intensive outpatient treatment
- Neuropsychological testing
- Psychological testing

How to Obtain Prior Approval

Program	Instructions
Emblem Behavioral Health Services Program (HIP members)	Requests may be submitted via the Beacon Health Options Provider Connect website: https://www.beaconhealthoptions.com/providers/beacon or by calling Beacon Health Options at 1-888-447-2526.
	(For members who have the Montefiore logo on the lower left corner of their ID card) Montefiore members can access behavioral health providers in the Montefiore network. Requests may be submitted by calling 1-800-401-4822.
EmblemHealth Behavioral Management Program (GHI members)	Requests may be submitted via the Beacon Health Options Provider Connect website: https://www.beaconhealthoptions.com/providers/beacon or by calling Beacon Health Options at 1-800-692-2489.

Note: Once Beacon Health Options approves the service, you must notify your patient of the approval. You must notify Beacon Health Options if you are unable to reach your patient (or his or her designee).

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

Claims

Beacon Health Options encourages electronic claim submission through their secure ProviderConnect website in order to expedite claims processing and assist participating providers in submitting claims and other routine transactions. Electronic claim submission is also accepted through clearinghouses. When using the services of a Clearinghouse, providers must reference Beacon Health Options' Payer ID, FHC &Affiliates, to ensure Beacon Health Options receives those claims. For more information, please contact a Beacon Health Options Electronic Claims Specialist at 1-888-247-9311.

If submitting on paper, outpatient professional services must be billed on a CMS-1500 form and include the billing and rendering providers' NPI and Tax Identification Numbers. Please note: Billed lines are limited to 10 per claim form. Please send paper claims submissions to:

Beacon Health Options
PO Box 1850
Hicksville, NY 11802-1850

To check on the status of a claim, please go to beaconhealthoptions.com or call 1-800-235-3149.

Case Management Program

The Case Management Program is administered by Beacon Health Options for all members (except for those with the Montefiore logo on their ID card).

Patients who have the greatest risk of needing intensive behavioral health services including inpatient care are eligible for case management services. Patients are identified through multiple sources including provider referrals.

An enrolled patient is assigned a case manager who will contact them, devise a treatment care plan and will work with their treatment provider(s) to assist with medication adherence and treatment plan compliance. The Case Management Program involves frequent telephonic counseling sessions between the case manager and patient to aid the patient in staying out of the hospital.

To refer a patient to the Case Management Program, please call the Mental Health number on the back of the member's ID card.

Behavioral Health Screening Tools

Behavioral Health Screenings for Patients

The role of health care professionals has evolved to include discussing and addressing mental health and substance use disorders with patients. In fact, the relationships that patients have with their doctors and other health care professionals have proven to be one of the most important factors in ensuring individuals receive appropriate behavioral health care.

Recognizing the signs of a behavioral health condition is not always easy. We are providing you with the following behavioral health screening tools to help you diagnose and refer individuals for further care.

Measure	Tool	About the Tool	Scoring and Action Steps
	PHQ-2[1]	Depression Screen - 2 Questions	Score of 0-2 = Negative screen Action: None Score of 3+ = Positive screen Action: Administer the PHQ-9[1].
	PHQ-9[1]	Depression Screen - 9 Questions	Score of 1-4 = Minimal depression Action: Watchful waiting; repeat PHQ-9 at follow-up visit. Score of 5-9 = Mild depression Action: Watchful waiting; repeat PHQ-9 at follow-up visit. Possible referral to behavioral health care professional for psychotherapy within 30 days of positive screen. Score of 10-14 = Moderate depression Action: Develop treatment plan, consider pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen. Score of 15-19 = Moderately severe depression Action: Active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen. Score of 20-27 = Severe depression Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management. Positive score on Item 9. Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.

Depression	PHQ-9 - Modified for Teens[2]	Depression Screen - 9 Questions	Score of 1-4 = Minimal depression Action: Watchful waiting; repeat PHQ-9 at follow-up visit. Score of 5-9 = Mild depression Action: Watchful waiting; repeat PHQ-9 at follow-up visit. Possible referral to behavioral health care professional for psychotherapy within 30 days of positive screen. Score of 10-14 = Moderate depression Action: Develop treatment plan, consider pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen. Score of 15-19 = Moderately severe depression Action: Active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen. Score of 20-27 = Severe depression Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management. Positive score on Item 9. Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.
	Edinburgh Postnatal Depression Scale[3]	Depression Screen - 10 Questions	Score of 0-9 = Low probability of depression Action: Watchful waiting; repeat Edinburgh Postnatal Depression Scale at follow-up visit. Score of 10-30 = High probability of moderate to severe depression Action: Develop treatment plan, possible active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen. If a patient scores a 1, 2, or 3 on question 10, please address suicidal thoughts immediately. Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.
	Geriatric Depression Scale (GDS)[4]	Depression Screen - 15 Questions	Score of 1-4 = Minimal depression Action: Watchful waiting; repeat GDS at follow-up visit. Score of 5-15 = Mild to severe depression Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.

Anxiety	GAD-2[1]	Anxiety Screen - 2 Questions	Score of 0-2 = Negative Screen Action: None Score of 3+ = Positive screen Action: Administer the GAD-7.[1]
	GAD-7[1]	Anxiety Screen - 7 Questions	Score of 1-4 = Minimal anxiety Action: Watchful waiting; repeat GAD-7 at follow-up visit. Score of 5-9 = Mild anxiety Action: Watchful waiting; repeat GAD-7 at follow-up visit. Score of 10-14 = Moderate anxiety Action: Further diagnostic assessment by PCP or behavioral health care professional. Consider pharmacotherapy and/or psychotherapy. Score of 15-21 = Severe anxiety Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.
Substance Abuse/ Dependence	NIDA-Quick Screen[5]	Alcohol/Drug and Tobacco Screen - 4 Questions (Single Question Screener Included)	If respondent indicates "No" for all drugs in prescreen. Action: Reinforce abstinence. If respondent indicates “Yes” to any of the drugs listed. Action: Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within 60 days of positive screen.
	AUDIT-C[6]	Alcohol Screen - 3 Questions	Score of 0-3 in Men / Score of 0-2 in Women = Minimal to moderate use. Low probability of abuse or dependence. Action: Reinforce abstinence. Watchful waiting; repeat AUDIT-C at follow-up visit. Score of 4-12 in Men / Score of 3-12 in Women =Moderate to severe use. High probability of abuse or dependence. Action: Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within 60 days of positive screen.

Substance Use	AUDIT[7]	Alcohol Screen - 10 Questions	Score of 1-7 = Minimal to moderate use. Low probability of abuse or dependence. Action: Reinforce abstinence. Watchful waiting; repeat AUDIT at follow-up visit. Score of 8-15 = Moderate to severe use. Moderate probability of abuse or dependence. Score of 16-19 = Moderate to severe use. Moderate to high probability of abuse or dependence. Score of 20-40 = Severe use. High probability of abuse or dependence. Action steps for scores of 8 or higher: Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within 60 days of positive screen.
Suicidality	CSSRS - Clinical Screener[8]	Suicide Severity Screen, Clinical Practice Screener - Recent - 6 Questions	1 or more “Yes” responses are a positive screen. Action: Refer to behavioral health care professional to evaluate risk factors and determine appropriate treatment setting. A “Yes” response to question #4 or #5 in the past month or any behavior in question #6 is an indication of severe risk. Action: Refer to behavioral health care professional to evaluate for hospitalization.

Our Physician Pocket Reference, a comprehensive booklet that incorporates all of these screening tools, is available for your use. We hope you find it useful in your practice.

Please also consult the Beacon Health Options PCP Toolkit for additional resources.

[1]Spitzer, R.; Williams, J. B.W.; Kroenke, K. and colleagues, with an educational grant from Pfizer. No permission required to reproduce, translate, display, or distribute. [2]Johnson J.G., Harris E.S., Spitzer R.L., Williams, J.B.W.: The Patient Health Questionnaire for Adolescents: Validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolescent Health 30:196–204, 2002. [3]Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*150:782-786. *and* K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199. [4]Yes average: The Use of Rating Depression Series in the Elderly, in Poon (ed.): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986. [5]National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services. [6]Bradley, K. A., Bush, K. R., Epler, A. J., et al (2003). Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female Veterans Affairs patient population. Arch Intern Med. 163:821-9 *and* Bush, K., Kivlahan, D.R., McDonell, M.B., et al (1998). The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Arch Intern Med. 158:1789-95. [7]Babor, T.F.; de la Fuente, J.R.; Saunders, J.; and Grant, M. AUDIT. *The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care*. Geneva, Switzerland: World Health Organization, 1992. [8]Developed by Drs. Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Additional Behavioral Health Screening Resources

Measures	Tool	About the Tool	Scoring and Action Steps
Depression	CES-D	Depression Screen - 20 Questions	See instructions for more information.
Depression	MFQ	Depression Screen - Several Versions	See instructions for more information.
Substance Use	ORT	Opioid Use Screen - 5 Questions	See instructions for more information.
Substance Use	CAGE-AID	Alcohol Screen - 4 Questions	See instructions for more information.
Substance Use	MSSI-SA	Alcohol/Drug Screen - 16 Questions	See instructions for more information.
Substance Use	NIAAA	Alcohol Screen - 3 Questions	See instructions for more information.
Substance Use	SOAPP	Opioid Screen - 14 Questions	See instructions for more information.
Suicidality	C-SSRS - Pediatric Lifetime /Recent	Suicide Severity Screen, Initial Visit - 5 Questions	See instructions for more information.
Suicidality	C-SSRS - Pediatric Since Last Visit	Suicide Severity Screen, Since Last Visit - 5 Questions	See instructions for more information.
Suicidality	C-SSRS - Risk Assessment Page	Protective and Risk Factors Checklist for Suicidality	See instructions for more information.

Mental Health Checkups for Adolescents

For Adolescents, or members that are between the ages of 11 to 18, emotional or mental health can affect how prepared they will be for school, their ability to connect with friends and family, and their ability to bounce back when faced with life's setbacks. Supporting an adolescent's emotional development and well-being is just as important as their physical health. Sometimes it is hard to know if an adolescent's emotional development is on track.

EmblemHealth engages practitioners with a wide range of services, supports and information to help our practitioners determine their member's emotional health needs.

The Mental Health Checkup

Primary care practitioners (PCPs) are responsible for conducting applicable behavioral health screenings. We ask our PCPs to have our adolescent members complete a Patient Health Questionnaire for Adolescents while they are in the waiting or exam room. The questionnaire can help evaluate if an adolescent is suffering from depression, anxiety or other condition. When a mental illness is identified early, the adolescent has the best chance to lead a healthy life and reach their full potential.

Why Primary Care Practitioners

PCPs are in a unique position to help detect mental health conditions. According to the US Surgeon General, 21 percent of our nation's youth suffers from a diagnosable mental disorder that causes impairment, but 80 percent are not identified and do not receive help. Further, about two million teenagers are affected by depression; however, most of them go undiagnosed and untreated.

EmblemHealth looks to its PCPs to be on guard for potential behavioral health diagnosis. Mental health screening is an effective way to identify an at-risk adolescent and its recommended by the US Preventive Services Task Force the Institute of Medicine, American Academy of Pediatrics, American Academy of Family Physicians and National Association of pediatric Nurse Practitioners.

PCPs may consult with Beacon Health Options, who manages the Behavioral Health benefit, regarding appropriate medication management. PCPs may also refer higher risk adolescents to a behavioral health practitioner. The New York State Office of Mental Health regulations define appropriate access to services and quality of care for children and adolescents treated in Clinics licensed by the New York State Office of Mental Health. For more information on these and other guidelines, please visit the New York State Office of Mental Health website: https://www.omh.ny.gov/omhweb/clinic_restructuring/appendix2.html.

Additional Resources

Note to all Providers: Although offered in context of FIDA, the downloadable provider trainings are a useful resource for you and your staff regarding cultural competency, identifying and supporting patients with behavioral health issues and accommodating the disabled and the elderly. The Behavioral Health Training explains how to identify and support individuals with various diagnoses. For more EmblemHealth training presentations and other learning

opportunities, please see the Learn Online.

Please click on the links below for additional resources that will assist providers in identifying and supporting patients with Behavioral Health needs:

- Serious and Persistent Mental Illness Disease Management Services
- Beacon Health Options Treatment Guidelines: http://www.beaconhealthoptions.com/providers/beacon/
- Depression: PHQ-2/PHQ-9 https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf
- Anxiety: http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf
- Mental Health Checkups for Adolescents
- Serious and Persistent Mental Illness Disease Management Services
- Drug & Alcohol Use (General): http://www.integration.samhsa.gov/images/res/CAGEAID.pdf
- Mental Health Problems in Older Adults - http://www.cdc.gov/aging/pdf/mental_health.pdf
- Suicide Risk: https://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf
- Additional screening tools and best practices: http://www.integration.samhsa.gov/clinical-practice/screening-tools

Mental Health Parity And Addiction Equity Act Of 2008 (MHPAEA)

On October 3, 2008 Congress enacted the Health Parity and Addiction Equity Act of 2008 (MHPAEA). The MHPAEA is a federal law that applies to large group, Medicare and Child Health Plus members whose group enrolled in a plan on or after October 3, 2009.

Under the MHPAEA, the expanded coverage for behavioral health services enacted by the New York State legislature under Timothy's Law was further enhanced to include substance abuse treatment and non-biologically based mental health treatment.

As a result of the MHPAEA, there is no day or visit limitation for members covered by the act who have a behavioral health benefit and meet medical necessity criteria. Prior approval requirements continue to apply to these services.

As of November 1, 2009 there are no limits to behavioral health services for Child Health Plus members.

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Table 21-1, Practitioner Complaint/Grievance Procedure

COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE HARD COPY**	TIME FRAMES*			ADDITIONAL RIGHTS
		Initial Practitioner Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter or Explanation of Payment (EOP), write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	60 calendar days from event.	15 calendar days from receipt of the request.	Complaint: 30 calendar days from receipt of request. Grievance: 45 calendar days from receipt of request.	Decision is final.
GHI HMO	Unless otherwise directed in the denial letter or Explanation of Payment (EOP), write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: 1-877-244-4466 TDD: 1-877-208-7920 Fax to: 1-845-340-3435	90 calendar days from event.	15 calendar days from receipt of the request.	Complaint: 30 calendar days from receipt of request. Grievance: 45 calendar days from receipt of request.	Decision is final.

GHI EPO/PPO and EmblemHealth EPO/PPO	Unless otherwise directed in the denial letter or Explanation of Payment (EOP), write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116-2857 Telephone: 1-212-501-4444	90 calendar days from event.	15 calendar days from receipt of the request.	Complaint: 30 calendar days from receipt of request. Grievance: 45 calendar days from receipt of request.	Decision is final.

*Privacy complaints are not subject to the above timeframes.

** Emblemhealth.com is the preferred method for filing.

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Member Complaint - First Level Process Tables

TABLE 21-2, FIRST MEMBER LEVEL COMPLAINT - EXPEDITED					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Member Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	60 business days from event.	N/A	Verbal response within 48 hours of receipt of necessary information. Written notice sent within 3 business days of determination	May file a second level complaint, expedited or standard. Additional complaint may be filed with the NYS DOH at any time by calling 1-800-206-8125.
GHI HMO	Write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: 1-877-244-4466 TTY/TDD: 711 Fax to: 1-845-340-3435	90 calendar days from event.	N/A	Verbal response within 48 hours of receipt of necessary information. Written notice sent within 3 business days of determination.	May file a second level complaint, expedited or standard Additional complaint may be filed with the NYS DOH at any time by calling 1-800-206-8125.

GHI and EmblemHealth EPO/PPO	Write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: 1-212-501-4444	90 calendar days from event.	N/A	Verbal response within 48 hours of receipt of necessary information Written notice sent within 3 business days of determination.	May file a second level complaint, expedited or standard.

TABLE 21-3, FIRST LEVEL MEMBER COMPLAINT - STANDARD

COMMERCIAL AND CHILD HEALTH PLUS PLANS

BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Member Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	60 business days from event.	15 business days from the receipt of the request	45 calendar days from receipt of all necessary information.	May file a second level complaint. Additional complaint may be filed with the NYS DOH at any time by calling 1-800-206-8125.

GHI HMO	Write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: 1-877-244-4466 TTY/TDD: 711 Fax to: 1-845-340-3435	90 calendar days from event.	15 business days from the receipt of the request	45 calendar days from receipt of all necessary information.	May file a second level complaint. Additional complaint may be filed with the NYS DOH at any time by calling 1-800-206-8125.
GHI and EmblemHealth EPO/PPO	Write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: 1-212-501-4444	90 calendar days from event.	15 business days from the receipt of the request	45 calendar days from receipt of all necessary information.	May file a second level complaint.

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Member Complaint - Second Level Process Tables

TABLE 21-4, SECOND LEVEL MEMBER COMPLAINT - EXPEDITED					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Member Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	60 business days from receipt of first level determination.	N/A	2 business days from receipt of necessary information.	Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.
GHI HMO	Write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: 1-877-244-4466 TTY/TDD: 711 Fax to: 1-845-340-3435	60 business days from receipt of first level determination.	N/A	2 business days from receipt of necessary information.	Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.

GHI and EmblemHealth EPO/PPO	Write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: 1-212-501-4444	60 business days from receipt of first level determination.	N/A	2 business days from receipt of necessary information.	Decision is final.

TABLE 21-5, SECOND LEVEL MEMBER COMPLAINT - STANDARD

COMMERCIAL AND CHILD HEALTH PLUS PLANS

BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Member Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	60 business days from receipt of first level determination.	15 business days from receipt of the request.	30 business days from receipt of all necessary information.	Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.
GHI HMO	Write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: 1-877-244-4466 TTY/TDD: 711 Fax to: 1-845-340-3435	60 business days from receipt of first level determination.	15 business days from receipt of the request.	30 business days from receipt of all necessary information.	Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.

GHI and EmblemHealth EPO/PPO	Write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: 1-212-501-4444	60 business days from receipt of first level determination.	15 business days from receipt of the request.	30 business days from receipt of all necessary information.	Decision is final.

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Member Grievance - First Level Process Tables

TABLE 21-6, FIRST LEVEL MEMBER GRIEVANCE - EXPEDITED					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Member Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	180 calendar days from receipt of written adverse determination.	N/A	No later than 48 hours from receipt of all necessary information but not to exceed 72 hours from receipt of the grievance. Verbally at time of determination. Written notice provided no later than 48 hours from receipt of all necessary information or 72 hours from receipt of the grievance.	May file a second level grievance. Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.

GHI HMO	Unless otherwise directed in the denial letter, write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: 1-877-244-4466 TTY/TDD: 711 Fax to: 1-845-340-3435	180 calendar days from receipt of written adverse determination.	N/A	No later than 48 hours from receipt of all necessary information but not to exceed 72 hours from receipt of the grievance. Verbally at time of determination. Written notice provided no later than 48 hours from receipt of all necessary information or 72 hours from receipt of the grievance.	May file a second level grievance. Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.
GHI and EmblemHealth EPO/PPO	Unless otherwise directed in the denial letter, write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: 1-212-501-4444	180 calendar days from receipt of written adverse determination.	N/A	No later than 48 hours from receipt of all necessary information but not to exceed 72 hours from receipt of the grievance. Verbally at time of determination. Written notice provided no later than 48 hours from receipt of all necessary information or 72 hours from receipt of the grievance.	May file a second level grievance.

TABLE 21-7, FIRST LEVEL MEMBER GRIEVANCE - STANDARD

FOR COMMERCIAL AND CHILD HEALTH PLUS PLANS

		TIME FRAMES		
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE:			ADDITIONAL RIGHTS

	INSTRUCTIONS	Initial Member Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	180 calendar days from receipt of written adverse determination.	Pre-Service: Acknowledgement is not required if the response is sent by the 15th calendar day of receipt. Post-Service: 15 calendar days from receipt of the grievance.	Pre-Service: 15 calendar days from receipt of the grievance. Post-Service: 30 calendar days from receipt of grievance.	May file a second level grievance. Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.
GHI HMO	Unless otherwise directed in the denial letter, write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: 1-877-244-4466 TTY/TDD: 711 Fax to: 1-845-340-3435	180 calendar days from receipt of written adverse determination.	*15 business days from receipt of the grievance (post-service) *acknowledgement is not required if responded to within 15 calendar days	Pre-Service: 15 calendar days from receipt of the grievance. Post-Service: 30 calendar days from receipt of grievance.	May file a second level grievance Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.
GHI and EmblemHealth EPO/PPO	Unless otherwise directed in the denial letter, write to: EmblemHealth/GHI PO Box 2857 New York, NY 10116 Telephone: 1-212-501-4444	180 calendar days from receipt of written adverse determination.	*15 business days from receipt of the grievance (post-service) *acknowledgement is not required if responded to within 15 calendar days	Pre-Service: 15 calendar days from receipt of the grievance. Post-Service: 30 calendar days from receipt of grievance.	May file a second level grievance.

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Member Grievance - Second Level Process Tables

TABLE 21-8, SECOND LEVEL MEMBER GRIEVANCE - EXPEDITED					
COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE: INSTRUCTIONS	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Member Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	60 business days from receipt of written grievance determination.	N/A	Within 2 business days of receipt of necessary information but not to exceed 72 hours. Verbally at time of determination. Written notice is provided no later than 2 business days from receipt of all necessary information, or 72 hours from receipt of the grievance.	Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.
GHI HMO	Unless otherwise directed in the denial letter, write to: GHI HMO Appeals and Complaints Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-877-244-4466	60 business days from receipt of written grievance determination.	N/A	Within 2 business days of receipt of necessary information but not to exceed 72 hours. Verbally at time of determination. Written notice is provided no later than 2 business days from receipt of all necessary information, or 72 hours from receipt of the grievance.	Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.

GHI and EmblemHealth EPO/PPO	Unless otherwise directed in the denial letter, write to: EmblemHealth/GHI PO Box 2844 New York, NY 10116 Telephone: 1-212-501-4444	60 business days from receipt of written grievance determination.	-- N/A	Within 2 business days of receipt of necessary information but not to exceed 72 hours. Verbally at time of determination. Written notice is provided no later than 2 business days from receipt of all necessary information, or 72 hours from receipt of the grievance.	Decision is final

TABLE 21-9, SECOND LEVEL MEMBER GRIEVANCE - STANDARD

COMMERCIAL AND CHILD HEALTH PLUS PLANS

BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE INSTRUCTIONS	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Practitioner Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	60 business days from receipt of written grievance determination.	Pre-Service: Acknowledgement is not required if responded to within 15 calendar days. Post-Service: 15 calendar days from receipt of the grievance-appeal.	Pre-Service: 15 calendar days from receipt of grievance-appeal. Post-Service: 30 calendar days from receipt of grievance-appeal.	Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.

GHI HMO	Unless otherwise directed in the denial letter, write to: GHI HMO Appeals and Complaints Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-877-244-4466	60 business days from receipt of written grievance determination.	Pre-Service: Acknowledgement is not required if responded to within 15 calendar days. Post-Service: 15 calendar days from receipt of the grievance-appeal.	Pre-Service: 15 calendar days from receipt of grievance-appeal. Post-Service: 30 calendar days from receipt of grievance-appeal.	Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.
GHI and EmblemHealth EPO/PPO	Unless otherwise directed in the denial letter, write to: EmblemHealth/GHI PO Box 2844 New York, NY 10116-2844 Telephone: 1-877-842-3625	60 business days from receipt of written grievance determination.	Pre-Service: Acknowledgement is not required if responded to within 15 calendar days. Post-Service: 15 calendar days from receipt of the grievance-appeal.	Pre-Service: 15 calendar days from receipt of grievance-appeal. Post-Service: 30 calendar days from receipt of grievance --	Decision is final.

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Table 21-10, Clinical Appeal - Expedited

COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	WHAT/HOW/ WHERE TO FILE: INSTRUCTIONS	TIME FRAMES Initial Member/Provider* Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	ADDITIONAL RIGHTS
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-888-447-6855 Fax to: 1-866-350-2168	Member: 180 calendar days from receipt of written adverse determination. Provider: Pre-Service on behalf of the member: 180 calendar days from receipt of written adverse determination.	Expedited determinations are made in less than 15 days.	2 business days from receipt of all necessary information, but not to exceed 72 hours from receipt of appeal.	May appeal using our standard appeal process. External appeal process. Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.
GHI HMO	Unless otherwise directed in the denial letter, write to: GHI HMO Appeals and Complaints Dept PO Box 2807 New York, NY 10117-2807 Telephone: 1-877-244-4466 TDD: 1-877-208-7920 Fax to: 1-845-340-3435	Member: 180 calendar days from receipt of written adverse determination. Provider: Pre-Service on behalf of the member 180 calendar days from receipt of written adverse determination.	Expedited determinations are made in less than 15 days.	2 business days from receipt of all necessary information, but not to exceed 72 hours from receipt of appeal.	May appeal using our standard appeal process. External appeal process. Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125.

GHI PPO and EmblemHealth PPO/EPO	Unless otherwise directed in the denial letter, write to: GHI or EmblemHealth Supervisor of Appeals PO Box 2809 New York, NY 10116 Telephone: 1-888-906-7668 Fax to: 1-212-287-2754	Member: 180 calendar days from receipt of written adverse determination. Provider: Pre-Service on behalf of the member: 180 calendar days from receipt of written adverse determination.	Expedited determinations are made in less than 15 days.	2 business days from receipt of all necessary information, but not to exceed 72 hours from receipt of appeal.	May appeal using our standard appeal process. External appeal process

*Contracted provider time frames in provider agreements will supersede time frames in this manual except in the case of regulatory requirements.

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Table 21-11, Appeal - Standard

COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE: INSTRUCTIONS	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Member/ Provider* Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
HIP Commercial, HIP Child Health Plus and EmblemHealth CompreHealth EPO (Retired August 1, 2018)	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-888-447-6855	Member: 180 calendar days from receipt of written adverse determination. Provider: Pre-Service on behalf of member: 180 calendar days from receipt of written adverse determination. For Payment: 45 calendar days from receipt of written adverse determination.	15 calendar days from receipt of the appeal	HMO: 30 calendar days from receipt for pre-service requests 60 calendar days from receipt of request for post service requests PPO/EPO: 30 calendar days for all requests Both member and provider notified within 2 business days of determination but not to exceed determination timeframe.	External Appeal Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125
GHI HMO	EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-877-244-4466 TDD: 1-877-208-7920 Fax to: 1-845-340-3435	Member: 180 calendar days from receipt of written adverse determination. Provider: Pre-Service on behalf of member: 180 calendar days from receipt of written adverse determination. For Payment: 45 calendar days from receipt of written adverse determination.	15 calendar days from receipt of the appeal	30 calendar days from receipt for pre-service requests 60 calendar days from receipt of request for post service requests Both member and provider notified within 2 business days of determination but not to exceed determination timeframe.	External Appeal Additional complaints may be filed with the NYS DOH at any time by calling 1-800-206-8125

GHI PPO and EmblemHealth PPO/EPO	Unless otherwise directed in the denial letter, write to: GHI or EmblemHealth Supervisor of Appeals PO Box 2809 New York, NY 10116 Telephone: 1-888-906-7668 Fax to: 1-212-287-2754	Member: 180 calendar days from receipt of written adverse determination. Provider: Pre-Service on behalf of member: 180 calendar days from receipt of written adverse determination. For Payment: 45 calendar days from receipt of written adverse determination.	15 calendar days from receipt of appeal	30 calendar days Both member and provider notified within 2 business days of determination but not to exceed determination timeframe.	External appeal

*Contracted provider time frames in provider agreements will supersede time frames in this manual.

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Table 21-12, Facility Retrospective Review Request

FOR DENIALS BASED ON "NO PRIOR APPROVAL"					
FOR DENIALS BASED ON "NO E.R. NOTIFICATION"					
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE INSTRUCTIONS	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Facility Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
All HIP** and EmblemHealth CompreHealth EPO	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	45 days from the claim denial, unless specified otherwise by your contract with HIP.	15 calendar days from receipt of necessary information.	Determination is made within 30 days from receipt of request for retrospective utilization review.	May file a facility clinical appeal.
GHI HMO**	See Member Appeal.				

GHI PPO** and EmblemHealth PPO/EPO	Unless otherwise directed in the denial letter, write to: GHI or EmblemHealth Supervisor of Appeals PO Box 2809 New York, NY 10116 Telephone: 1-866-447-9717 Fax to: 1-212-287-2754	Member: 180 calendar days from receipt of written adverse determination. Provider: 45 calendar days from receipt of written adverse determination.	15 calendar days from receipt of necessary information.	60 calendar days from receipt. (30 days for PPO accounts) Both member and provider notified within 2 business days of determination.	External appeal

EmblemHealth

Table 21-13, Facility Clinical Appeal

FOR DENIALS BASED ON "NO INFORMATION"					
WHEN MEMBERS ARE ALREADY DISCHARGED					
		TIME FRAMES			
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE INSTRUCTIONS	Initial Facility Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	ADDITIONAL RIGHTS
All HIP and EmblemHealth CompreHealth EPO	Unless otherwise directed in the denial letter, write to: EmblemHealth Grievance and Appeal Dept. PO Box 2844 New York, NY 10116-2844 Telephone: 1-800-447-8255	45 calendar days from receipt of written adverse determination.	15 calendar days from receipt of necessary information	For members already discharged or "no information" denial: 5 business days from determination. For no E.R. notification: Within 2 business days of determination. 60 calendar days. (30 days for PPO accounts) Both member and provider notified within 2 business days of determination.	

GHI HMO	For members already discharged: This process does not exist for these plans. Please file a member appeal. For "no information" denial or no E.R. notification: This process does not exist for these plans. Please file a dispute of this type as a practitioner grievance.				
GHI PPO and EmblemHealth PPO/EPO	Unless otherwise directed in the denial letter, write to: GHI or EmblemHealth Supervisor of Appeals PO Box 2809 New York, NY 10116 Telephone: 1-866-447-9717 Fax to: 1-212-287-2754	Member: 180 calendar days from receipt of written adverse determination. Provider: 45 calendar days from the claim denial, unless specified otherwise by your contract with HIP.	15 calendar days from receipt of necessary information.	60 calendar days from receipt . (30 days for PPO accounts) Both member and provider notified within 2 business days of determination.	External appeal

EmblemHealth

Provider Manual

Chapter 32: Dispute Resolution for Commercial and CHP Plans

This chapter contains processes for our members and practitioners to dispute a determination that results in a denial of payment or covered service.

Overview

EmblemHealth provides processes for members and practitioners to dispute a determination that results in a denial of payment and/or covered services. Process, terminology, filing instructions, applicable time frames and additional and/or external review rights vary based on the type of plan in which the member is enrolled. The processes in this section apply to Commercial/CHP plans.

View the processes for Medicaid plans.

We do not discriminate against practitioners or members, or attempt to terminate a practitioner's agreement or disenroll a member, for filing a request for dispute resolution.

We have interpreter services available to assist members with language and hearing/vision impairments.

Payments for Services in Dispute

EmblemHealth network practitioners may not seek payment from members for either covered services or services determined by EmblemHealth's Care Management program not to be medically necessary unless the member agrees, in writing and in advance of the service, to such payment as a private patient and the written agreement is placed in the member's medical record. Any practitioner attempting to collect such payment from the member in the absence of such a written agreement does so in breach of the contractual provisions with EmblemHealth. Such breach may be grounds for termination of the practitioner's contract.

Key Terminology

The following descriptions provide a general overview of the terminology used with Commercial plans (including

Child Health Plus).

Adverse Determination
A notification sent when a health care service, procedure or treatment is denied.

Appeal
A request to review any aspect of an adverse clinical determination based on medical necessity.

Complaint
A request to review an administrative process, service or quality-of-care issue that does not pertain to a determination based on claims, benefits or medical necessity.

Grievance
A request to review any aspect of an adverse benefit or claim determination that is not based on medical necessity.

Certain disputes - whether they are appeals, complaints or grievances - may be filed as expedited or standarddepending on the urgency of the patient's condition.

Certain disputes may also be filed as pre-service or post-service depending on the timing of the determination in question.

Managing Entities' Role in Dispute Resolution

EmblemHealth contracts with separate managing entities to provide care for certain types of medical conditions. In these cases, the designated managing entity will determine the applicable process for filing a dispute. Any aspect of service rendered by EmblemHealth or any entity designated to perform administrative functions on our behalf is hereafter jointly referred to as "EmblemHealth."

Initial Adverse Determinations

EmblemHealth will send a written notice on the date when a health care service, procedure or treatment is given an adverse determination (denial) on the following grounds:

- Service does not meet or no longer meets the criteria for medical necessity, based on the information provided to us.
- Service is considered to be experimental or investigational (rare disease, clinical trial and out-of-network services).
- Service is approved, but the amount, scope or duration is less than requested.
- Service is not a covered benefit under the member's benefit plan.
- Service is a covered benefit under the member's benefit plan, but the member has exhausted the benefit for that service.

The written notice will be sent to the member and provider and will include:

- The reasons for the determination, including the clinical rationale, if any.
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals.
- Notice of the availability, upon request of the member or the member's designee of the clinical review criteria relied upon to make such determination.
- A description of what additional information, if any, must be provided to, or obtained by, EmblemHealth in order for EmblemHealth to make an appeal determination.

- The description of the Action to be taken.
- A statement that EmblemHealth will not retaliate or take any discriminatory action against the member if an appeal is filed.
- The process and time frame for filing/reviewing an appeal with EmblemHealth, including the member's right to file an expedited review.
- The member's right to contact the DOH, with 1-800 number regarding their complaint.

The failure of EmblemHealth to make a utilization review (UR) determination within the time periods prescribed in the Care Management chapter is deemed to be an adverse determination subject to appeal. EmblemHealth must send notice of denial on the date that the utilization review's time frames expire.

Reconsideration

When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one business day of receipt of the request (except for retrospective, which is within 5 days) and shall be conducted by the member's health care provider and the clinical peer reviewer making the initial determination. See the Care Management chapter for more information.

Retrospective Review Requests

For retrospective review requests, EmblemHealth must make a decision and notify member by mail on the date of the payment denial, in whole or in part. The decision must be made within 30 days of receipt of the necessary information.

EmblemHealth may reverse a prior approval decision for a treatment, service or procedure on retrospective review pursuant to section 4905(5) of PHL when:

- Relevant medical information presented to EmblemHealth or the utilization review agent upon retrospective review is materially different from the information that was presented during the prior approval; and
- The information existed at the time of the prior approval review but was withheld or not made available; and
- EmblemHealth or the utilization review agent was not aware of the existence of the information at the time of the prior approval review; and
- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Home Health Care Determinations Following an Inpatient Hospital Admission

EmblemHealth will provide notice of our determination within one business day of receipt of the necessary information, or if the day after the request for services falls on a weekend or holiday, within 72 hours of receipt of necessary information. If a request for home health care services and all necessary information is provided to us prior to a member's inpatient hospital discharge, we will not deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the review determination is pending. There may, however, be other reasons for denying the service such as the exhaustion of a benefit. Denials for home health services following a discharge from a hospital admission will be treated as expedited appeals.

Final Adverse Determinations

For decisions that uphold or partially uphold a determination made regarding a clinical issue for which no additional internal appeal options are available, EmblemHealth will issue a final adverse determination (FAD) in writing to the member and provider.

The FAD contains the following information:

- The basis and clinical rationale for the determination.
- The words "final adverse determination."
- EmblemHealth contact person and phone number.
- The member's coverage type.
- EmblemHealth's contact person or UR agent, address and phone number.
- A summary of the appeal.
- The date the appeal was filed.
- The date the appeal process was completed.
- The health service that was denied, including the name of the facility/provider and developer/manufacturer of the health care service as available.
- A statement that the member may be eligible for external appeal and time frames for appeal.
- A standard description of external appeals process, including a clear statement in bold that the member/designee has 4 months and the provider has 60 days (45 days before July 1, 2014) from the final adverse determination to request an external appeal and choosing a second level of internal appeal may cause the time to file external appeal to expire. This applies to GHI PPO FEHB plan members only.
- Standard description of external appeals process attached.
- The terms "medical necessity", "experimental/investigational", "out-of-network", "clinical trial" or "rare disease treatment".
- Information on available alternative and/or external dispute resolution options.

Notice of Final Appeal Determination

EmblemHealth will notify the member or member's designee in writing of the final appeal determination within two business days of when we make the decision. However, written notice of final adverse determination concerning an expedited utilization review appeal shall be transmitted to the member within 24 hours of rendering the determination.

Practitioner Dispute Resolution Procedures: Complaints and Grievances

Practitioner Complaint Process

If a practitioner is dissatisfied with an administrative process, quality of care issue and/or any aspect of service rendered by EmblemHealth that does not pertain to a benefit or claim determination, the practitioner may file a complaint on his/her own behalf. Examples of such dissatisfaction include:

- Long wait times on EmblemHealth's authorization phone lines

- Difficulty accessing EmblemHealth's systems
- Quality-of-care issues

Once a decision is made on a practitioner's complaint, it is considered final and there are no additional internal review rights.

Complaints must be submitted in writing to the EmblemHealth's Grievance and Appeals (GAD) department. A complaint should include a detailed explanation of the clinician's request and any documentation to support the practitioner's position.

The Plan will acknowledge receipt of the practitioner's complaint in writing no later than 15 days after its receipt. Practitioner complaints will be reviewed and a written response will be issued directly to the practitioner no later than 30 days after receipt.

Practitioner Grievance Process

If a practitioner is not satisfied with any aspect of a claim determination rendered by the Plan (or any entity designated to perform administrative functions on its behalf) which does not pertain to a medical necessity determination, that practitioner may file a grievance with EmblemHealth.

Examples of reasons for filing grievances include dissatisfaction with a decision resulting from a failure to follow a Plan policy or procedure, or failure to obtain prior approval for an inpatient admission. A practitioner may also file a grievance regarding how a claim was processed, including issues such as computational errors, interpretation of contract reimbursement terms, or timeliness of payment. The Grievance and Appeal Department is not involved in determining claim payment or authorizing services, but independently investigates all grievances.

In addition, providers who wish to challenge the recovery of an overpayment or request a reconsideration for commercial claims denied exclusively for untimely filing may follow the grievance procedures in this sub-section. Note: The right to reconsideration shall not apply to a GHI claim submitted 365 days after the service, or a HIP claim submitted 120 days after service unless the participation agreement states an alternative time frame to be applied. If a claim was submitted more than one year from date of service, EmblemHealth may deny the claim in full or in the alternative may agree to reduce payments by up to twenty five percent of the amount that would have been paid had the claim been submitted in a timely manner. For grievances related to untimely filing, the provider must demonstrate that the late submission was an unusual occurrence and that they have a pattern of submitting claims in a timely manner. Examples of an unusual occurrence include:

- Medicaid Reclamation
- Member submitted the wrong insurance information to the provider
- Coordination of Benefits related issues
- Member retroactively reinstated

The practitioner has the option to question a claim's payment by submitting an inquiry along with supporting documentation within the Claim's Inquiry function in the secure site at www.emblemhealth.com. For multiple claims, utilize the messenger center function to send grievance and attach files.

The grievance should be accompanied by a copy of the notice of the standard denial or other documentation of the denial, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision.

EmblemHealth will acknowledge, in writing, receipt of a grievance that is submitted in writing no later than 15 days after its receipt. The grievance will be reviewed and a written response will be issued for grievances with a final disposition of partial overturn or upheld, no later than 45 days after receipt. The determination included in the response will be final.

Grievances with a favorable disposition will receive a claims remittance advice in lieu of a written response no later than 45 days after receipt.

View TABLE 21-1, PRACTITIONER COMPLAINT/GRIEVANCE PROCEDURES here

Member Dispute Resolution Procedures: Complaints and Grievances

Appointing a Designee

Members wishing to dispute a determination or claim denial may do so themselves or designate a person or practitioner to act on their behalf. To appoint a designee, members must submit by fax or by mail a signed HIPAA Compliant Authorization Form or a Power of Attorney form that specifies the individual as an authorized party.

Extensions

In certain circumstances, dispute resolution time frames may be extended if permitted by law and requested by the complainant, or if EmblemHealth believes an extension is in the best interest of the member.

Member Complaint - First Level Process

A member or designee may file a first level complaint when the member is dissatisfied with any aspect of an EmblemHealth-rendered service that does not pertain to a benefit or claim determination. Examples of such dissatisfaction include:

- Dissatisfaction with treatment received from EmblemHealth, its practitioners or benefit administrators
- Quality-of-care complaints
- Privacy complaints regarding EmblemHealth's practices in using or disclosing protected health information
- Alleged violation of EmblemHealth's privacy practices and/or state and federal law regarding the privacy of protected health information
- Fraud and abuse

Complaints should include a detailed description of the circumstances surrounding the occurrence. EmblemHealth will acknowledge receipt of the complaint and request any necessary information in writing. Complaints will be reviewed and a response will be issued in writing according to the time frames applicable to the member's benefit plan and detailed in the table on the following pages.

View Member Complaint - First Level Process Tables here

Member Complaint - Second Level Process

If a member or designee is not satisfied with the resolution of a first level complaint, EmblemHealth provides a second level complaint review.

To initiate a second level complaint, a member or designee must submit the second level complaint for review. We will respond within the timeframes noted in the tables on the following pages. Once we reach a decision, that decision is final and there are no further formal appeals or external mediation opportunities. Please refer to the grids, as in some instances, a member may have the right to complain to the NYS Department of Health.

Second level complaints should include a detailed explanation of the request and any documentation to support the member's position.

View Member Complaint - Second Level Process Tables here

Member Grievance - First Level Process

If a member or designee is not satisfied with any aspect of a benefit or claim determination rendered by EmblemHealth that does not pertain to a medical necessity, experimental determination or investigational determination, he/she may file a first level grievance.

Grievances should be accompanied by a copy of the adverse determination, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision. We will acknowledge receipt of the grievance and request any necessary information in writing. Grievances will be reviewed and a response will be issued according to the time frames detailed in the tables on the following pages.

View Member Grievance - First Level Process Tables here

Member Grievance - Second Level Process

If a member or designee is not satisfied with the resolution of a first level grievance, we provide a second level grievance review.

To initiate a second level member grievance, the member or designee must submit the second level grievance with all supporting documentation. We will review the grievance and respond within the time frames noted in the tables on the following pages.

View Member Grievance - Second Level Process Tables here

Provider and Member Clinical Appeal Processes

Waiving the Internal Appeal Process

Waiving the Internal Appeal Process

The member or designee and EmblemHealth may jointly agree to waive the internal expedited and standard appeal processes. If this occurs, EmblemHealth must provide a written letter with information regarding filing an External Appeal to the member and the member's health care provider within 24 hours of the agreement to waive EmblemHealth's internal appeal process. For more information, please see the section on New York State External Appeals later in this chapter.

Clinical Appeal - Expedited Process

If a member or designee is not satisfied with a service or a determination that was rendered based on issues of medical necessity, an experimental or investigational use, a rare disease or (in certain instances) out-of-network services, an expedited appeal may be filed if we determine or the provider indicates that a delay would seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. The member or designee may request expedited review of a prior approval request or concurrent review request.

An expedited appeal may be filed:

- For continued or extended health care services, procedures or treatments
- For additional services for members undergoing a course of continued treatment
- When the health care provider believes an immediate appeal is warranted
- When EmblemHealth honors the member's request for an expedited review

Expedited appeals should be accompanied by a copy of the denial letter, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision. The expedited utilization review appeal may be filed in writing or by telephone.

Missing Information

If EmblemHealth required information necessary to conduct an expedited appeal, EmblemHealth shall immediately notify the member and the member's health care provider by phone or fax and to identify and request the necessary information followed by written notification.

Reviewer of Expedited Appeal Requests

The review will be conducted by a qualified EmblemHealth medical director who was neither involved in prior determinations nor the subordinate of any person involved in the initial adverse determination. A clinical peer reviewer will be available to discuss the appeal within one business day.

Denial of Expedited Appeal Process

If we deny the request for expedited review because it does not meet the criteria for an expedited appeal, we will process the request through the standard appeal review time frames and will notify the appellant of this verbally and in writing.

Failure to Render a Decision

If we do not render a decision on the appeal within the applicable timelines, the adverse determination will be reversed automatically and the requested services or benefits will be approved.

Expedited Appeal Not Resolved to Member's Satisfaction

Expedited appeals not resolved to the satisfaction of the member or designee may be re-appealed through EmblemHealth's process for standard appeals described below. In the alternative, the member or designee may request an external appeal process.

We will review the request and respond within the time frames noted in the following table

Clinical Appeal - Standard Process

If a member or designee or provider is not satisfied with a service or a determination that was rendered based on issues of medical necessity, an experimental or investigational use, a clinical trial, a rare disease or (in certain instances) out-of-network services, an appeal may be filed. The standard Clinical Appeal may be filed in writing or by telephone.

Missing Information

If we require information necessary to conduct a standard internal appeal, we will notify the member and the member's health care provider, in writing, within 15 calendar days of receipt of the appeal (as noted in the tables below), to identify and request the necessary information. In the event that only a portion of such necessary information is received, we shall request the missing information, in writing, within five business days of receipt of the partial information.

Reviewer of Standard Appeal Requests

The review will be conducted by a qualified EmblemHealth medical director who was neither involved in prior determinations nor the subordinate of any person involved in the initial adverse determination. A clinical peer reviewer will be available to discuss the appeal within one business day.

Failure to Render A Decision

If we do not render a decision on the appeal within the applicable timelines, the adverse determination will be reversed automatically and the requested services or benefits will be approved.

Standard Appeal Not Resolved to Members Satisfaction

Member or designee may request an External Appeal as described in this chapter.

Procedures for initiating a standard appeal are outlined in the tables on the following pages. View TABLE 21-11, APPEAL - STANDARD here.

New York State External Appeals

New York State External Appeals

A member has a right to an external appeal of a final adverse determination. New York State's External Appeal Law provides the opportunity for the external review of adverse determinations for members and providers based on lack of medical necessity, experimental or investigational treatment, a clinical trial or (in certain instances) out-of-network services. Further, a member, the member's designee and, in conjunction with concurrent and retrospective adverse determinations, a member's health care provider has the right to request an external appeal.

As of January, 1, 2010, this law also applies to rare diseases, which are defined as any life threatening or disabling condition that is or was subject to review by the National Institutes of Health's Rare Disease Council or affects less than 200,000 US residents per year and there is no standard health service or treatment more beneficial than the requested health service or treatment. To qualify as a rare disease, the condition must be certified by an outside physician specialized in an area appropriate to treat the disease in question, the patient should be likely to benefit from the proposed treatment and the benefits must outweigh the risks.

The provider may only file an external review on their own behalf for concurrent and retrospective adverse determinations.

The Circumstances When an External Appeal May Be Filed

1. When the member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary and
2. EmblemHealth has rendered a final adverse determination with respect to such health care service or
3. both EmblemHealth and the member have jointly agreed to waive any internal appeal.

An External Appeal May Also Be Filed

1. When the member has had coverage of a health care service denied on the basis that such service is experimental or investigational and
2. the denial has been upheld on appeal or both EmblemHealth and the member have jointly agreed to waive any internal appeal
3. and the member's attending physician has certified that the member has a life-threatening or disabling condition or disease
   - for which standard health services or procedures have been ineffective or would be medically inappropriate or
   - for which there does not exist a more beneficial standard health service or procedure covered by the health care plan or
   - for which there exists a clinical trial or rare disease treatment
4. and the member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must have recommended either
   - a health service or procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B)

that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure, or in the case of a rare disease, based on the physician's certification required by Section 4900 (7)(g) of the PHL and such other evidence as the member, the designee or the attending doctor may present, that the requested health service or procedure is likely to benefit the member in the treatment of the enrollee's rare disease and that the benefit outweighs the risks of such health service or procedure; or

- a clinical trial for which the member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation,

5. and the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

External Appeal for Denial of Out-of-Network Service

The member has had coverage of the health service, which would otherwise be a covered benefit under the member's benefit plan which is denied on appeal, in whole or in part, on the grounds that such health service is out-of-network and an alternate recommended health service is available in-network, and EmblemHealth has rendered a final adverse determination with respect to an out-of-network denial or both EmblemHealth and the member have jointly agreed to waive any internal appeal; and

the member's attending doctor, who shall be a licensed, board-certified or eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health service sought, certifies that the out-of-network health service is materially different from the alternate recommended in-network service, and recommends a health care service that, based on two documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.

EmblemHealth has only one level of internal appeal; it does not require the member to exhaust any second level of internal appeal to be eligible for an external appeal.

How to File an External Clinical Appeal

To file an external clinical appeal, the practitioner appealing on his/her own behalf must complete a New York State External Appeal Application, accessible at https://www.dfs.ny.gov/docs/insurance/extapp/extappl.pdf and send it to the New York State Department of Financial Services within 60 days (45 days before July 1, 2014) from the date of the final adverse determination of the first level appeal.

The member and member's designee (including the provider in the capacity of the member's designee) may submit the same form within 4 months of the final adverse determination. If the member files on their own behalf, signed applications authorizing the release of medical records must also be sent to the New York State Department of Financial Services along with the application. (Note: Application fees are waived for Child Health Plus members.)

An external appeal must be submitted within the applicable time frame upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested. If a member chooses to request a second level internal appeal, the time may expire for the member to request an external appeal. Second level internal appeals are for GHI PPO FEHB plan participating providers only.

The New York State Department of Financial Services screens applications and assigns eligible appeals to state-certified external appeals agents. The Department of Financial Services then notifies both the filer and EmblemHealth whether the request is eligible for appeal, provides explanation thereof and sends a copy of the signed release form.

EmblemHealth will provide medical and treatment records and an itemization of the clinical standards used to determine medical necessity within three business days of receiving the agent's information and completed release forms. For an expedited appeal, this information will be provided within 24 hours of receipt.

For urgent medical circumstances, an expedited review may be requested which will render a decision within three days.

For standard cases, a determination will be made within 30 days from receipt of the member's request, in accordance with the commissioner's instructions. The external appeal agent shall have the opportunity to request additional information from the member, practitioner and EmblemHealth within the 30-day period, in which case the agent shall have up to five additional business days to make a determination.

The decision of the external appeal agent is final and binding on both the member and EmblemHealth.

To obtain an application or to inquire about external appeals, please contact the New York State Department of Financial Services at 1-800-400-8882 or e-mail externalappealquestions@dfs.ny.gov.

Note: Practitioners appealing concurrent review determinations cannot pursue reimbursement from members other than copayments from a member for services deemed not medically necessary by the external appeal agent.

Facility Dispute Resolution Procedures

Alternative Dispute Resolution

An Article 28 facility may agree to an alternative dispute resolution in lieu of an external appeal. The alternative dispute process does not affect a member's external appeal rights or the member's right to establish the provider as their designee.

Retrospective Utilization Review Requests

If an EmblemHealth-contracted facility fails to follow prior approval and/or emergency admittance procedures, payments for such services may be denied and the facility, EmblemHealth or its managing entity may initiate a retrospective utilization review (RUR).

- For Denials Based on "No Prior Approval"
  If the facility fails to obtain prior approval, payment will be denied for "no prior approval." The remittance statement will include information regarding the facility's right to request a retrospective utilization review for medical necessity. See the Care Management chapter.

If the facility fails to request a retrospective utilization review and submit the medical record within 45 days of receipt of the remittance statement, the claim denial will be upheld and the facility will have no further appeal rights.

If EmblemHealth or the managing entity fails to render and communicate a decision to the facility within 30 days of receipt of all information, the case will be deemed automatically denied and the facility will have the right to appeal the decision.

- For Denials Based on "No E.R. Notification" If the facility admits a patient through the emergency room without notifying EmblemHealth or the managing entity and submits a claim for services rendered, EmblemHealth will request medical records to initiate a retrospective utilization review for medical necessity.

- If the facility fails to submit the medical record within the time frame, the facility will receive an adverse determination stating inability to establish medical necessity based on no information received. The facility will then have the opportunity to file a facility clinical appeal.
- For Facility Retrospective Utilization Review requests for outpatient PT/OT Services managed by Palladian, please follow the process in the PT/OT section.

View TABLE 21-12, FACILITY RETROSPECTIVE REVIEW REQUEST here

Facility Clinical Appeals

If an EmblemHealth-contracted facility is not satisfied with a claim determination regarding denial of payment for inpatient services based on medical necessity, the facility may file a facility clinical appeal.

EmblemHealth provides one internal level of appeal for facilities. Federal Accounts do not have external appeal rights. Effective 1/1/2010, in cases where the initial adverse determination was made retrospectively or concurrently, the facility has the additional right to file a New York State External Appeal.

EmblemHealth handles all facility clinical appeals, except in the following situations, where the managing entity handles the appeal:

- If the managing entity has a direct contract with the facility.
- The managing entity has denied the case based on medical information.
- The managing entity has denied the case for "no information."

EmblemHealth or the managing entity will render a decision within 30 days of receipt of the appeal request (for PPO accounts) or 60 days of receipt of the appeal request for all others.

- For Members Already Discharged
  If the facility provides additional information after the denial is issued and after the member is already discharged, no reconsideration review will be performed. However, the facility may exercise its right to a clinical appeal.

- The appeal request must be filed within 45 days of the initial adverse determination or as stated in the facility contract. If the appeal request is received outside of this time frame, the original denial will be upheld and there will be no further appeal rights. Facilities are not permitted to balance bill members for such denials.

- For Denials Based on "No Information"
  If the facility fails to provide any clinical information to establish medical necessity for an admission or procedure, the claim will be denied based on "no information" and the facility may file a clinical appeal.

View TABLE 21-13, FACILITY CLINICAL APPEAL here

EmblemHealth

Provider Manual

Chapter 33: Dispute Resolution for Medicaid Managed Care Plans

This chapter contains the processes for our Medicaid managed care plan members and practitioners to dispute a determination that results in a denial of payment and/or covered service.

Members have the right to file complaints, complaint appeals, and action appeals. This chapter includes the processes and time frames and provides toll-free numbers for filing orally. Members have the right to a designee to file on their behalf. EmblemHealth's Customer Service department is available to provide members with assistance to file. We have interpreter services available to assist members with language and hearing/vision impairments.

EmblemHealth contracts with separate managing entities to provide care for certain types of medical conditions. In these cases, the designated managing entity will determine the applicable process for filing a dispute.

We do not discriminate against practitioners or members, attempt to terminate a practitioner's agreement or attempt to disenroll a member for filing a request for dispute resolution.

Chapter Overview

This chapter contains the processes for our Medicaid managed care plan members and practitioners to dispute a determination that results in a denial of payment and/or covered service.

Members have the right to file complaints, complaint appeals, and action appeals. This chapter includes the processes and time frames and provides toll-free numbers for filing orally. Members have the right to a designee to

file on their behalf. EmblemHealth's Customer Service department is available to provide members with assistance to file. We have interpreter services available to assist members with language and hearing/vision impairments.

EmblemHealth contracts with separate managing entities to provide care for certain types of medical conditions. In these cases, the designated managing entity will determine the applicable process for filing a dispute.

We do not discriminate against practitioners or members, attempt to terminate a practitioner's agreement or attempt to disenroll a member for filing a request for dispute resolution.

Review Request Notification and Timeframes

Failure by EmblemHealth to make a utilization review (UR) determination within the specified regulatory time periods chapter is deemed an adverse determination subject to appeal. EmblemHealth must send notice of denial on the date the utilization review's time frames expire.

For Prior Approval and Concurrent Review Requests

Certain requests for prior approval and concurrent review may be filed as expedited or *standard* depending on the urgency of the patient's condition. EmblemHealth must make a decision and notify member and provider, by phone and in writing as fast as the member's condition requires for both prior approval and concurrent review requests. In addition, for prior approval requests, the decision must be made: within 72 hours of our receipt of an expedited authorization request (this includes Certified Court Mental Health/Substance abuse disorder Services) or (2) in all other cases, within 3 business days of receipt of necessary information but no more than 14 calendar days of the request. For concurrent review requests, the time frame for a decision is (1) within 1 business day of receipt of necessary information but no more than 72 hours of an expedited authorization request or (2) in all other cases, within 1 business day of receipt of necessary information but no more than 14 days of the request.

For Retrospective Review Requests

EmblemHealth must make a decision and notify the member by mail on the date of the payment denial, in whole or in part. The decision must be made within 30 days of receipt of the necessary information.

EmblemHealth may reverse a prior approval treatment, service, or procedure on retrospective review pursuant to section 4905(5) of Public Health Law (PHL) when:

- Relevant medical information presented to EmblemHealth or the utilization review agent upon retrospective review is materially different from the information that was presented during the prior approval review
- The information existed at the time of the prior approval review but was withheld or not made available
- EmblemHealth or the utilization review agent was not aware of the existence of the information at the time of the prior approval review
- EmblemHealth or the UR agent would not have been authorized the treatment, service or procedure being requested if they were aware of the information

Expedited Review Requests

Expedited review requests must be conducted when EmblemHealth or the provider indicates delay would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum functions. Members have the right to request expedited review, but EmblemHealth may deny and will process under standard time frames.

Extensions for Expedited and Standard Review Time Frames

Reviews of expedited and standard reviews of prior approval and concurrent review requests may be extended by an additional 14 days if:

(1) The member, designee or provider requests an extension; or

(2) EmblemHealth demonstrates there is a need for more information and the extension is in the member's interest. Notice of extension will be provided to the member.

Notice to members regarding an extension initiated by EmblemHealth shall include:

- The reason for the extension.
- An explanation of how the delay is in the best interest of the member.
- A description of any additional information that EmblemHealth requires to make its determination.
- Information regarding the member's right to file a complaint regarding the extension.
- The process for filing a complaint and the time frames within which a complaint determination must be made.
- The member's right to designate a representative to file a complaint on his/her behalf.
- Information regarding the member's right to contact the New York State Department of Health, including a toll-free number.

Initial Adverse Determination

EmblemHealth sends a written notice of action on the date of denial when a service authorization request for a health care service, procedure or treatment is given an adverse determination (denial) based on the following grounds:

- Service does not meet, or no longer meets, the criteria for medical necessity, based on the information provided.
- Service is considered experimental or investigational, clinical trial, rare disease and out-of-network services.
- Service is approved, but the amount, scope or duration is less than requested.
- Service is not a covered benefit under the member's benefit plan.
- Service is a covered benefit under the member's benefit plan, but the member has exhausted the benefit for the service.

All notices of action shall be in writing, in easily-understood language, and accessible to non-English speaking and visually impaired members. Oral interpretation and alternate formats of written material for members with special needs are available. EmblemHealth makes reasonable effort to provide oral notice to the member and provider at the time the initial adverse determination is made.

The written notice is sent to the member and provider, and includes:

- The reasons for the determination, including the clinical rationale and a reference to the criteria used, if any.
- Instructions on how to initiate internal appeals (standard and expedited), and eligibility for external appeals.
- Notice that the clinical review criteria used to make such determination is available upon request from the member or the member's designee.
- A description of what additional information, if any, must be provided to, or obtained by, EmblemHealth to make an appeal determination.
- The description of the action to be taken.
- A statement that EmblemHealth will not retaliate or take any discriminatory action against the member if an appeal is filed.
- The process and time frame for filing/reviewing an appeal with EmblemHealth, including the member's right to file an expedited review.
- The member's right to contact the NYSDOH regarding their complaint, with the toll-free telephone number.
- A statement that notice is available in other languages and formats for special needs and how to access these

formats.

- The member's right to file an action appeal, including:
  - The member's right to designate a representative to file action appeals on his/her behalf.
  - Notice that an expedited review of the action appeal can be requested if a delay would significantly increase the risk to a member's health, a toll-free number for filing an oral action appeal, and a form for filing a written action appeal, if used by EmblemHealth.
  - The time frames within which the action appeal determination must be made.

For actions based on issues of medical necessity or an experimental/investigational treatment, the written notice of action shall also include:

- A clear statement that the notice constitutes the initial adverse determination and specific use of the terms "medical necessity" or "experimental/investigational", "rare disease", "clinical trial" or in certain instances, "out of network."
- A statement that the specific clinical review criteria used in making the determination is available upon request.
- A statement that the member may be eligible for an external appeal.

For actions based on a determination that a requested out-of-network service is not materially different from an alternate service available from a participating provider, the notice of action shall also include:

- Notice of the required information for submission when filing an action appeal as provided for in PHL 4904(1-a).
- A statement that the member may be eligible for an external appeal.
- A statement that if the denial is upheld on action appeal, the member has 4 months from the receipt of the final adverse determination to request an external appeal.
- A statement that if the denial is upheld on an expedited action appeal, the member may request an external appeal or a standard action appeal.
- A statement that the member and EmblemHealth may agree to waive the internal appeal process and the member has 4 months to request an external appeal from receipt of written notice of that agreement.

Notices of action regarding denial of an expedited review request shall specify the request is reviewed under standard time frames and shall include a description of the standard time frames.

When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one business day of receipt of the request (except for retrospective, which is within 30 days) and shall be conducted by the member's health care provider and the clinical peer reviewer making the initial determination.

In general, denials, grievances, and appeals must be peer-to-peer — that is, the credential of the licensed clinician denying the care must be at least equal to the recommending clinician. In addition, the reviewer should have clinical experience relevant to the denial (e.g., a denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist).

In addition:

i. A physician board-certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of 21.

ii. A physician certified in addiction treatment must review all inpatient level of care/continuing stay denials for substance use disorder treatment.

iii. Any appeal of a denied behavioral health medication for a child should be reviewed by a board-certified child psychiatrist.

iv. A physician must review all denials for services for a Medically Fragile child and such determinations must take into consideration the needs of the family/caregiver.

Action Appeals (Standard Appeal)

The dual-eligible member has the choice of selecting a Medicaid or Medicare appeal process. In the written notice of the initial adverse determination, EmblemHealth provides notice that:

- A Medicare appeal must be filed within 60 days from the date of the denial.
- Filing a Medicare appeal means that the member cannot file for a State Fair Hearing.
- The member may still file for Medicare appeal after filing for Medicaid appeal, if it is within the 60-day period.

How to File an Action Appeal

Members wishing to dispute an action may do so themselves or designate a person to act on their behalf by filing an action appeal. To appoint a designee, members must submit by fax or by mail a signed HIPAA-compliant Appointment of Representative form or a Power of Attorney form that specifies the individual as an authorized party. An Appointment of Representative form is not necessary for members who choose to have their practitioner file a dispute on their behalf. A provider may file a UR appeal for concurrent and retrospective denials.

Action appeals should be accompanied by a copy of the action, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision. The appeal may be filed in writing or by telephone. We send acknowledgement within 15 days of receipt of the appeal and request any necessary information in writing. Oral appeals are followed up by written and signed appeals. Oral appeal acknowledgement letters include a statement summarizing the substance of the appeal. If the substance of this summary is not accurate or is not understood by the member/representative, he/she is instructed in the letter to correct the attached confirmation statement and return it to the attention of EmblemHealth.

Procedures for initiating a standard action appeal are provided in Table 22-1: Standard Action Appeals Procedures for Members and Practitioners.

Aid Continuing (AC)

EmblemHealth must provide Aid Continuing immediately upon receipt of a Plan Appeal disputing the termination, suspension or reduction of a previously authorized service, the partial approval, termination, suspension or reduction in quantity or level of services authorized for long-term services and supports or nursing home stay for a subsequent authorization period, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (Initial Adverse Determination), or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

EmblemHealth and its contractors will be required to continue or restore the provision of services that are the subject of appeal under the following circumstances:

- When EmblemHealth has or is seeking to reduce, suspend or terminate a treatment or benefit package service currently being provided.
- When the enrollee is in receipt of LTSS or nursing home services (short-term or long-term) and the plan determines to partially approve, suspend, terminate or reduce level or quantity of LTSS or nursing home stay (short-term or long-term) for a subsequent authorization period.
- While a Plan Appeal or Fair Hearing is pending, if the enrollee timely requests the Plan Appeal and/or Fair Hearing
  - Timely filing means:
    - The enrollee must ask for a Plan Appeal within 10 days of the Initial Adverse Determination notice or by the effective date of the decision, whichever is later
    - The enrollee must ask for a Fair Hearing within 10 days of the Final Adverse Determination, or by the effective date of the appeal decision, whichever is later

EmblemHealth will provide Aid Continuing until one of the following occurs (whichever comes first):

- The enrollee withdraws the request for AC, the plan appeal or the fair hearing;
- The enrollee fails to request a fair hearing within 10 days of the plan´s Final Adverse Determination or the effective date of the decision, whichever is later;
- The provider order has expired, except in the case of a home bound enrollee.

Action Appeal Reviews

The review is conducted by a qualified EmblemHealth medical director who was neither involved in prior determinations nor the subordinate of any person involved in the initial action determination. A clinical peer reviewer is available within one business day.

Before and during the appeal review period, the member or designee may see their case file. The member may present evidence to support their appeal in person or in writing.

Note: When a claim is denied exclusively due to untimely filing, the practitioner acting on their own behalf may file a request for reconsideration. In order to qualify, the practitioner must demonstrate that the late submission was an unusual occurrence and that they have a pattern of submitting claims in a timely manner.

For Medically Fragile children, a physician reviews all denials for services and such determinations must take into consideration the needs of the family/caregiver.

Expedited Action Appeals

If a member, designee, practitioner acting on member's behalf or practitioner acting on their own behalf is not satisfied with an action, including a medical necessity determination, experimental/investigational determination, rare disease determination or (in certain instances) out-of-network determination, and a delay would seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, the member may request an expedited action appeal.

The member or designee may request expedited review of a prior authorization request or concurrent review request. EmblemHealth's time frame to file the appeal is at least 90 calendar days after notification to the member of the UR decision.

An expedited appeal may be filed:

- For continued or extended health care services, procedures or treatments.
- For additional services for member undergoing a course of continued treatment.
- When the health care provider believes an immediate appeal is warranted.
- When EmblemHealth honors the member's request for an expedited review.

Process for Filing an Expedited Action Appeal

Expedited action appeals should be accompanied by a copy of the action, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision. The utilization review appeal may be filed in writing or by telephone.

Time Frame for Expedited Action Appeal Decisions

The review time frame begins upon receipt of the appeal, whether filed orally or in writing. If EmblemHealth requires information necessary to conduct an expedited appeal, EmblemHealth shall immediately notify the member and the member's health care provider by telephone or by fax to identify and request the necessary information followed by written notification.

An expedited appeal is decided as fast as the member's condition requires and within two business days of receipt of

the necessary information, but no more than 72 hours from receipt of the appeal. This time may be extended for up to 14 days upon the member or provider's request, or if EmblemHealth demonstrates more information is needed and a delay is in best interest of member and so notifies member.

Denial of an Expedited Action Appeal Request

EmblemHealth may deny the member's request for expedited review and the notice of action will be processed under standard action appeal time frames. If EmblemHealth denies the member's request for an expedited review, EmblemHealth must immediately provide notice by phone, followed by written notice within two days of the denial.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process.

Review of Expedited Action Appeal Requests

The review is conducted by a qualified EmblemHealth medical director who was neither involved in prior determinations nor the subordinate of any person involved in the initial adverse determination. A clinical peer reviewer is available to discuss the action appeal within one business day.

Before and during the appeal review period, the member or designee may see their case file. The member may present evidence to support their appeal in person or in writing.

Expedited action appeals are reviewed and a written notice of final adverse determination concerning an expedited utilization review appeal is transmitted to the member within 24 hours of rendering the determination. EmblemHealth makes reasonable efforts to provide oral notice to the member and provider at the time the determination is made. Failure by EmblemHealth to make a determination with the applicable time periods is deemed a reversal of the utilization review agent's adverse determination. Procedures for initiating an expedited action appeal are outlined in Table 22-2: Expedited Action Appeals Procedures for Members.

Final Adverse Determinations

Waiving the Internal Appeal Process

The member and EmblemHealth may jointly agree to waive the internal appeal process. If this occurs, EmblemHealth must provide a written letter with information regarding filing an external appeal to the member within 24 hours of the agreement to waive EmblemHealth's internal appeal process. For more information, please see the section on New York State External Appeals later in this chapter.

Missing Information

If we require information necessary to conduct a standard internal appeal, we will notify the member and the member's health care provider, in writing, within 15 days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, we shall request the missing information, in writing, within five business days of receipt of the partial information.

Notice of Final Appeal Determination

We will notify the member, the member's designee and provider in writing of the appeal determination within two business days of when we make the decision.

We will make an appeal determination as fast as the member's condition requires, and no later than 30 days from receipt of the appeal. This time may be extended for up to 14 days upon the member or provider's request, or if we demonstrate that more information is needed and a delay is in the best interest of the member, and we provide the member with notice.

Action appeals are reviewed and EmblemHealth notifies the member, the member's designee, and provider in writing of the appeal determination within 2 business days of when EmblemHealth makes the decision. Failure by EmblemHealth to make a determination within the applicable time periods is deemed a reversal of the utilization

review agent's adverse determination.

Payments for Services in Dispute

EmblemHealth network practitioners may not seek payment from members for either covered services or services determined by EmblemHealth's Care Management program not to be medically necessary unless the member is told the cost of the service and agrees, in writing and in advance of the service, to such payment as a private patient and the written agreement is placed in the member's medical record. Any practitioner attempting to collect such payment from the member in the absence of such a written agreement does so in breach of the contractual provisions with EmblemHealth. Such breach may be grounds for termination of the practitioner's contract.

Final Adverse Determinations Notifications

When a decision regarding an action appeal is upheld in whole or in part, EmblemHealth issues a final adverse determination (FAD). Written notice of final adverse determination concerning an expedited utilization review appeal shall be transmitted to the member within 24 hours of rendering the determination.

EmblemHealth makes reasonable effort to provide oral notice to the member and provider at the time the determination is made. Written notice of final adverse determination concerning an expedited UR appeal shall be transmitted to the member within 24 hours of rendering the determination.

Notices to members of final action appeal adverse determinations are in writing, dated and include:

- The basis and clinical rationale for the determination.
- The words "final adverse determination."
- EmblemHealth contact person and phone number.
- The member's coverage type.
- EmblemHealth's UR agent, address and phone number.
- A summary of the action appeal.
- The date the action appeal was filed.
- The date the appeal process was completed.
- The health service denied, including the name of the facility/provider and developer/manufacturer of the health care service as available.
- A statement advising the member may be eligible for external appeal and time frames for appeal.
- Standard description of the external appeals process attached.
- Summary of appeal and date filed.
- Date appeal process was completed.
- Description of enrollee's fair hearing rights.
- Right of member to complain to the Department of Health at any time with 1-800 number.
- A statement that notice available in other languages and formats for special needs and how to access these formats.

For action appeals involving medical necessity or an experimental or investigational treatment, a clinical trial, rare disease or in certain instances out of-network services, the final adverse determination notice shall also include:

- A clear statement that the notice constitutes the final adverse determination, and specifically use the terms "final adverse determination", "medical necessity" or "experimental/investigational", "clinical trial", "rare disease", or in certain instances, "out of network."

- A list of titles and qualifications of the individuals participating in the review, including the title and specialty of the clinical peer reviewer.
- A copy of the "Standard Description and Instructions for Health Care Consumers to Request an External Appeal" and the External Appeal application form.

Practitioner Complaint and Grievance Procedures

Practitioner Complaint Process

If a practitioner is dissatisfied with an administrative process, quality of care issue and/or any aspect of service rendered by EmblemHealth that does not pertain to a benefit or claim determination, the practitioner may file a complaint on his/her own behalf. Examples of such dissatisfaction include:

- Long wait times on EmblemHealth's authorization phone lines
- Difficulty accessing EmblemHealth's systems
- Quality-of-care issues

Once a decision is made on a practitioner's complaint, it is considered final and there are no additional internal review rights.

Complaints must be submitted in writing to the EmblemHealth's Grievance and Appeals (GAD) department. A complaint should include a detailed explanation of the clinician's request and any documentation to support the practitioner's position.

EmblemHealth acknowledges receipt of the practitioner's complaint in writing no later than 15 days after its receipt. Practitioner complaints are reviewed and a written response is issued directly to the practitioner no later than 30 days after receipt. See Table 22-3: Complaint Procedures for Practitioners.

Practitioner Grievance Process

If a practitioner is not satisfied with any aspect of a claim determination rendered by EmblemHealth (or any entity designated to perform administrative functions on its behalf) which does not pertain to a medical necessity determination, that practitioner may file a grievance with EmblemHealth.

Examples of reasons for filing grievances include: dissatisfaction with a decision resulting from a failure to follow EmblemHealth policy or procedure, or failure to obtain prior approval for an inpatient admission. A practitioner may also file a grievance regarding how a claim is processed, including issues such as computational errors, interpretation of contract reimbursement terms, or timeliness of payment. The Grievance and Appeal Department is not involved in determining claim payment or authorizing services, but independently investigates all grievances.

In addition, providers who wish to challenge the recovery of an overpayment or request a reconsideration for claims denied exclusively for untimely filing may follow the grievance procedures in this sub-section. Note: The right to reconsideration shall not apply to a GHI claim submitted 365 days after the service, or a HIP claim submitted 120 days after service unless the participation agreement states an alternative time frame to be applied. If a claim was submitted more than one year from date of service, EmblemHealth may deny the claim in full or in the alternative may reduce payments by up to twenty five percent of the amount that would have been paid had the claim been submitted in a timely manner. For grievances related to untimely filing, the provider must demonstrate that the late submission was an unusual occurrence and that they have a pattern of submitting claims in a timely manner. Examples of an unusual occurrence include:

- Medicaid Reclamation
- Member submitted the wrong insurance information to the provider
- Coordination of Benefits related issues

- Member retroactively reinstated

The practitioner has the option to question a claim's payment by submitting an inquiry along with supporting documentation within the Claim's Inquiry function in the secure site at emblemhealth.com. For multiple claims, utilize the messenger center function to send grievance and attach files.

The grievance should be accompanied by a copy of the notice of the standard denial or other documentation of the denial, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision.

EmblemHealth acknowledges, in writing, receipt of a grievance that is submitted in writing no later than 15 days after its receipt. The grievance is reviewed and a written response is issued for grievances with a final disposition of partial overturn or upheld, no later than 45 days after receipt. The determination included in the response is final. See Table 22-8: Grievance Procedures for Practitioners.

Grievances with a favorable disposition receive a claims remittance advice in lieu of a written response no later than 45 days after receipt.

Member Complaint Process

A member, member's designee or practitioner acting on a member's behalf may file a complaint when the member is dissatisfied with any aspect of service rendered by EmblemHealth that does not pertain to an action. Examples of such dissatisfaction include:

- Treatment received from EmblemHealth, its practitioners or benefit administrators
- Quality-of-care
- EmblemHealth's privacy practices in using or disclosing protected health information
- Alleged violation of EmblemHealth's privacy practices and/or state and federal law regarding the privacy of protected health information
- Fraud and abuse

Complaints should include a detailed description of the circumstances surrounding the occurrence. EmblemHealth acknowledges receipt of the complaint and requests any necessary information in writing. Complaints are reviewed and a response is issued in writing within the time frames applicable to the member's benefit plan as detailed in Table 22-4: Expedited Complaint Procedures for Members and Table 22-5: Standard Complaint Procedures for Members.

Member Complaint Appeal Process

If a member, member's designee or practitioner acting on behalf of a member is not satisfied with the resolution of a complaint, EmblemHealth provides a complaint appeal process.

To initiate a complaint appeal, a member, designee or practitioner must make the request in writing. EmblemHealth responds within the time frames noted in Table 22-6: Expedited Complaint Appeals Process for Members and Table 22-7: Standard Complaint Appeals Process for Members. Once we reach a decision, that decision is final and there

are no further internal appeals.

Complaint appeals should include a detailed explanation of the request and any documentation to support the member's position.

Complaint appeals filed verbally must be followed up with a written, signed appeal.

New York State External Appeals

A member has a right to an external appeal of a final adverse determination. New York State's External Appeal Law provides the opportunity for the external review of adverse determinations for members and providers based on lack of medical necessity, experimental/investigational treatment, clinical trial, or in certain instances, out-of-network services. Further, a member, the member's designee and, in conjunction with retrospective adverse determinations, a member's health care provider has the right to request an external appeal.

This law also applies to rare diseases, which are defined as any life threatening or disabling condition that is or was subject to review by the National Institutes of Health's Rare Disease Council or affects fewer than 200,000 U.S. residents per year, and there is no standard health service or treatment more beneficial than the requested health service or treatment. To qualify as a rare disease, the condition must be certified by an outside physician specialized in an area appropriate to treat the disease in question. The patient should likely benefit from the proposed treatment and the benefits must outweigh the risks.

The provider may only file an external review on their own behalf for concurrent and retrospective adverse determinations.

Right to Request an External Appeal

Members have the right to request an external appeal when:

1. The member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary and
2. EmblemHealth has rendered a final adverse determination with respect to such health care service or both EmblemHealth and the member have jointly agreed to waive any internal appeal.

Filing an External Appeal

An external appeal may also be filed when:

1. The member has had coverage of a health care service denied on the basis that such service is experimental or investigational and the denial has been upheld on appeal or both EmblemHealth and the member have jointly agreed to waive any internal appeal, and
2. The member's attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan or (c) for which there exists a clinical trial or rare disease treatment, and
3. The member's attending physician, who must be a licensed, board-certified or board- eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must have recommended either (a) a health service or procedure including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B) that, based on two documents from the available medical and scientific

evidence, is likely to be more beneficial to the member than any covered standard health service or procedure, or in the case of a rare disease, based on the physician's certification required by Section 4900 (7)(g) of the PHL and such other evidence as the member, the designee or the attending doctor may present, that the requested health service or procedure is likely to benefit the member in the treatment of the enrollee's rare disease and that the benefit outweighs the risks of such health service or procedure; or (b) a clinical trial for which the member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

4. The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the EmblemHealth's determination that the health service or procedure is experimental or investigational.

External Appeal for Denial of Out-of-Network Service

1. The member has had coverage of the health service, which would otherwise be a covered benefit under the member's benefit plan which is denied on appeal, in whole or in part, on the grounds that such health service is out-of-network and an alternate recommended health service is available in-network, and EmblemHealth has rendered a final adverse determination with respect to an out-of-network denial or both EmblemHealth and the member have jointly agreed to waive any internal appeal; and
2. The member's attending doctor, who shall be a licensed, board- certified or eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health service sought, certifies that the out-of-network health service is materially different from the alternate recommended in-network service, and recommends a health care service that, based on two documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.

EmblemHealth has only one level of internal appeal; it does not require the member to exhaust any second level of internal appeal to be eligible for an external appeal.

How to File an External Clinical Appeal

To file an external clinical appeal, the practitioner appealing on his/her own behalf must complete a New York State External Appeal Application with the New York State Department of Financial Services (DFS) within 60 days of the date of the final adverse determination.

The member and member's designee (including the provider in the capacity of the member's designee) may submit the same form within 4 months of the final adverse determination. If the member files on their own behalf, signed applications authorizing the release of medical records must also be sent to DFS along with the application. (Note: Application fees are waived for Medicaid members.)

An external appeal must be submitted within the applicable time frame upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested. If a member chooses to request a second level internal appeal, the time may expire for the member to request an external appeal.

DFS screens applications and assigns eligible appeals to state-certified external appeals agents. DFS then notifies both the filer and EmblemHealth whether the request is eligible for appeal, provides explanation thereof, and sends a copy of the signed release form.

EmblemHealth provides medical and treatment records and an itemization of the clinical standards used to determine medical necessity within three business days of receiving the agent's information and completed release forms. For an expedited appeal, this information is provided within 24 hours of receipt.

For urgent medical circumstances, an expedited review may be requested which renders a decision within three days. For standard cases, a determination is made within 30 days from receipt of the member's request, in accordance with the commissioner's instructions. The external appeal agent shall have the opportunity to request additional information from the member, practitioner and EmblemHealth within the 30-day period, in which case the agent shall have up to five additional business days to make a determination.

The decision of the external appeal agent is final and binding on both the member and EmblemHealth.

For questions or help with an application, contact DFS at 1-800-400-8882 or email externalappealquestions@dfs.ny.gov.

Note: Practitioners appealing concurrent review determinations cannot pursue reimbursement from members other than copayments from a member for services deemed not medically necessary by the external appeal agent.

New York State Fair Hearings

Medicaid Members' Rights to a State Fair Hearing

In accordance with applicable federal and state laws and regulations, Medicaid members may request a fair hearing after receiving an appeal resolution that an adverse benefit determination has been upheld. An enrollee may be deemed to have exhausted the plan's appeal process and may request a state fair hearing where notice and timeframe requirements have not been met. EmblemHealth must abide by and participate in New York State's Fair Hearing Process and comply with determinations made by a fair hearing officer.

Along with the right to a fair hearing for the reasons stated above, the member has a right to information on how to request a fair hearing, the rules of a fair hearing, the right to aid continuing and information on their liability for services if EmblemHealth's denial is upheld in fair hearing.

EmblemHealth members may request a fair hearing for adverse local department of social service (LDSS) determinations concerning enrollment, disenrollment and eligibility, and the denial, termination, suspension or reduction of a clinical treatment or other benefit package services by EmblemHealth or the delegate entity responsible for managing the member's medical care. For issues related to disputed services, members must have received a final adverse determination either overriding a recommendation to provide services by a participating provider or confirming the decision of a participating provider to deny those services. Members who choose to request a fair hearing must do so within 120 days from the date of our final adverse determination notice.

Members may also seek a fair hearing for a failure by EmblemHealth to comply with required notification timeframes.

Members may request a fair hearing by:

- Telephone: 1-800-342-3334
- Fax: 1-518-473-6735
- Internet: www.otda.ny.gov
- Mail:
  New York State Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  PO Box 22023
  Albany, NY 12201

Members have a right to:

- Designate an individual to represent them in fair hearing proceedings. Members may also be able to get legal help by contacting their local Legal Aid Society or advocate group.
- Free copies of the Evidence Package that EmblemHealth gives to the fair hearing officer. We send a copy of the Evidence Package to members at the same time we send it to the fair hearing officer.
- Free copies of other documents from the member's file that the member may want for the fair hearing.

To ask for copies of documents, the member may call 1-800-447-8255 or write to EmblemHealth at PO Box 2844, New York, NY 10116. Members should ask for these documents before the date of the fair hearing. Usually, they are sent within three working days of when the request was received.

If the services a member is receiving are scheduled to end, the member can choose to ask to continue the services ordered by his/her doctor pending the fair hearing decision. If the fair hearing officer grants Aid Continuing, the member will continue to receive services until the fair hearing determination is made. However, if the fair hearing is decided against the member, the member may have to pay the cost for the services received while waiting for the decision.

Fair hearing officer determinations are final and supersede New York State External Review determinations.

Aid Continuing

EmblemHealth must provide Aid Continuing immediately upon receipt of a Plan Appeal disputing the termination, suspension or reduction of a previously authorized service, the partial approval, termination, suspension or reduction in quantity or level of services authorized for long term services and supports or nursing home stay for a subsequent authorization period, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (Initial Adverse Determination), or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

EmblemHealth and its contractors will be required to continue or restore the provision of services that are the subject of the fair hearing if so ordered by the New York State Office of Administrative Hearings (OAH) under the following circumstances:

- When EmblemHealth has or is seeking to reduce, suspend or terminate a treatment or benefit package service currently being provided.
- When the enrollee is in receipt of LTSS or nursing home services (short-term or long-term) and the plan determines to partially approve, suspend, terminate or reduce level or quantity of LTSS or nursing home stay (short-term or long-term) for a subsequent authorization period.
- While a Plan Appeal or Fair Hearing is pending, if the enrollee timely requests the Plan Appeal and/or Fair Hearing'
  - Timely filing means:
    - The enrollee must ask for a Plan Appeal within 10 days of the Initial Adverse Determination notice or by the effective date of the decision, whichever is later
    - The enrollee must ask for a Fair Hearing within 10 days of the Final Adverse Determination, or by the effective date of the appeal decision, whichever is later

EmblemHealth will provide Aid Continuing until one of the following occurs (whichever comes first):

- The enrollee withdraws the request for AC, the plan appeal or the fair hearing;
- The enrollee fails to request a fair hearing within 10 days of the plan´s Final Adverse Determination or the effective date of the decision, whichever is later;
- OAH determines that the enrollee is not entitled to aid continuing;
- OAH completes the administrative process and/or issues a fair hearing decision adverse to the enrollee; orb
- The provider order has expired, except in the case of a home bound enrollee.

Reconsideration Rights for Network Terminations and Non-Renewal

A reconsideration request may be initiated if the terminated or non-renewed provider believes that there is significant and relevant information about his/her practice which might be unknown to EmblemHealth. EmblemHealth will review this additional information in reconsideration of this decision. Please note, however, that reconsideration may only apply to the Enhanced Care Prime Network. All decisions are final. The terminated or non-renewed provider has thirty days from receipt of the termination letter or provider contract non-renewal notification letter to request reconsideration. Upon receipt of a completed reconsideration request, EmblemHealth will schedule

an in-person meeting to be held during normal business hours at an EmblemHealth location. For terminations and non-renewals from the VIP Prime Network and/or Medicare Essential Network see Dispute Resolution for Medicare Plans.

To request a reconsideration of your termination or non-renewal from the Enhanced Care Prime Network, please follow these instructions:

- Should you exercise your right to an appeal/hearing of this decision, your response should be sent to Tonya Volcy, Director of Credentialing by certified mail, return receipt requested, to the following address:

Tonya Volcy
Director of Credentialing
EmblemHealth
55 Water Street, 2nd floor
New York, NY 10041

- Requests submitted must include a letter describing special circumstances of which EmblemHealth may be unaware.
- Reconsideration meetings will be scheduled and conducted via phone at an EmblemHealth location during normal business hours.
- An Ad hoc Reconsideration Board, consisting of three physicians will conduct the reconsideration hearing.
- The Ad hoc Reconsideration Board makes the final decision.
- The provider will be notified in writing within seven business days of the decision.
- Providers whose termination or non-renewal status is upheld will be notified, citing the original date of the change. Participation in the impacted networks will continue uninterrupted for providers whose termination or non-renewal status is overturned.

EmblemHealth

Provider Manual

Chapter 38: Glossary

ABMS - Organized originally in 1933 as the Advisory Board of Medical Specialties, the ABMS (1970), in collaboration with the American Medical Association (AMA), is the recognized certifying agent for establishing and maintaining standards of medical specialization and pattern of training.

Accreditation - An evaluative process in which a health care organization undergoes an examination of its policies and procedures to determine whether the procedures meet designated criteria as defined by the accrediting body, and to ensure that the organization meets a specified level of quality.

Action - An activity of EmblemHealth or its subcontractor that results in:

- Denial or limited authorization of a service authorization request, including the type or level of service
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure of EmblemHealth to act within the time frames for resolution and notification of determinations regarding complaints, action appeals and complaint appeals

Action Appeal - Oral or written request for EmblemHealth to review or reconsider an action by EmblemHealth or its subcontractor.

Actual Charge - The amount a physician or other practitioner actually bills a patient for a medical service or procedure.

Acute Illness - A physical condition or illness that begins abruptly and requires medical care or restricted activity for a short period of time (usually three months or less).

Adjudication - The process by which a claim is paid or denied based on eligibility and contract determination.

Admission - Formal acceptance as an inpatient by an institution, hospital or health care facility.

Admitting Physician - The physician responsible for admission of a patient to a hospital or other inpatient health facility.

Adverse Determination - A determination by EmblemHealth or its agents that an admission, extension of stay or other health care service has been reviewed and, based on the information provided, is not medically necessary.

Allowed Charge - The amount EmblemHealth will reimburse for covered services rendered by out-of-network providers.
Ambulatory Care - All types of health services provided on an outpatient basis.

Ambulatory Care Facility - A medical care center that provides a wide range of health care services, including preventive care, acute care, surgery and outpatient care in a centralized facility.

Ambulatory Surgery - Surgical procedures that do not require an overnight hospital stay. Procedures can be performed in a hospital or a licensed surgical center. Also called Outpatient Surgery.

American Board of Medical Specialties - Organized originally in 1933 as the Advisory Board of Medical Specialties, the ABMS (1970), in collaboration with the American Medical Association (AMA), is the recognized certifying agent for establishing and maintaining standards of medical specialization and pattern of training.

Ancillary Services - Auxiliary or supplemental services (i.e., diagnostic services, physical therapy and medications) used to support diagnosis and treatment of a patient's condition.

Appeal - Oral or written request from a member or their designee for EmblemHealth to review or reconsider a decision made by the plan.

Assignment - An agreement in which a patient assigns to another party, usually a physician or hospital, the right to receive payment from a public or private insurance program for the service the patient has received.

Attending Physician - The physician primarily responsible for the care of a patient during hospitalization. The physician is licensed, board-certified or board-eligible and qualified to practice in the area appropriate to treat the member's life-threatening or disabling condition or disease. The attending physician must be a network provider with EmblemHealth or one to which EmblemHealth has referred the member.

Authorization - Services that have been approved for payment based on a review of EmblemHealth's policies.

Authorized - Services that have been approved for payment based on a review of EmblemHealth's policies.

Balance Billing- Billing a member or other responsible party for the difference between the insurer's payment and the actual charge.

Beacon Health Options - Provides managed mental health and substance abuse (MHSA) programs, workplace services, employee assistance programs (EAP), psychiatric disability management, Medicaid behavioral health management and child welfare programs for over 23 million lives. Visit the Beacon Health Options website at https://www.beaconhealthoptions.com/.

Behavioral Health - Conditions that affect thinking and the ability to figure things out that affect perception, mood and behavior.

Benefit Plan – A health insurance product offered by a health plan company that is defined by the benefit contract and represents a set of covered services. Also called a health benefit plan.

Benefit Program - Any HMO (with or without primary care physician referral requirements), POS, Medicaid, Child Health Plus, Medicare Advantage, ASO or other line of business offered by the EmblemHealth plans.

Benefits - Services available to a member as defined in his or her contract. Benefit design includes the types of benefits offered, limits (e.g., number of visits, percentage paid or dollar maximums applied) and subscriber responsibility (cost sharing components).

Benefits Exhausted - When the maximum number of visits for a specific service is reached, further benefits will not be considered.

Board Certification - A process by which a physician who has been tested for proficiency in a medical specialty or subspecialty, by a medical specialty board, has passed those tests and been certified as proficient in that medical specialty.

Brand Name Drug - A prescription drug that has been patented and is only available through one manufacturer.

Carrier - An insurance company that either administers insurance or self-insures.

Case Management - A program that assists the patient in determining the most appropriate and cost effective treatment plan, including coordinating and monitoring care with the ultimate goal of achieving the optimum health care outcome.

Centers for Medicare & Medicaid Services - The government agency responsible for administering the Medicare and Medicaid programs.

Certificate of Insurance - The member's Certificate of Insurance is evidence of coverage under the Group Contract between EmblemHealth and the member's group. The Certificate of Insurance typically consists of a booklet along with an Attachment (the "Certificate Attachment" and any applicable riders or amendments). Together these documents describe the health insurance benefits available to the member from EmblemHealth as well as other important applicable information to the member's coverage.

Certification- A process in which an individual, institution or educational program is evaluated and recognized as meeting certain predetermined standards. Certification usually applies to individuals; accreditation to institutions.

Chemical Dependency - The use of one or more drugs for purposes other than those for which they are prescribed or recommended.

Chemotherapy - Treatment of malignant disease by chemical or biological antineoplastic agents.

Chiropractic Care - An alternative medicine therapy administered by a licensed chiropractor. Chiropractors specialize in the relief, correction, and prevention of musculoskeletal problems of the spine, peripheral joints and related areas through manipulation.

Chronic Care - A pattern of medical care that focuses on long-term care of chronic diseases or conditions.

Claim - An itemized statement of health care services and their costs provided by a hospital, physician's office or other health care facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.

Claim Form - An application for payment of benefits under a health care plan.

Clinical Decision - A decision about the patient's medical treatment.

Clinical Issue - Information relating to the patient's health.

Clinical Peer Reviewer - A physician who possesses a current and valid license to practice medicine or a health care professional other than a licensed physician who:

- Where applicable possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body to the profession
- Is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review

Clinical Professional – A doctor, nurse or other health care professional.

Clinical Rationale - A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the patient's condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

Clinical Review – Occurs when a clinical professional reviews information about a patient's health.

Clinical Review Criteria - The written screens, decision rules, medical protocols or guidelines used by the utilization management agent as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures and services under the auspices of the applicable health benefit plan.

CMS - The government agency responsible for administering the Medicare and Medicaid programs.

COB - When a member is covered by more than one benefit plan, with both providing similar benefits, EmblemHealth coordinates with the other carrier to ensure appropriate reimbursement. Also called Coordination of Benefits.

COBRA - A federal act that requires an eligible group's health plan to allow employees and certain dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, death or divorce of a covered employee, and termination of employment. Also called the Consolidated Omnibus Budget Reconciliation Act.

Coinsurance - A percentage of the allowed charge that is payable by the member, not EmblemHealth, for covered services rendered by an out-of-network provider. After the member has met his or her deductible, EmblemHealth will pay a percentage of the allowed charge for those covered services in accordance with the member's benefit program. The member is responsible to pay the remaining percentage of the allowed charge. This remaining percentage is the coinsurance charge.

Community-based Long-Term Services and Supports - A range of medical, habilitation, rehabilitation, home care or social services a person needs over months or years to improve or maintain function or health that are provided in the person’s home or a community-based setting such as an assisted-living facility. These home and community-based services are designed to meet an individual’s needs as an alternative to long-term nursing facility care and to enable a person to live as independently as possible. Also called community-based LTSS.

Complaint - Initial oral or written communication from a member or their designee or provider that expresses discontent with any aspect of their care or coverage with EmblemHealth. Specifically, it is dissatisfaction with:

- A determination made by the plan, other than a determination of medical necessity or a determination that a service is considered experimental or investigational
- Treatment experienced through the plan, its providers or contractors
- Any concern with the plan, its benefits, employees or providers.

Consolidated Omnibus Budget Reconciliation Act - A federal act that requires an eligible group's health plan to allow employees and certain dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, death or divorce of a covered employee, and termination of employment. Also called COBRA.

Consultation - Services rendered by a physician whose opinion or advice is requested by another physician for further evaluation or management of the patient.

Consumer - An individual person who is the direct or indirect recipient of the services of the organization. Depending on the context, consumers may be identified by different names, such as "member," "enrollee," "beneficiary," or "patient." A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.

Continuing Care Services Program - Utilization review activities performed by a utilization management agent that include evaluation of requests for prior approval where necessary for covered services.

Contraception - The process by which pregnancy is prevented by either barring conception of an embryo or the implantation of an embryo in the uterine wall.

Contract - A legal agreement between an individual member or an employer group and a health plan that describes the benefits and limitations of the coverage.

Contract Holder - The individual in whose name a contract is issued or the employee covered under an employer's group health contract. The contract holder can enroll dependents under family coverage.

Contractor - A business entity that performs delegated functions on behalf of the insurer or managed care organization.

Coordinated Care - The evaluation of the medical necessity, appropriateness and efficiency of the use of health care services, procedures and facilities under the provisions of the applicable health benefit plan. It is sometimes called utilization review or utilization management.

Coordination of Benefits - When a member is covered by more than one benefit plan, with both providing similar benefits, EmblemHealth coordinates with the other carrier to ensure appropriate reimbursement. Also called COB.

Copay - The fixed dollar amount members must pay for certain covered services. It is generally paid to a network provider at the time the service is rendered.

Copayment - The fixed dollar amount members must pay for certain covered services. It is generally paid to a network provider at the time the service is rendered.

Cost Sharing - A general term for the deductible, copayment and coinsurance provisions in the member's plan.

Covered Service – A medically necessary service for which a member is entitled to receive partial or complete coverage under the terms and conditions of the benefit program, is within the scope of the practitioner's practice and the practitioner is authorized to render pursuant to the terms of the agreement.

Covering Physician - A licensed doctor of medicine or osteopathy who has an agreement with a network provider to provide covered services to members when the network provider is not available.

Cultural Competence - Understanding the values, beliefs and needs associated with an individual’s age, gender identity, sexual orientation, and/or racial, ethnic or religious background. Cultural competence also includes a set of competencies required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

Custodial Care - Maintenance care of a patient that is designed to assist the patient in daily living and not primarily provided for the treatment of an illness, disease or condition. Custodial care includes but is not limited to help in walking, bathing and feeding.

Customary Charge - The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and the reasonable cost of services for a given patient after medical review of the case. Also called customary and reasonable (C&R) and usual, customary and reasonable (UCR).

Date of Service - The date a service was rendered.

Deductible - A portion of eligible expenses that an individual or family must pay during a calendar year before

EmblemHealth will begin to pay benefits for covered services.

Delegate – An entity contracted with EmblemHealth to perform various services including utilization review, credentialing and claims processing. Also called managing entities and carve outs.

Delegation - The process by which the organization permits another entity to perform functions and assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate.

Denial of Benefits -A rejection of an entire claim or part of a claim.

Dental Care - The treatment of the oral cavity.

Department of Health and Human Services - The US government's principal agency for protecting the health of all Americans and providing essential human services. Also called the DHHS.

Dependent - An individual other than the subscriber who is eligible to receive health care services under the member's Certificate of Insurance. Generally, dependents are limited to the subscriber's spouse and eligible children.

Designee - A person authorized by the insured to assist in obtaining access to, or payment to, the insured for health care services. If the insured has already received health care services and has no liability for payment of services, a designee will not be authorized for the purpose of requesting an external appeal.

DHHS - The US government's principal agency for protecting the health of all Americans and providing essential human services. Also called the Department of Health and Human Services.

Diagnostic Test - A test or procedure ordered by a physician to determine if the patient has a certain condition or disease based upon specific signs or symptoms demonstrated by the patient. Such diagnostic tools include radiology, ultrasound, nuclear medicine, laboratory or pathology services.

Direct Payment - Individual subscribers who are billed and pay premiums directly to the insurer or managed care organization.

Disabling Condition - Any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months and renders the member unable to engage in any substantial gainful activities.

Disabling Disease - Any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months and renders the member unable to engage in any substantial gainful activities.

Discharge Date - Date the patient left the hospital.

Disease Management - A coordinated system of preventive, diagnostic and therapeutic measures intended to provide cost-effective, quality health care for a patient population who have or are at risk for a specific chronic illness or medical condition.

DME - Medical equipment, goods, implements and prosthetics that are prescribed for patient care, usually in an outpatient setting. Examples of such equipment include hospital beds, wheelchairs and walkers.

Durable Medical Equipment - Medical equipment, goods, implements and prosthetics that are prescribed for patient care, usually in an outpatient setting. Examples of such equipment include hospital beds, wheelchairs and walkers.

Effective Date - The date on which the coverage of an insurance policy goes into effect at 12:01 am.

Elective Surgery - Surgery for a condition not considered an emergency.

Eligibility - A determination of whether or not a person meets the requirements to participate in the plan and receive coverage under the plan.

Eligible Expense - The total dollar amount allowed by EmblemHealth for a covered service. Eligible expenses are set forth in EmblemHealth's Schedule of Allowances.

Emergency Care (Emergent) - See Emergency Condition.

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

Emergency Medical Condition - See Emergency Condition.

Emergency Medical Services and Surprise Bills Law - means legislation (passed in the 2014-2015 New York State budget) which provides for greater transparency of out-of-network charges and network participation as well as safeguards against “surprise bills” from out of network providers. Also called Out-of-Network Law.

Enrollee - An individual enrolled and eligible for coverage under a health plan contract. Also called a member.

EOB - A form sent to the enrollee after a claim for payment has been processed by the health plan. The form explains the action taken on that claim. This explanation usually includes the amount paid, the benefits available, reasons for denying payment and the claims appeal process. Also called Explanation of Benefits.

EPO - A health care benefit arrangement that is similar to a preferred provider organization in administration, structure and operation but does not cover out-of-network care. Also called an Exclusive Provider Organization.

Exclusion - Specific conditions or circumstances not covered under the benefit agreement or Certificate of Insurance. It is very important to consult the benefit contract to understand what services are not covered benefits.

Exclusive Provider Organization - A health care benefit arrangement that is similar to a preferred provider organization in administration, structure and operation but does not cover out-of-network care. Also called an EPO.

Expedited Appeal - Oral or written request to review or reconsider an initial adverse determination when waiting for a standard decision could seriously harm the enrollee's life, health or ability to regain maximum function. For pre-service expedited requests, the practitioner may act on behalf of the member. Also called a fast track appeal.

Experimental and Investigational - Treatment, procedure, drug, biological product or medical device that has not been of proven benefit for the particular diagnosis or treatment of the particular condition or is not generally recognized by the medical community, as reflected in the published peer-reviewed medical literature, as effective or appropriate for the particular diagnosis or treatment of the particular condition.

Expiration Date - The date indicated in an insurance contract as the date coverage expires at 12 midnight.

Explanation of Benefits - A form sent to the enrollee after a claim for payment has been processed by the health plan. The form explains the action taken on that claim. This explanation usually includes the amount paid, the benefits available, reasons for denying payment and the claims appeal process. Also called an EOB.

External Appeal - Written request for an independent entity that has been certified by the State to conduct a review of a denial of coverage, based on lack of medical necessity or that the service requested is experimental and investigational.

Facility - A hospital, ambulatory surgical facility, birthing center, dialysis center, rehabilitation facility, skilled nursing facility or other provider certified under New York Public Health Law. A hospice is a facility. An institutional provider of mental health substance abuse treatment operating under New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services is a facility.

Facility-based Long-Term Services and Supports - A range of medical, social or rehabilitation services a person needs over months or years to improve or maintain function or health that are provided in a long-term care facility such as a nursing home (not including assisted-living residences). Also called facility-based LTSS.

Fee-For-Service - A payment method in which the insurer reimburses the member or provider directly for each covered medical expense.

Fee Schedule - The fee determined by the insurer to be acceptable for a procedure or service that the physician agrees to accept as payment in full.

FIDA Demonstration - A Medicare-Medicaid alignment initiative developed to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees). Also called fully-integrated duals advantage demonstration.

FIDA Plan - A managed care plan under contract with the Centers for Medicare & Medicaid Services and the State to provide the fully-integrated Medicare and Medicaid benefits under the FIDA demonstration. Also called fully-integrated duals advantage plan.

Final Adverse Determination - Final determination made on a first level utilization review appeal, where an initial adverse determination has been upheld.

First Tier Entity - Any party that enters into a written arrangement, acceptable to the Centers for Medicare & Medicaid Services, with a Medicare Advantage organization or applicant to provide administrative services or health care services for a Medicare-eligible individual under the Medicare Advantage program.

Formulary - A list of preferred pharmaceutical products that health plans, working with pharmacists and physicians, have developed to encourage greater efficiency in the dispensing of prescription drugs without sacrificing quality. Also called a Drug Formulary.

Full-Time Student - A dependent enrolled at an accredited institution of learning. The student's principal residence, when not away at school, must be the same as the parents.

Fully-Integrated Duals Advantage Demonstration - A Medicare-Medicaid alignment initiative developed to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees). Also called FIDA demonstration.

Fully-Integrated Duals Advantage Plan - A managed care plan under contract with the Centers for Medicare & Medicaid Services and the State to provide the fully-integrated Medicare and Medicaid benefits under the FIDA demonstration. Also called FIDA plan.

Generic Drug - A drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug.

Grievance - A request to change an adverse determination that was based on administrative policies, procedures or guidelines.

Grievance Procedure - A complaint process whereby the member or the member's duly authorized representative may seek review of benefit determinations or other determinations made by EmblemHealth or a delegate relating to the member's health plan.

Group Contract - The Agreement EmblemHealth has with the member's group to provide health insurance.

Group Number - This number identifies the subscriber's employer or Union Benefits Fund.

Health Care Provider - A professionally licensed individual, facility or entity giving health-related care to patients. Physicians, hospitals, skilled nursing facilities, pharmacies, chiropractors, nurses, nurse-midwives, physical therapists, speech pathologist, laboratories are providers. All network providers are health care providers, but not all providers are network providers.

Health Insurance Portability and Accountability Act - A federal act that protects people who change jobs, are self-employed or have pre-existing medical conditions. The act standardizes an approach to the continuation of health care benefits for individuals and members of small group health plans and establishes parity between the benefits extended to these individuals and those offered to employees in large group plans. The act also contains provisions to ensure that prospective or current enrollees in a group health plan are not discriminated against based on health status and protects the confidentiality of protected health information of members. Also known as HIPAA.

Health Maintenance Organization - An organization that provides comprehensive health care coverage to its members through a network of doctors, hospitals and other health care providers. Also called an HMO.

Health Professional - An individual who: (1) has undergone formal training in a health care field; (2) holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and (3) has professional experience in providing direct patient care.

HIPAA - A federal act that protects people who change jobs, are self-employed or have pre-existing medical conditions. The act standardizes an approach to the continuation of health care benefits for individuals and members of small group health plans and establishes parity between the benefits extended to these individuals and those offered to employees in large group plans. The act also contains provisions to ensure that prospective or current enrollees in a group health plan are not discriminated against based on health status and protects the confidentiality of protected health information of members. Also known as the Health Insurance Portability and Accountability Act.

HMO - An organization that provides comprehensive health care coverage to its members through a network of doctors, hospitals and other health care providers. Also called a Health Maintenance Organization.

Hold Harmless – when a practitioner/provider renders services to an EmblemHealth Member under the participating network agreement, Hold Harmless means that he/she/it will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from an EmblemHealth Member, or persons acting on a Member’s behalf (other than the Payor), for such services. Such Hold Harmless agreement includes but is not limited to, non-payment by or insolvency of the Payor, as well as breach of the participating network agreement by the Payor. This provision does not prohibit the practitioner/provider from: (1) collecting copayments, coinsurance or deductibles as specifically provided in the Member’s benefit plan; (2) fees for Non-Covered Services delivered on a fee-for-service basis to Members; and (3) continuing services solely at the expense of the Member, provided the practitioner/provider has informed the Member in advance, and in writing, that the Payor will not cover or continue to cover such specified services and the Member has agreed, in writing, to be financially responsible for such continuation services.

Home Health Care - Health care services rendered to a member in their home in lieu of confinement in a hospital or skilled nursing facility. Care must be under the supervision of a registered professional nurse. This type of care may include physical, occupational or speech therapy, medical supplies and medication prescribed by a doctor.

Home Infusion Therapy - The administration of intravenous drug therapy in the home. Home infusion therapy includes the following services: solutions and pharmaceutical additives; pharmacy compounding and dispensing services; durable medical equipment; ancillary medical supplies; and nursing services.

Hospice - A facility or service that provides care for the terminally ill patient and support to the family. The care, primarily

for pain control and symptom relief, can be provided in the home or in an inpatient setting.

Hospital - An institution that provides inpatient services under the supervision of a physician, and meets the following requirements:

- Provides diagnostic and therapeutic services for medical diagnosis, treatment and care of injured and sick persons and has, as a minimum, laboratory and radiology services and organized departments of medicine and surgery
- Has an organized medical staff which may include, in addition to doctors of medicine, doctors of osteopathy and dentistry
- Has bylaws, rules and regulations pertaining to standards of medical care and service rendered by its medical staff
- Maintains medical records for all patients
- Has a requirement that every patient be under the care of a member of the medical staff;
- Provides 24-hour patient services
- Has in effect agreements with a home health agency for referral and transfer of patients to home health agency care when such service is appropriate to meet the patient's requirements

ID Card - A card that allows the subscriber to identify himself or his covered dependents to a provider for health care services.

ID Number - A unique number that identifies the member's enrollment with EmblemHealth. EmblemHealth's claims are processed by this number. Also known as Member ID Number.

Identification Card - A card that allows the subscriber to identify himself or his covered dependents to a provider for health care services.

Identification Number - A unique number that identifies the member's enrollment with EmblemHealth. EmblemHealth's claims are processed by this number. Also known as Member ID Number.

IDT - The group of individuals who provide person-centered care coordination and care management to participants in a FIDA plan. Each participant will have an interdisciplinary team (IDT). Each IDT will be comprised, first and foremost, of the participant and/or his or her designee, and the participant’s designated care manager, primary care physician, behavioral health professional, home care aide, and other providers either as requested by the participant or his or her designee or as recommended by the care manager or primary care physician and approved by the participant and/or his or her designee. The IDT facilitates timely and thorough coordination between a FIDA plan and the IDT, primary care physician and other providers. The IDT makes coverage determinations. Accordingly, the IDT’s decisions serve as service authorizations, may not be modified by a FIDA plan outside of the IDT, and are appealable by the participant, their providers and their representatives. IDT service planning, coverage determinations, care coordination and care management are delineated in the participant’s person-centered service plan and are based on the assessed needs and articulated preferences of the participant.

Independent Practice Association - An organization comprised of individual physicians or physicians in group practices that contracts with the managed care organization on behalf of its member physicians to provide health care services. Also called an IPA.

Initial Adverse Determination - Initial determination made by a utilization management agent for a denial of a service authorization request on the basis that the requested service is not medically necessary or an approval of a service authorization in a amount, duration or scope less than requested.

Infertility - The inability to conceive or an inability to carry a pregnancy to a live birth after a year or more of regular sexual relations without the use of contraception.

Infusion Therapy - Treatment accomplished by placing therapeutic agents into the vein, including intravenous feeding.

Such therapy also includes enteral nutrition that delivers nutrients into the gastrointestinal tract by tube.

In-Network – The use of providers who participate in the health plan's provider network. Many benefit plans encourage enrollees to use network providers to reduce the enrollee's out-of-pocket expense.

Inpatient - Service provided after the patient is admitted to the hospital. Inpatient stays are those lasting 24 hours or more.

Inpatient Care - Treatment provided to a patient who stays overnight (24 hours or more) in a hospital or other facility.

Interdisciplinary Team - The group of individuals who provide person-centered care coordination and care management to participants in a FIDA plan. Each participant will have an interdisciplinary team (IDT). Each IDT will be comprised, first and foremost, of the participant and/or his or her designee, and the participant's designated care manager, primary care physician, behavioral health professional, home care aide, and other providers either as requested by the participant or his or her designee or as recommended by the care manager or primary care physician and approved by the participant and/or his or her designee. The IDT facilitates timely and thorough coordination between a FIDA plan and the IDT, primary care physician and other providers. The IDT makes coverage determinations. Accordingly, the IDT's decisions serve as service authorizations, may not be modified by a FIDA plan outside of the IDT, and are appealable by the participant, their providers and their representatives. IDT service planning, coverage determinations, care coordination and care management are delineated in the participant's person-centered service plan and are based on the assessed needs and articulated preferences of the participant.

IPA - An organization comprised of individual physicians or physicians in group practices that contracts with the managed care organization on behalf of its member physicians to provide health care services. Also called an Independent Practice Association.

Itemized Bill - A bill from a provider that itemizes all charges for services rendered needed to process for payment.

LDSS – A city or county social services district as constituted by Section 61 of the New York State Social Services Law (SSL). Also called a Local Department of Social Services.

License - A permit (or equivalent) to practice medicine or a health profession that is: 1) issued by any state or jurisdiction in the United States and 2) required for the performance of job functions.

Life-threatening Condition or Disease - A condition or disease that has a high probability of death, according to the current diagnosis of the attending physician.

Limitation - Specific circumstances or services listed in the contract for which benefits will be limited.

Local Department of Social Services - A city or county social services district as constituted by Section 61 of the New York State Social Services Law (SSL). Also called a LDSS.

MA - Acronym for Medicare Advantage. An alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

MA Organization - A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by the Centers for Medicare & Medicaid Services as meeting the Medicare Advantage contract requirements. Also called Medicare Advantage organization.

Mail Order Pharmacy Program - A program that offers drugs ordered and delivered through the mail to plan members.

Mailing Address - The address designated by the member for all correspondence.

Managed Care - Any form of health plan that uses selective provider contracting to have patients seen by a network of contracted providers and that requires prior approval of certain services.

Medicaid - A jointly funded federal and state program that provides hospital and medical coverage to the low-income population and certain aged and disabled individuals.

Medical Care - Professional services rendered by a physician for the treatment or diagnosis of an illness or injury.

Medical Director - A doctor of medicine or doctor of osteopathic medicine who is duly licensed to practice medicine and is an employee of, or party to a contract with, a utilization management organization, and has responsibility for clinical oversight of the utilization management organization's utilization management, credentialing, quality management and other clinical functions.

Medical Emergency - A medical or behavioral condition with a sudden onset that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Medically Necessary - Health care that is rendered by a hospital or a licensed or certified provider and is determined by EmblemHealth to meet all of the criteria listed below:

- It is provided for the diagnosis or direct care or treatment of the condition, illness, disease, injury or ailment.
- It is consistent with the symptoms or proper diagnosis and treatment of the medical condition, disease, injury or ailment.
- It is in accordance with accepted standards of good medical practice in the community.
- It is furnished in a setting commensurate with the member's medical needs and condition.
- It cannot be omitted under the standards referenced above.
- It is not in excess of the care indicated by generally accepted standards of good medical practice in the community.
- It is not furnished primarily for the convenience of the member, the member's family or the provider.
- In the case of a hospitalization, the care cannot be rendered safely or adequately on an outpatient basis or in a less intensive treatment setting and, therefore, requires the member receive acute care as a bed patient.

The fact that a provider has prescribed a service or supplies care does not automatically mean the service or supply will qualify for reimbursement under the EmblemHealth plan. To be eligible for reimbursement by EmblemHealth, all covered services must meet EmblemHealth's medical necessity criteria, described above.

Medically Fragile Child (MFC) - Defined as an individual who is under 21 years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meets one or more of the following criteria:

(1) is technologically dependent for life or health-sustaining functions,

(2) requires a complex medication regimen or medical interventions to maintain or to improve their health status and,

(3) is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health, or development at risk. Chronic debilitating conditions include, but are not limited to, bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy.

Medically Necessary with respect to Medicaid members means health care and services that are necessary to prevent, diagnose, manage, or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity,

interfere with such a person's capacity for normal activity, or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate, or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability.

Medicare - A nationwide insurance program for the disabled and people age 65 and over, created by the 1965 amendments to the Social Security Act and operated under the provisions of the Act. It consists of two separate but coordinated programs, Part A and Part B.

Medicare Advantage - An alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program. Also known as MA.

Medicare Advantage Organization - A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by the Centers for Medicare & Medicaid Services as meeting the Medicare Advantage contract requirements. Also called MA organization.

Medicare Part A - This part of Medicare provides benefits for hospitalization, extended care and nursing home care to Medicare beneficiaries with no premium payment for qualified individuals.

Medicare Part B - This part of Medicare provides medical surgical benefits for Medicare beneficiaries for a modest premium.

Member - An individual and each of his or her eligible dependents, including Medicare beneficiaries who are enrolled or participate in a benefit program and who are entitled to receive covered services from the practitioner pursuant to such benefit program and the terms of the practitioner's agreement.

Member ID Number - A unique number that identifies the member's enrollment with EmblemHealth. EmblemHealth's claims are processed by this number. Also known as ID Number.

Member Services - The department responsible for helping members with problems and questions.

Mental Health - Conditions that affect thinking and the ability to figure things out that affect perception, mood and behavior.

Mental Health Care - The provision of mental health and substance abuse services.

National Committee for Quality Assurance - A nonprofit organization that performs quality-oriented accreditation reviews of HMOs and similar types of managed care plans. Also called NCQA.

NCQA - A nonprofit organization that performs quality-oriented accreditation reviews of HMOs and similar types of managed care plans. Also called the National Committee for Quality Assurance.

Network - The group of physicians, hospital and other medical care providers that a specific plan has contracted with to deliver medical services to its members.

Network Facility - A facility that is part of EmblemHealth's provider network and has signed an agreement to provide covered services to its members. Sometimes, network facilities are referred to as participating facilities.

Network Hospital - A hospital that is part of EmblemHealth's provider network and has signed an agreement to provide covered services to its members. Sometimes, network hospitals are referred to as participating hospitals.

Network Provider - A physician, hospital or other provider who has signed an agreement to covered services to EmblemHealth plan members. A network provider is a member of the EmblemHealth network of network providers applicable to the member's certificate. Therefore, they are sometimes referred to as participating providers. Payment is

made directly to a network provider. Please consult the EmblemHealth Directory or go online to search for network providers.

New York City Department of Health and Mental Hygiene - A public agency that works to control the spread of infectious diseases, monitor the health of New Yorkers and create an environment that protects and promotes health by using regulations, education and advocacy and providing direct health services. Also known as NYCDOHMH.

New York State Department of Health - The state regulatory agency that certifies reimbursement methods and rates to hospitals and reviews HMO activities in the state of New York. Also called NYSDOH.

No Fault- A law in several states including New York State requiring all registered motor vehicles to be covered by personal injury protection insurance. Under this law, a person's own motor vehicle insurance company pays for expenses relating to an accident regardless of who caused the accident.

Non-Certification - A determination by a utilization management organization that an admission, extension of stay or other health care service has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, appropriateness, level of care or effectiveness under the auspices of the applicable health benefit plan.

Non-Participating Partner - A non-participating partner is a non-par individual practitioner that shares the same TIN# or NPI# and specialty and location as a participating (aka regular) partner (i.e., when a covering practitioner treats a member). These non-par partners sometimes see EmblemHealth patients as an advising or covering physician. These are also referred to as substitute physicians.

Non-Participating Provider- A health care provider, such as a physician, skilled nursing facility, home health agency or laboratory, that does not have an agreement with EmblemHealth plans to provide covered services to members. Also called an Out-of-Network Provider.

NYCDOHMH - A public agency that works to control the spread of infectious diseases, monitor the health of New Yorkers and create an environment that protects and promotes health by using regulations, education and advocacy and providing direct health services. Also known as the New York City Department of Health and Mental Hygiene.

NYSDOH - The state regulatory agency that certifies reimbursement methods and rates to hospitals and reviews HMO activities in the state of New York. Also called the New York State Department of Health.

Occupational Therapy - Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting and bathing (activities of daily living).

Ordering Physician - The physician or other provider who specifically prescribes the health care service being reviewed.

Out-of-Network - The use of health care providers who have not contracted with the health plan to provide services. Depending on the member's contract, out-of-network services may not be covered.

Out-of-Network Benefits - Reimbursement for covered services provided by out-of-network providers and suppliers. Out-of-network benefits are generally subject to a deductible and coinsurance and, therefore, have higher out-of-pocket costs. Depending on the member's contract, out-of-network services may not be covered.

Out-of-Network Facility – A facility that does not have a participation agreement with EmblemHealth or another EmblemHealth plan to provide facility services to persons covered under EmblemHealth.

Out-of-Network Hospital - A hospital that does not have a participation agreement with EmblemHealth or another EmblemHealth plan to provide hospital services to persons covered under EmblemHealth.

Out-of-Network Law – See Emergency Medical Services and Surprise Bills Law.

Out-of-Network Provider - A health care provider, such as a physician, skilled nursing facility, home health agency or laboratory, that does not have an agreement with EmblemHealth plans to provide covered services to members. Also called a Non-Participating Provider.

Outpatient Care - Treatment provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

Outpatient Surgery - Surgical procedures that do not require an overnight stay in the hospital or an ambulatory surgery facility. Such surgery can be performed in the hospital, a surgery center or physician office.

Participating Facility - A facility that is part of EmblemHealth's provider network and has signed an agreement to provide covered services to its members. More commonly referred to as a network facility.

Participating Hospital - A hospital that is part of EmblemHealth's provider network and has signed an agreement to provide covered services to its members. More commonly referred to as a network hospital.

Participating Provider - A physician, hospital or other provider who has signed an agreement to covered services to EmblemHealth plan members. A participating provider is a member of the EmblemHealth network of providers applicable to the member's certificate. Therefore, they are more commonly referred to as network providers. Payment is made directly to a participating provider. Please consult the EmblemHealth Directory or go online to search for participating providers.

PCP - A family physician, family practitioner, general practitioner, internist or pediatrician who is responsible for delivering or coordinating care. Also called a primary care physician.

Physical Therapy - Treatment involving physical movement to relieve pain, restore function and prevent disability following disease, injury or loss of limb.

POS - A type of health benefit plan that allows enrollees to go outside the health plan's provider network for care, but requires enrollees to pay higher out-of-pocket fees when they do. Also called Point of Service.

Postpartum Visit - During the postpartum visit, that must occur within 21 – 56 days following delivery, an assessment of the mother’s blood pressure, weight, breasts, abdomen and a pelvic exam is conducted to determine the mothers physical health status and general well-being following childbirth.

PPO - A health plan that offers benefits in-network and out-of-network. In-network services are available to enrollees at lower out-of-pocket cost than the services of non-network providers. In addition, PPO enrollees may self-refer to any network provider at any time. Also called a Preferred Provider Organization.

Pre-Existing Condition - A pre-existing condition is any disease, symptom or condition present on the first day of coverage and for which medical advice or treatment was recommended or received during the six-month period prior to the enrollment date.

Preferred Provider Organization - A health plan that offers benefits in-network and out-of-network. In-network services are available to enrollees at lower out-of-pocket cost than the services of non-network providers. In addition, enrollees may self-refer to any network provider at any time. Also called a PPO.

Premium - A prepaid payment or series of payments made to a health plan by purchasers and often plan members for health insurance coverage.

Prescription - A written order or refill notice issued by a licensed medical professional for drugs available only through a pharmacy.

Prescription Drugs - Drugs and medications required by law to be dispensed by written prescriptions from a licensed physician.

Preventive Care - Comprehensive care emphasizing prevention, early detection and early treatment of conditions, and generally including routine physical examinations and immunization.

Primary Care Physician - A family physician, family practitioner, general practitioner, internist or pediatrician who is responsible for delivering or coordinating care. Also called a PCP.

Prior Approval - The process of obtaining advanced approval of coverage for a health care service or medication. The request for services is reviewed to assess medical necessity and appropriateness of elective hospital admissions and non-emergency outpatient services before the services are provided. Also called pre-authorization or pre-certification or pre-determination.

Provider- A medical practitioner or covered facility recognized by EmblemHealth for reimbursement purposes. A provider may be any of the following, subject to the conditions listed in this paragraph:

- Doctor of medicine
- Doctor of osteopathy
- Dentist
- Chiropractor
- Doctor of podiatric medicine
- Physical therapist
- Nurse midwife
- Certified and registered psychologist
- Certified and qualified social worker
- Optometrist
- Nurse anesthetist
- Speech-language pathologist
- Audiologist
- Clinical laboratory
- Screening center
- General hospital
- Any other type of practitioner or facility specifically listed in the member's Certificate of Insurance as a practitioner or facility recognized by EmblemHealth for reimbursement purposes

A provider must be licensed or certified to render the covered service. The covered service must be within the scope of the Provider's license or certification.

Provider Network - A set of providers contracted with a health plan to provide services to the enrollees.

Provider Number - The seven-digit identification number issued to the provider by EmblemHealth. This is the tax identification number issued to the provider by the Internal Revenue Service.

Quality Improvement - The process to objectively and systematically monitor and evaluate the quality, timeliness and appropriateness of covered services, including both clinical and administrative functions, to pursue opportunities to

improve health care and to resolve identified problems in any of these services.

Radiation Therapy- Treatment of disease by X-ray, radium, cobalt or high energy particle sources.

Reconsideration - A request for inpatient review, made while the member is still in the facility, of a case that was denied on the basis of medical necessity.

Referral - A recommendation by a physician that an enrollee receive care from a specialty physician or facility.

Retrospective Adverse Determination - A determination for which utilization review was initiated after health care services were provided. Retrospective adverse determination does not mean an initial determination involving continued or extended health care services or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider.

Retrospective Review - A review done after services are completed (usually as part of a claim or appeal), that ensures the care given was medically necessary.

Rider - A provision added to a contract whereby the scope of its coverage is increased or decreased.

SDOH - The state regulatory agency that certifies reimbursement methods and rates to hospitals and reviews HMO activities in the state of New York.

Second Opinion - The voluntary option or mandatory requirement to visit another physician or surgeon regarding diagnosis, course of treatment or having specific types of elective surgery performed.

Service Area - The geographic area in which a health plan is prepared to deliver health care through a contracted network of participating providers.

Service Authorization Request - A request by the member or their provider (on the member's behalf) to have a service provided. This includes a:

- Request for referral
- Request for non-covered service
- Request for prior authorization for coverage of a new service
- Request for concurrent review for continued, extended or additional services than what is currently authorized.

Skilled Nursing Facility - A licensed institution (or distinct part of a hospital) that is primarily engaged in providing continuous skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services. Also called a SNF.

SNF - A licensed institution (or distinct part of a hospital) that is primarily engaged in providing continuous skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services. Also called a skilled nursing facility.

Specialist Physician - A physician who performs specialized services.

Specialized Services - Services provided by specialists, not by the PCP. For example, an allergist (who treats allergies) or a radiologist (who uses X-rays for diagnosis and treatment) are specialists.

Speech Therapy - Treatment of the correction of a speech impairment that resulted from birth, disease, injury or prior medical treatment

Subscriber - An active member enrolled under an EmblemHealth group Certificate or an individual enrolled under a direct payment contract. A "retiree" may also be a subscriber under a group Certificate.

Substance Abuse - The use of one or more drugs for purposes other than those for which they are prescribed or recommended.

Surprise bill – means a bill for health care services, other than emergency services, received by: (1) an EmblemHealth Member for services rendered by a non-EmblemHealth participating physician at an EmblemHealth participating hospital or ambulatory surgical center, where a participating physician is unavailable or a non-participating physician renders services without the Member's knowledge, or unforeseen medical services arise at the time the services are rendered, or (2) an EmblemHealth Member for services rendered by a non-participating provider, where the services were referred by an EmblemHealth participating physician to such non-participating provider without the explicit written consent of the Member acknowledging that the participating physician is referring the Member to a non-participating provider and that the referral may result in costs not covered by the Plan.

A surprise bill does NOT mean a bill for services when a participating physician is available and the EmblemHealth Member opts to obtain services from a nonparticipating physician.

Urgent Care - Services received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering or severe pain, such as a high fever.

Utilization Management - A review to determine whether covered services that have been provided or are proposed to be provided to a member, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. Also called Coordinated Care.

Utilization Management Agent – A person who performs utilization management under a contract with EmblemHealth on behalf of EmblemHealth (also known as a Delegate) and Emblem Health.

Utilization Review - A formal evaluation (prospective, concurrent or retrospective) of the coverage, medical necessity, efficiency or appropriateness of health services and treatment plans. Also called Coordinated Care.

Waiting Period - A period of time an individual must wait to become eligible for insurance coverage.

Workers' Compensation - Insurance carried by employers to cover occupation-related injuries or conditions incurred by the employees.

The following definitions apply to the Medically Fragile Children population

Advocacy: The spirit of this work is one that promotes effective parent/caregiver-professionalsystems partnerships. Advocacy in this role does not include legal consultation or representation. It is defined as constructive, collaborative work with and on behalf of families to assist them to obtain needed services and supports to promote positive outcomes for their children.

Behavioral Health(BH): Refers to mental health and/or SUD benefits and/or conditions. Behavioral Health Service (BH Service): Any or all of the services identified in Table 2 (Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care Populations under 21) of this document.

Behavioral Health Professional (BHP): An individual with an advanced degree in the mental health or addictions field who holds an active, unrestricted license to practice independently or an individual with an associate's degree or higher in nursing who is a registered nurse with three years of experience in a mental health or addictions setting. BHPs, as described in Section 3.2 (Personnel) of this document, will be specified as either a NYS or United States (U.S.) BHP. When specified as an NYS BHP, the individual must hold an active, unrestricted license to practice independently in NYS or be a registered nurse in NYS. When specified as a U.S. BHP, the individual may meet the licensure requirement with an active, unrestricted license to practice independently or be a registered nurse in any state in the U.S. Caregiver/legal guardian:

The adult or adults that have the legal decision making and consent authority for the child or youth in care/services. This may include the parent(s), OCFS, LDSS, etc.

Community First Choice Option (CFCO): Enhanced services and supports for eligible individuals who need assistance with everyday activities due to a physical, developmental or behavioral disability. These services and supports address activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision and/or cueing. Medicaid recipients must meet HCBS setting requirements and institutional LOC criteria, as well as other eligibility criteria, to be eligible for CFCO services. CFCO services must be provided pursuant to a Person-Centered Service Plan. More information is available at https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm.

Credentialed Alcoholism and Substance Abuse Counselor (CASAC): Credentialed Alcoholism and Substance Abuse Counselor as defined by OASAS in 14 NYCRR Part 853. 12 The term Behavioral Health Professional (BHP) is also used to describe certain direct services providers (i.e., not a Managed Care Plan employee). When referencing a crisis intervention provider, for example, BHPs include: Psychiatrist, Physician, Licensed Psychoanalyst, LCSW, LMSW, Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background in treatment of mental health and/or SUDs. For other rehabilitative services where specifically noted, a BHP may include a Creative Arts Therapist, Physician Assistant, Licensed Practical Nurse and Registered Professional Nurse.

Certified Recovery Peer Advocate-Family: OASAS-certified peer support specialist with special “Family” training and designation.

Certified Recovery Peer Advocate-Youth: OASAS-certified peer support specialist with special “Youth” training and designation.

Child and Adolescent Needs and Strengths assessment — New York (CANS-NY): Validated, structured, child/youth assessment tool comprised of domains relevant to determining a child/youth’s and family’s strengths and needs. This tool is used to assist with care coordination for members enrolled in Health Homes. The CANS-NY will also be used to determine certain child/youth populations’ HCBS eligibility. For more detailed information on eligibility, refer to Attachments A and B.

Child/Adolescent/Youth: Individuals under age 21. Children’s Medicaid Redesign Team: A subcommittee of the MRT commissioned by Governor Andrew Cuomo in an effort to restructure the Medicaid program. The Children’s subcommittee participated in the development and design of the children´s MRT initiatives. For more information visit: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/child_mrt.htm

Children’s Continuous Episode of Care: A course of ambulatory health or behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to the effective date of the Children’s Expanded Benefit Inclusion in which a service under the NY OMH Serious Emotional Disturbance Waiver (0296.R03.00), NY Bridges to Health for Children w/Serious Emotional Disturbance Waiver (0469.R01.00), NY Bridges to Health for Children w/Developmental Disabilities Waiver (0470.R01.00), NY Bridges to Health for Children who are Medically Fragile (0471.R01.00), or NY Care at Home I/II (4125.R04.00) Waivers had been provided at least twice during the six months preceding the Children’s Expanded Benefit Inclusion date by the same provider to an Enrollee under the age of 21 for the treatment of the same or related health or behavioral health condition.

Children’s Specialty Services: Services to address mental health, physical health, and/or substance use disorders, including: Early Periodic Screening, Diagnostic, and Treatment Services, and health and behavioral health; services as defined in 18 NYCRR Part 507 and authorized by the State to be provided by designated treatment providers pursuant to rules and regulations of the State for individuals under the age of 21; and Children’s Home and Community Based Services.

Collateral: A person who is a member of the child/youth’s family or household, or other individual who regularly interacts with the child/youth and is directly affected by or has the capability of affecting his or her condition, and is identified in the treatment plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the child/youth.

Complex Trauma: Complex Trauma is a single qualifying eligibility condition for Health Home and is part of the LON target criteria for HCBS for the Abuse, Neglect and Maltreatment or Health Home complex trauma population. The definition of Complex Trauma was developed in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) 18 and the National Child Traumatic Stress Network (NCTSN), www.nctsn.org. The definition of complex trauma

is as follows:

A. The term complex trauma incorporates at least:

1. infants/children/adolescents' with exposure to multiple traumatic events, often of an invasive, interpersonal nature,[1] and
2. the wide ranging, long-term impact of this exposure.

B. The nature of the traumatic events:

1. Often is severe and pervasive, such as abuse or profound neglect;
2. Usually begins early in life;
3. Can be disruptive of the child's development and the formation of a healthy sense of self (with selfregulatory, executive functioning, self-perceptions, etc.);
4. Often occur in the context of the child's relationship with a caregiver; and
5. Can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.

C. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.

D. Wide-ranging, long-term adverse effects can include impairments in:

1. Physiological responses and related neurodevelopment,
2. Emotional responses,
3. Cognitive processes including the ability to think, learn, and concentrate,
4. Impulse control and other selfregulating behavior,
5. Self-image,
6. Relationships with others, and
7. Dissociation. Complex trauma information, tools, and forms (including Complex Trauma Exposure, Assessments and Eligiblity Determination forms) can be found at the Department of Health's website.

Court-Ordered Services: Services the Plan is required to provide to enrollees pursuant to orders of courts of competent jurisdiction, provided however, that such ordered services are within the Plan's benefit package and reimbursable under Title XIX of the Federal Social Security Act, SSL 364-j(4)(r).

Crisis Plan: A tool utilized by providers for children/youth in order to assist in: reducing or managing crisis-related symptoms; promoting healthy behaviors; addressing safety measures; and/or preventing or reducing the risk of harm or diffusion of dangerous situations. The child/youth/family will be an active participant in the development of the crisis plan. With the [1]) 19 family's consent, the crisis plan may be shared with collateral contacts also working with that child/youth/family who might provide crisis support or intervention in the future. Sharing the crisis plan helps to promote future providers' awareness of and ability to support the strategies being implemented by the child/youth/family. Cultural Competency: An awareness and acceptance of cultural differences, an awareness of individual cultural values, an understanding of how individual differences affect those participating in the helping process, a basic knowledge about the client's culture, knowledge of the client's environment, and the ability to adapt practice skills to fit the individual or family cultural context.

Days: Refers to calendar days except as otherwise stated.

Demonstration: The four BH demonstration services already included under the 1115 demonstration in managed care and will be expanded to children enrolled in managed care:

- Outpatient addiction services,
- Residential addiction services,

- Licensed Behavioral Health Practitioners, and
- Crisis Intervention.

Department of Health (DOH): https://www.health.ny.gov/health_care/managed_care/

Developmental Disability: A child having a DD as defined by OPWDD which: is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism; is attributable to any other condition found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such children; is attributable to dyslexia resulting from a disability described above; originated before the child turns 22 years old; has continued or can be expected to continue indefinitely; and constitutes a substantial handicap to such child's ability to function normally in society.

Developmental Milestones: Markers across lifespan that are typically assessed throughout childhood. Milestones include physical, emotional, cognitive, social, and communication skills. Early and Periodic Screening.

Diagnostic and Treatment (EPSDT): Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

Essential Community Behavioral Health Providers:

Essential Community Behavioral Health Providers include the following:

A) State-operated providers of ambulatory mental health services, service providers;

B) State-operated providers of Behavioral Health Home and Community Based Services;

C) Opioid Treatment Programs;

D) OMH licensed outpatient clinics licensed to treat children ages 0-5 years;

E) Comprehensive Psychiatric Emergency Programs that serve children;

F) OMH licensed inpatient psychiatric services for children located within hospitals licensed under Article 28 of the New York State Public Health Law; and

G) Hospitals designated under Mental Hygiene Law § 9.39 serving children. Evidence-Based Practice (EBP): The Institute of Medicine (IOM) defines "evidencebased practice" as a combination of the following three factors:

(1) best research evidence,

(2) best clinical experience, and

(3) consistent with patient values.

These factors are also relevant for child welfare. The State has adopted the IOM's definition for EBP with a slight variation that incorporates child welfare language: best research evidence, best clinical experience, and consistent with family/client values. This definition builds on a foundation of scientific research while honoring the clinical experience of child welfare practitioners, and being fully cognizant of the values of the families served. Family: Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. Family Member: Parent, grandparent, sibling, aunt, uncles, etc. that is biological, foster/adoptive or invested in the care of the child/youth.

Family of One: A commonly used phrase to describe a child that becomes eligible for Medicaid through use of institutional eligibility rules for certain medically needy individuals. These rules allow a budgeting methodology for children to meet Medicaid financial eligibility criteria as a "family of one," using the child's own income and disregarding parental income. Family Peer Advocate: OMH certified peer support specialist.

First Episode Psychosis (FEP): Members with FEP are individuals who have displayed psychotic symptoms suggestive of recently-emerged schizophrenia. FEP generally occurs in individuals age 16–35. FEP includes individuals whose emergence of psychotic symptoms occurred within the previous two years, who remain in need of mental health services, and who have a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, psychotic disorder not otherwise specified (DSM-IV), or other specified/unspecified schizophrenia spectrum and other psychotic disorder (DSM-5). The

definition of FEP excludes individuals whose psychotic symptoms are due primarily to a mood disorder or substance use.

Healthcare Effectiveness Data and Information Set (HEDIS): The set of performance measures used in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

Health Home Care Management: Health Home is a care management service model for individuals enrolled in Medicaid with complex chronic medical and/or behavioral health needs. Health Home care managers provide person-centered, integrated physical and behavioral health 13 Institute of Medicine, 2001.

Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press 21 care management, transitional care management, and community and social supports to improve health outcomes of high-cost, high-need Medicaid members with chronic conditions. In April 2016, New York State received CMS approval to expand and tailor the Health Home model to serve children under 21 beginning in the Fall of 2016. As defined and implemented by the Medicaid State Plan, Health Home care management includes the six core functions, and the provision of required care plans for HCBS. The six core functions include:

1. Comprehensive Care Management

2. Care Coordination and Health Promotion

3. Comprehensive Transitional Care

4. Enrollee and Family Support

5. Referral to Community and Social Supports

6. Use of Health Information Technology to Link Services. All children receiving HCBS are eligible for Health Home care management under the children's 1115 MRT waiver amendment in addition to children eligible for Health Home under the Medicaid State Plan. For children who opt out of Health Homes, the Plan or a State Designated Entity for FFS enrolled children will conduct the HCBS assessment, plan of care (POC) development and ongoing monitoring of the Plan of Care. Home Setting or Community Setting: The setting in which a child primarily resides or spends time, as long as it is not a hospital nursing facility, Intermediate Care Facility (ICF), or psychiatric nursing facility.

Note: this is distinguished from an HCBS. State Plan services, including the new EPSDT OLP and Rehabilitation services as well as Clinic Services, do not have to comply with the HCBS settings rule, 42 CFR 441.301 and 530. Inpatient Classified Settings: Medicaid compensable 24 hour levels of care that NYS has classified as inpatient, including but not limited to, acute psychiatric inpatient facilities, psychiatric RTFs, and Chemical Dependence RRSY. Level of Care for Alcohol and Drug Treatment Referral (LOCADTR): LOCADTR is developed and updated, as appropriate, by OASAS and is the clinical LOC tool that assesses the intensity and need of services for an individual with an SUD. It is to be used in making all initial and ongoing LOC decisions in NYS. For more information, please visit: https://oasas.ny.gov/treatment/health/locadtr/index.cfm

Level of Care (LOC) populations: See Attachment A for a description of HCBS eligibility criteria for LOC population meeting institutional admission criteria. Level of Need (LON) populations: See Attachment B for description of HCBS eligibility criteria for LON population at-risk of institutionalization.

Licensed Practitioner of the Healing Arts (LPHA): An individual professional who is licensed practicing within the scope of their State license including: Physician, Psychiatrist, Licensed Psychoanalyst, Registered Professional Nurse, Nurse Practitioner, Clinical Nurse Specialist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, Licensed Psychologist, Licensed Master Social Worker (LMSW), Clinical Nurse Specialist, and Physician Assistants. The licensed professional is responsible for 22 ensuring that the diagnosis, recommendation, referral, supervision, and/or care provided is within their scope of practice under current state law.

Local Department of Social Services (LDSS): Each County has an LDSS that provides or administers the full range of publicly funded social services and cash assistance programs. In NYC, these departments are named the Human Resources Administration and Administration for Children's Services. Medicaid Managed Care Organization (MMCO): MCOs certified by NYS to manage health and BH services for Medicaid beneficiaries who are not also eligible for Medicare. MMCOs also include HIV Special Needs Plans (HIV SNPs).

Medically Fragile Children: The NYS Office of Health Insurance Programs (OHIP) has historically defined Medically Fragile as children who have a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meet one or more of the following criteria: is technologically dependent for life or health-sustaining functions; requires complex medication regimen or medical interventions to maintain or to improve their health status; or

is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. Chronic debilitating conditions include, but are not limited to: bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy. All health plans must comply with MFC requirements for any MFC child.

Medically Fragile Level of Care (LOC) Population: A child under age 21 with a documented physical disability following state demonstration protocols. A LPHA who has the ability to diagnose within his or her scope of practice under state law has determined in writing that the child, in the absence of HCBS, is at risk of institutionalization. The LPHA has submitted written clinical documentation to support the determination. The child has received a face-to-face assessment and been found to meet hospital or nursing facility admission criteria. The child is eligible to receive LOC HCBS services including CFCO services if CFCO requirements are met. Medical Necessity: New York law defines “medically necessary medical, dental, and remedial care, services, and supplies” in the Medicaid program as those “necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law” (N.Y. Soc. Serv. Law, § 365-a).

Mental Health Parity and Addiction Equity Act (MHPAEA)14: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or SUD benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. In March 2016, the CMS published the final rule addressing the 14 https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html 23 application of certain requirements set forth in MHPAEA to coverage offered by MMCOs, Medicaid Alternative Benefit Plans, and Children’s Health Insurance Programs. https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf

Natural Supports: Natural supports are individuals and informal resources that a family/caregiver can access, independent of formal services. These supports are a significant source of culturally relevant emotional support and caring friendships for children and families. Natural supports can be shortterm or long-term and are usually sustainable and available to the child and family/caregiver after formal services have ended. Natural supports can include, but are not limited to, family members, friends, neighbors, clergy, and other acquaintances.

Non-Physician Licensed Behavioral Health Professional (NP-LBHP): NP-LBHPs include individuals licensed and able to practice independently for which reimbursement is authorized under the Other Licensed Practitioner section of the Medicaid State Plan.

Non-physician NP-LBHP include: Licensed Psychoanalysts, LCSW, Licensed Marriage & Family Therapists, and Licensed Mental Health Counselors. NP-LBHPs also include the followingindividuals who are licensed to practice under supervision or direction of a LCSW, a Licensed Psychologist, or a Psychiatrist: LMSW. Note: Psychiatrists, Licensed Physician Assistants, Licensed Physicians, Psychologists, and Licensed Nurse Practitioners are licensed practitioners, but not referred to as NP-LBHPs.

Office of Alcoholism and Substance Abuse Services (OASAS): https://oasas.ny.gov/

Office of Children and Family Services (OCFS): https://ocfs.ny.gov/main/

Office of Mental Health (OMH): https://www.omh.ny.gov/omhweb/about/

Office for People With Developmental Disabilities (OPWDD): https://www.opwdd.ny.gov

Person-Centered Care: Services that are family-driven, youth-guided and reflect a child and family’s goals and emphasize shared decision-making approaches that empower families, provide choice, and minimize stigma. Services must be designed to optimally treat illness, improve clinical and psychosocial outcomes, and emphasize wellness and attention to the family’s overall well-being and the child’s full community inclusion.

Plan: the MMCO.

Plan of Care (POC): The written plan that describes the type, level and duration of services and care necessary to treat the assessed needs for children/youth. Preventive Care: The are or services rendered to avert disease/illness and/or its consequences. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Commonly, the term “preventive care” is used to designate prevention and early detection programs rather than treatment programs.

Provider Agreement: Any written contract between the Plan and a participating service provider to provide medical care and/or services to Plan enrollees.

Recovery-Oriented: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or SUDs. Specifically, services support the acquisition of living, vocational, and social skills and are offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

Regional Planning Consortium (RPC): A Regional Behavioral Health planning Consortium, which is comprised of theLocal Government Unit(s) in each region, representatives of mental health and Substance Use Disorder service providers, child welfare system, peers, families, Health Homes, and MCOs. The RPC works closely with State agencies to guide policy as it relates to Medicaid Managed Care in the region, problem-solve regional service delivery challenges, and recommend provider training topics.

Resilience: The principle that children/youth have qualities that equip them and/or can be strengthened to help them manage through the effects of adversity or trauma and help them to cope, survive, and even thrive. Serious Emotional Disturbance (SED): A designated mental illness diagnosis according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a child or adolescent who has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

- Ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school). To be eligible for HCBS SED LOC, see Attachment

A. To be eligible for HCBS SED LON, see Attachment B. To be eligible for Health Home due to SED, SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following DSM categories15 as defined by the most recent version of the DSM of Mental Disorders AND has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. DSM Qualifying Mental Health Categories* 15 Any diagnosis in these categories can be used when evaluating a child for SED. However, any diagnosis that is secondary to another medical condition is excluded.

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders

- Personality Disorders
- Paraphilic Disorders

Functional Limitations Requirements for SED Definition of Health Home - To meet definition of SED for Health Home, the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

- Ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school). https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/4_29_2015_children_webinar.pdf(p. 16 and 17).

Single Case Agreement (SCA): An agreement between a non-contracted provider and the MMCO in which the provider is reimbursed for the care for one specific child's case. Start-up date: The date the Plan will begin providing health services described in this document. Substance Use Disorder (SUD): A diagnosis of an SUD is a pathological pattern of behaviors related to the use of a substance. The diagnosis of SUD is based on criteria defined in the DSM and can be applied to all 10 classes of drugs including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, anxiolytics; stimulants; tobacco; and other (or unknown) substances. Teaching Family Home: A home which provides specially trained teaching parents who provide individualized care for up to four children/adolescents with SEDs at a time in a family setting.

Transition Aged Youth (TAY): Individuals under age 23 transitioning into the adult system from any OMH, OASAS or OCFS licensed, certified, or funded children's program. This also includes individuals under age 23 transitioning from State Education 853 schools (these are operated by private agencies and provide day and/or residential programs for students with disabilities).

Trauma: Affects a child's sense of safety, ability to regulate emotions, and capacity to relate well to others. Trauma is defined as exposure to a single severely distressing event or multiple, chronic, or prolonged traumatic events as a child or adolescent that is often invasive and interpersonal in nature. Trauma-Informed: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be modified to be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA, 2014).

Treatment Plan: A treatment plan describes the child's condition and services that will be needed for that Episode of Care, detailing the practices to be provided, expected outcome, and expected duration of the treatment for each provider. The treatment plan should be culturally relevant, trauma-informed, and person-centered.

Voluntary Foster Care Agency(VFCA): A foster care agency responsible for the temporary custody and care of children/youth placed in foster care either by order of a court (involuntary) or because their parents are willing to have them cared for temporarily outside the home (voluntary). As of December 2016, there were 93 VFCAs operating in NYS.

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Chapter 39: Forms Brochures & More...

To view the provider toolkit, click here.

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Table 23-1, Provider Complaint/Grievance Procedures

TABLE 23-1, PROVIDER COMPLAINT/GRIEVANCE PROCEDURES					
EMBLEMHEALTH MEDICARE HMO AND PPO PLANS					
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE HARD COPY **: INSTRUCTIONS	TIME FRAMES*			ADDITIONAL RIGHTS
		Initial Practitioner Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
EmblemHealth Medicare HMO Plans	Sign in to: www.emblemhealth.com. Write to: EmblemHealth Medicare HMO P.O. Box 2807 New York, NY 10116-2807	45 calendar days from event. Exceptions:SUNY Downstate - 90 calendar days from event; Stony Brook Affiliations - 120 calendar days from event.	15 calendar days from receipt of request.	Complaint: 30 calendar days from receipt of request. Grievance: 45 calendar days from receipt of request.	Decision is final.
EmblemHealth Medicare PPO Plans	Sign in to: www.emblemhealth.com. Write to: EmblemHealth Medicare PPO PO Box 2807 New York, NY 10116-2807	45 calendar days from event.	15 calendar days from receipt of request.	Complaint: 30 calendar days from receipt of request. Grievance: 45 calendar days from receipt of request.	Decision is final.

* Contracted facility time frames in provider agreements will supersede time frames in this manual.

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Table 23-2, Facility Retrospective Review Request

TABLE 23-2, FACILITY RETROSPECTIVE REVIEW REQUEST					
FOR DENIALS BASED ON "NO PRIOR APPROVAL"					
FOR DENIALS BASED ON "NO E.R. NOTIFICATION"					
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE INSTRUCTIONS	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Facility Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
EmblemHealth Medicare HMO plans	Write to: EmblemHealth Medicare HMO PO Box 2807 New York, NY 10116-2807 Telephone: 1-800-447-8255	45 calendar days from receipt of remittance statement. Exceptions:North Shore - 180 calendar days; SUNY Downstate - 90 calendar days; NY Presbyterian - 365 calendar days from discharge date or 60 calendar days from denial date (whichever is later).	15 calendar days from receipt of necessary information.	30 days from receipt of all information.	May file a facility clinical appeal.

* Contracted facility time frames in provider agreements will supersede time frames in this manual.

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Table 23-3, Appeal - Contracted Facility Clinical Appeal

TABLE 23-3, APPEAL - CONTRACTED FACILITY CLINICAL APPEAL					
EMBLEMHEALTH MEDICARE HMO PLANS					
BENEFIT PLAN(S)	WHAT/HOW/WHERE TO FILE: INSTRUCTIONS	TIME FRAMES			ADDITIONAL RIGHTS
		Initial Provider* Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification	
EmblemHealth Medicare HMO Plans	Write to EmblemHealth Medicare HMO PO Box 2807 New York, NY 10116-2844 Telephone: 1-888-447-8255	45 calendar days from receipt of written adverse determination. Exceptions:NY Presbyterian - 365 calendar days from discharge date or 60 calendar days from denial date (whichever is later); Long Island Health Network - 60 calendar days; SUNY Downstate - 120 calendar days.	15 calendar days from receipt of request.	60 calendar days from receipt of request. The provider notified within 2 days of determination.	N/A

* Contracted facility time frames in provider agreements will supersede time frames in this manual.

EmblemHealth

Provider Manual

Chapter 34: Dispute Resolution for Medicare Plans

This chapter contains processes for our members and practitioners to dispute a determination that results in a denial of payment or covered service.

Overview

EmblemHealth provides processes for members and practitioners to dispute a determination that results in a denial of payment and/or covered services. Process, terminology, filing instructions, applicable time frames and additional and/or external review rights vary based on the type of plan in which the member is enrolled. The processes in this section apply to EmblemHealth Medicare HMO and EmblemHealth Medicare PPO plans, as well as Medicare Part D.

View the processes for HIP Medicaid and HIP Family Health Plus plans.

View the processes for Commercial and HIP Child Health Plus plans.

We do not discriminate against practitioners or members, or attempt to terminate a practitioner's agreement or disenroll a member, for filing a request for dispute resolution.

We have interpreter services available to assist members with language and hearing/vision impairments.

Payments for Services in Dispute

EmblemHealth network practitioners may not seek payment from members for either covered services or services determined by EmblemHealth's Care Management program not to be medically necessary unless the member agrees, in writing and in advance of the service, to such payment as a private patient and the written agreement is placed in the member's medical record. Any practitioner attempting to collect such payment from the member in the absence of such a written agreement does so in breach of the contractual provisions with EmblemHealth. Such breach may be grounds for termination of the practitioner's contract.

Key Terminology

The descriptions below provide a general overview of the dispute resolution terminology used with Medicare Advantage plans.

- Appeal
  A request to review any aspect of a claim determination or adverse benefit determination or a clinical adverse determination denied with regards to medical necessity.
- Coverage Determination
  A notification sent when a Part D drug is denied.
- Grievance
  A request to review an administrative process, service or quality of care issue NOT pertaining to a medical necessity determination, a benefit determination or a claims determination.
- Organization Determination
  A notification sent when a health care service, procedure or treatment is denied.

Medicaid Advantage plans include coverage components from both Medicare Advantage and Medicaid managed care. These dual-eligible members have the right to select which dispute process to use. In the written notice of initial adverse determination to all dual-eligible members, EmblemHealth will provide notice that:

- A Medicare appeal must be filed within 60 days from the date of the denial.
- Filing a Medicare appeal means that the member cannot file for a state fair hearing.
- The member may still file for Medicare appeal after filing for Medicaid appeal, if it is within the 30-day period.

Certain disputes may be filed as Expedited or Standard depending on the urgency of the patient's condition.

Certain disputes may also be filed as Pre-Service or Post-Service depending on the timing of the determination in question.

Managing Entities' Role in Dispute Resolution

EmblemHealth contracts with separate managing entities to provide care for certain types of medical conditions. In these cases, the designated managing entity will determine the applicable process for filing a dispute.

Appointing a Designee

Members wishing to dispute a determination or claim denial may do so themselves or designate a person or practitioner to act on their behalf. To appoint a designee, members must submit by fax or by mail a signed Appointment of Representative (AOR) form or a Power of Attorney form that specifies the individual as an authorized party.

Extensions

In certain circumstances, dispute resolution time frames may be extended if permitted by law and requested by the complainant or if EmblemHealth believes an extension is in the best interest of the member.

Initial Adverse Determinations

EmblemHealth will send a written notice on the date when a request for health care service, procedure or treatment is given an adverse determination (denial) on the following grounds:

- Service does not meet or no longer meets the criteria for medical necessity, based on the information provided to us.

- Service is considered to be experimental or investigational (rare disease).
- Elective non-urgent service requested by an out-of-network provider can be provided by a participating provider, and there is no medical necessity to access an out-of-network provider.
- Service is approved, but the amount, scope or duration is less than requested.
- Service is not a covered benefit under the member's benefit plan.
- Service is a covered benefit under the member's benefit plan, but the member has exhausted the benefit for that service.

The written notice will be sent to the member and provider and will include:

- The description of the action EmblemHealth has taken or intends to take.
- The reasons for the initial adverse determination, including the clinical rationale, if any.
- The member's right to file an appeal, including the member's right to designate a representative to file an appeal on his or her behalf.
- The process and time frame for filing/reviewing an appeal with EmblemHealth, including
  - an explanation that an expedited review of the appeal can be requested if a delay would significantly increase the risk to a member's health.
  - a toll-free number for filing an appeal.
- Instructions on how to initiate an appeal and time frames for submitting the appeal.
- Notice of the availability, upon request of the member or the member's designee, of the clinical review criteria relied upon to make such determination.
- EmblemHealth's time frame for making a decision on an appeal.

For retrospective review requests, EmblemHealth must make a decision and notify the member by mail on the date of the payment denial, in whole or in part. The decision must be made within 60 calendar days of receipt of the request.

EmblemHealth may reverse a prior approval decision for a treatment, service or procedure on retrospective review when:

- Relevant medical information presented to EmblemHealth or the utilization review agent upon retrospective review is materially different from the information that was presented during the prior approval.
- The information existed at the time of the prior approval review but was withheld or not made available.
- EmblemHealth or the utilization review agent was not aware of the existence of the information at the time of the prior approval review.
- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Final Adverse Determinations

For decisions that uphold or partially uphold a determination made regarding a clinical issue for which no additional internal appeal options are available to the contracted provider, EmblemHealth will issue a final adverse determination (FAD) in writing to the contracted facility.

The FAD contains the following information:

- The date the review request was received.
- A summary of the review.
- The results and the reasons for the determination, including the clinical rationale.
- The words "final adverse determination."
- A clear statement that the notice constitutes the final adverse determination.
- The terms "medical necessity" or "experimental/investigational."
- The member's coverage type.
- The service in question and, if available and applicable, the name of the provider and developer/manufacturer of the health care service.
- Information on available alternative and/or external dispute resolution options. To determine if further resolution options are applicable, please refer to your contract agreement.

Notice of Final Appeal Determination

We will notify the contracted facility in writing of the final appeal determination within three calendar days of when we make the decision.

Provider Dispute Resolution Procedures: Complaints and Grievances

Practitioner Complaint Procedures

If a practitioner is dissatisfied with an administrative process, quality of care issue and/or any aspect of service rendered by EmblemHealth that does not pertain to a benefit or claim determination, the practitioner may file a complaint on his/her own behalf. Examples of such dissatisfaction include:

- Long wait times on EmblemHealth's authorization phone lines
- Difficulty accessing EmblemHealth's systems
- Quality-of-care issues

Once a decision is made on a practitioner's complaint, it is considered final and there are no additional internal review rights.

Complaints must be submitted in writing to the EmblemHealth's Grievance and Appeals (GAD) department. A complaint should include a detailed explanation of the clinician's request and any documentation to support the practitioner's position.

The Plan will acknowledge receipt of the practitioner's complaint in writing no later than 15 days after its receipt. Practitioner complaints will be reviewed and a written response will be issued directly to the practitioner no later than 30 days after receipt.

Contracted Provider Grievance Process for Medicare HMO and PPO Plans

If a provider is not satisfied with any aspect of a claim determination rendered by the plan (or any entity designated to perform administrative functions on its behalf) which does not pertain to a medical necessity determination, that provider may file a grievance with EmblemHealth.

Examples of reasons for filing grievances include dissatisfaction with a decision resulting from a failure to follow a plan policy or procedure, or failure to obtain prior approval for an inpatient admission. A provider may also file a grievance regarding how a claim was processed, including issues such as computational errors, interpretation of contract reimbursement terms, or timeliness of payment. The Grievance and Appeal department is not involved in determining claim payment or authorizing services, but independently investigates all grievances.

In addition, providers who wish to challenge the recovery of an overpayment or request a reconsideration for claims denied exclusively for untimely filing may follow the grievance procedures in this sub-section.

Note: The right to reconsideration shall not apply to a GHI claim submitted 365 days after the service date, or a HIP claim submitted 120 days after service unless the participation agreement states an alternative time frame to be applied. If a claim was submitted more than one year from date of service, EmblemHealth may deny the claim in full or in the alternative may reduce payments by up to 25 percent of the amount that would have been paid had the claim been submitted in a timely manner.

For grievances related to untimely filing, the provider must demonstrate that the late submission was an unusual occurrence and that they have a pattern of submitting claims in a timely manner. Examples of an unusual occurrence include:

- Medicaid Reclamation
- Member submitted the provider the wrong insurance information
- Coordination of Benefits related issues
- Member retroactively reinstated

The provider has the option to question a claim's payment by submitting an inquiry along with supporting documentation within the Claim's Inquiry tool in the secure provider website: www.emblemhealth.com/Providers. For multiple claims, use the Message Center tool to send grievance and attach files.

The grievance should be accompanied by a copy of the notice of the standard denial or other documentation of the denial, an explanation outlining the details of the request for a review and all documentation to support a reversal of the decision.

EmblemHealth will acknowledge, in writing, receipt of a grievance that is submitted in writing no later than 15 days after its receipt. The grievance will be reviewed and a written response will be issued for grievances with a final disposition of partial overturn or upheld, no later than 45 days after receipt. The determination included in the response will be final.

Grievances with a favorable disposition will receive a claims remittance advice in lieu of a written response no later than 45 days after receipt.

Procedures for initiating a Contracted Provider Grievance with respect to an EmblemHealth Medicare member are

outlined in the table below.

Notice of Determinations of Grievance Decision

The written Notice of Determination will include the following:

- The date the request was received
- Detailed reasons for the determination, including the clinical rational if applicable.
- A statement that the notice is a final determination
- Notice that the member and EmblemHealth will be held harmless

View Table 23-1, Provider Complaint/Grievance Procedures here

Facility Retrospective Utilization Reviews Requests For Medicare HMO

If an EmblemHealth-contracted facility fails to follow prior approval and/or emergency admittance procedures, payments for such services may be denied and the facility, EmblemHealth or its managing entity may initiate a retrospective utilization review (RUR).

For Denials Based on No Prior Approval Medicare HMO Only

If the facility fails to obtain prior approval, payment will be denied for "no prior approval." The remittance statement will include information regarding the facility's right to request a retrospective utilization review for medical necessity. See the "Care Management" chapter.

If the facility fails to request a retrospective utilization review and submit the medical record within 45 days of receipt of the remittance statement, the claim denial will be upheld and the facility will have no further appeal rights.

If EmblemHealth or the managing entity fails to render and communicate a decision to the facility within 30 days of receipt of all information, the case will be deemed automatically denied and the facility will have the right to appeal the decision.

For Denials Based on "No E.R. Notification" - Medicare HMO Only

If the facility admits a patient through the emergency room without notifying EmblemHealth or the managing entity and submits a claim for services rendered, EmblemHealth will request medical records to initiate a retrospective utilization review for medical necessity.

If the facility fails to submit the medical record within the time frame, the facility will receive an adverse determination stating inability to establish medical necessity based on no information received. The facility will then have the opportunity to file a facility clinical appeal.

For facility retrospective utilization review requests for outpatient physical and occupational therapy services managed by Palladian, please follow the process outlined in the Physical and Occupational Therapy Program chapter.

View Table 23-2, Facility Retrospective Review Request here

Facility Clinical Appeals

Contracted Facility Clinical Appeals - Medicare HMO Plans

If an EmblemHealth-contracted facility is not satisfied with an initial adverse determination related to an EmblemHealth Medicare HMO member for a retrospective review that was rendered based on issues of medical necessity, experimental or investigational use, or services cannot be approved because the facility has not submitted information to establish medical necessity, an appeal may be filed. EmblemHealth provides one internal level of appeal for facilities. EmblemHealth will acknowledge receipt of the appeal request in writing within 15 calendar days.

EmblemHealth handles all facility clinical appeals, except in the following situations, where the managing entity handles the appeal:

- If the managing entity has a direct contract with the facility.
- The managing entity has denied the case based on medical information.
- The managing entity has denied the case for "no information."

An EmblemHealth medical director reviews appeals. Personnel who have previously rendered decisions in the case or subordinate(s) of that person are not permitted to render a decision on the appeal.

EmblemHealth or the managing entity will render a decision within 60 days of receipt of the appeal request.

Procedures for initiating a contracted facility clinical appeal are outlined in Table 23-3, Appeal - Contracted Facility Clinical Appeal

For Medicare PPO facility disputes, please refer to the Contracted Provider Grievances - Medicare PPO Plans section in this chapter.

Member Dispute Resolution Procedures: Grievances and Appeals

The processes members need to follow if they want to report a problem, file a complaint or submit an appeal are documented in the members' Evidence of Coverage. This is the same process a provider would follow when acting on behalf of a member. Copies of each Medicare plan's Evidence of Coverage can be found on our Web site at emblemhealth.com/plans/medicare-advantage by searching under the applicable plan.

Member Grievance Procedures

An EmblemHealth Medicare enrollee may file a grievance if he or she has a problem with us or one of our network providers or pharmacies related to office or prescription fill waiting times, the behavior of a network provider or pharmacist, or the inability to reach someone by phone. Complaints regarding coverage for a service or prescription drug are not considered a grievance under these terms.

An EmblemHealth Medicare enrollee or his or her representative may file a grievance by phone or in writing no later than 60 days after the incident that precipitated the grievance. Grievances submitted in writing will be responded to in writing. Grievances submitted by phone may be responded to either by phone or in writing unless the enrollee requests a written response. All grievances related to quality of care, regardless of how the grievance is filed, will be responded to in writing.

EmblemHealth will notify the enrollee of its decision as soon as possible, but no later than 30 days after the date EmblemHealth receives the grievance. This time period may be extended by up to 14 days if the enrollee requests such an extension or EmblemHealth can justify the need. If EmblemHealth extends the timeframe, the enrollee will be immediately notified.

Grievances can be filed as follows:

EmblemHealth Medicare HMO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-877-344-7364

EmblemHealth Medicare PPO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-866-557-7300

EmblemHealth Medicare PDP (non-City of New York)

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-877-444-7241

EmblemHealth Medicare PDP (City of New York employees)

- In writing: Express Scripts
  Attn: Pharmacy Appeals GH3
  6625 West 78th Street
  Mail Route B20390
  Bloomington, MN 55439

- By phone: 1-800-585-5786

EmblemHealth members who use a TTY/TDD can dial 711 for Telecommunications Relay Services.

Standard Reconsiderations (Appeals) - Part C

An enrollee who has received an adverse organization determination may request that it be reconsidered.

For standard reconsiderations, an enrollee or his or her representative must make a request within 60 calendar days of the notice of the coverage determination. This may be extended if the enrollee shows good cause (in writing). For expedited reconsiderations, an enrollee or his or her prescribing physician may make a request by phone or in writing. EmblemHealth will promptly decide whether to expedite the request.

EmblemHealth will notify the enrollee of its decision no later than 60 calendar days from the date the request was received. If a standard reconsideration request is granted in whole or in part, EmblemHealth will effectuate the decision no later than 60 calendar days from the date the reconsideration request was received.

Standard reconsiderations (appeals) for Medicare Part C can be filed as follows:

EmblemHealth Medicare HMO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-877-344-7364

EmblemHealth Medicare PPO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-866-557-7300

EmblemHealth members who use a TTY/TDD can dial 711 for Telecommunications Relay Services.

Reopening Medicare Part C

EmblemHealth, as a NCQA (National Committee for Quality Assurance)-certified Medicare Managed Care Organization, does not recognize Peer-to-Peer Conversations as a mechanism to change adverse determination decisions. Therefore, the only mechanisms available for physicians to challenge an initial adverse organization determination are to either:

1. Submit Reconsideration per Section 70.2 in the Medicare Managed Care Manual (MMCM) as described in the Appeal Rights page attached to the Medicare Denial Notice. Reopening requests must be clearly stated in writing and include the specific reason for requesting the Reopening such as good cause and new and additional material evidence or;
2. Submit a written Reopening Request per Section 130.1 in the MMCM.

In the event the subject of an appeal is to address a clerical error, (minor errors or omission) EmblemHealth will process the request as a Reopening, instead of a Reconsideration. A Reopening is defined as a remedial action taken

to change a final determination or decision even though the determination or decision was correct based on the evidence of record. The process of Reopening applies only to Medicare Part C products and does not apply to Medicare Part D services.

Reopening requests must be submitted within 1 year of the initial determination however the timeframe may be extended if good cause is established. EmblemHealth will not reopen an issue that is under appeal until all appeal rights, at the particular appeal level, have been exhausted. The decision to grant the Reopening request is solely EmblemHealth's discretion.

Good cause is established when:

- The evidence that was considered in making the organization determination decision clearly shows on its face that an obvious error was made at the time of the organization determination decision. For example, a piece of evidence could have been contained in the file, but misinterpreted or overlooked by the person making the determination;
- There is new and additional material evidence that was not available or known at the time of the initial organization determination decision. New and material evidence is evidence that may result in a conclusion different from that reached in the initial organization determination.

Note: A general statement of dissatisfaction is not grounds for a Reopening. When possible, please use the Medicare Organization Determination Reopening Request Form when submitting Reopening requests.

The Reopening Request Form, along with any additional relevant information, can be mailed or faxed to:

EmblemHealth
ATTN: Predetermination Department, 4th Floor
441 9th Avenue
New York, NY 10001

Fax: 212-510-3006

If the request is found not to qualify under the Reopening Process, EmblemHealth will advise the enrollee or his or her representative of any appeal rights they may have and provide the time frame to request an appeal assuming the original denial has not expired.

For additional information, please go to the Medicare Managed Care Appeals & Grievances section of the CMS website: http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html.

Standard Redeterminations (Appeals) - Part D

An enrollee who has received an adverse coverage determination for a drug may request that it be redetermined.

For standard redeterminations, an enrollee or his or her representative must make a redetermination request within 60 calendar days of the notice of the coverage determination. This may be extended if the enrollee shows good cause (in writing). For expedited redeterminations, an enrollee or their prescribing physician may make a request by phone or in writing. EmblemHealth will promptly decide whether to expedite the request.

EmblemHealth will notify an enrollee of the decision no later than 7 calendar days from receipt of the request. If a standard redetermination request is granted in whole or in part, EmblemHealth will authorize the drug in question no later than 7 calendar days from receipt. If a standard redetermination request for payment is granted in whole or in part, EmblemHealth will effectuate the decision no later than 7 calendar days from receipt of the request and make payment no more than 30 days from receipt.

Standard redeterminations (appeals) for Medicare Part D can be filed as follows:

EmblemHealth Medicare HMO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-877-344-7364

EmblemHealth Medicare PPO

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-866-557-7300

EmblemHealth Medicare PDP (non-City of New York)

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-877-444-7241

EmblemHealth Medicare PDP (City of New York employees)

- In writing: EmblemHealth Grievance and Appeal Department
  PO Box 2807
  New York, NY 10116
- By phone: 1-877-444-7241

EmblemHealth members who use a TTY/TDD can dial 711 for Telecommunications Relay Services.

2016 Reconsideration Rights for Network Non-renewal: for Medicare HMO Line of Business Only

A reconsideration request may be initiated if the non-renewed provider believes that there is information about his/her practice which might be unknown to EmblemHealth and should be reviewed in reconsideration of this decision. Please note, however, that reconsideration applies only to the Medicare HMO line of business; no other plans/lines of business are subject to reconsideration. All decisions are final. The non-renewed Medicare HMO provider has thirty days from receipt of the provider contract non-renewal notification letter to request reconsideration for the Medicare HMO line of business. Upon receipt of a completed reconsideration request, EmblemHealth will schedule an in-person meeting to be held during normal business hours at an EmblemHealth location.

To request a reconsideration of your non-renewal from the Medicare Essential and/or Medicare Advantage HMO networks, please follow these instructions:

- Submit requests for reconsideration in writing to:

EmblemHealth
55 Water Street, North Tower

Dept. 30301 – Non Renewal Coordinator
New York, NY 10041-8190

- Requests must include the following:
  - A letter describing what special circumstances of which EmblemHealth may be unaware.
  - A checklist of the following, along with supporting documentation, as specified.

Applicability	Present in Practice (Yes/No)	Criteria	Documentation Required
PCPs		Patient Center Medical Home (PCMH)	Evidence of participation in a Level 2 or Level 3 PCMH.
Specialists		Patient Centered Medical Practice (PCSP)	Evidence of participation as a PCSP.
All Physicians		Electronic Health Record (EHR)	A copy of the CMS attestation proving EHR stage 1 or stage 2 meaningful use.
All Physicians		E-Prescribing	Identification of the E-prescribing vendor used and the date implemented.
All Physicians		Hierarchical Condition Categories (HCC)	Any evidence of adoption of ePASS® for reporting HCC gap closure to EmblemHealth.
All Physicians		Wellness Programs	Example(s) of any wellness programs administered by the practice to EmblemHealth members. Please include any improved outcomes demonstrated by these wellness programs.
All Physicians		Electronic Lab Results	Any evidence of the practice's adoption of Care360®, a free tool used to order lab tests and obtain results from Quest Diagnostics, EmblemHealth's preferred diagnostic testing laboratory.
All Physicians		Other info	Any documentation supporting specified criteria.

- After receipt of this information, reconsideration meetings will be scheduled and conducted at an EmblemHealth location during normal business hours.
- An Adhoc Reconsideration Board, consisting of three physicians will conduct the reconsideration hearing.
- The Adhoc Reconsideration Board makes the final decision.
- The provider will be notified in writing within seven business days of the decision.
- Providers whose non-renewal status is upheld will be notified, citing the original date of non-renewal. Participation in the Medicare HMO line of business will continue uninterrupted for providers whose non-renewal status is overturned.

2017 Reconsideration Rights for Network Terminations and Non-renewal: EmblemHealth Medicare HMO

A reconsideration request may be initiated if the terminated or non-renewed provider believes that there is significant and relevant information about his/her practice which might be unknown to EmblemHealth. EmblemHealth will review this additional information in reconsideration of this decision. All decisions are final. The terminated or non-renewed provider has thirty days from receipt of the termination letter or provider contract non-renewal notification letter to request reconsideration for the applicable Medicare networks. Upon receipt of a completed reconsideration request, EmblemHealth will schedule an in-person meeting to be held during normal business hours at an EmblemHealth location. For terminations and non-renewals from the Enhanced Care Prime Network (Medicaid, HARP and Essential Plan) see Dispute Resolution for Medicaid Managed Care Plans.

To request a reconsideration of your non-renewal or termination, please follow these instructions:

- Should you exercise your right to an appeal/hearing of this decision, your response should be sent to Tonya Volcy, Director of Credentialing by certified mail, return receipt requested, to the following address:

Tonya Volcy
Director of Credentialing
EmblemHealth
55 Water Street, 2nd floor
New York, NY 10041

- Requests submitted must include a letter describing special circumstances of which EmblemHealth may be unaware.
- Reconsideration meetings will be scheduled and conducted via phone at an EmblemHealth location during normal business hours.
- An Ad hoc Reconsideration Board, consisting of three physicians will conduct the reconsideration hearing.
- The Ad hoc Reconsideration Board makes the final decision.
- The provider will be notified in writing within seven business days of the decision.
- Providers whose termination or non-renewal status is upheld will be notified, citing the original date of the change. Participation in the impacted networks will continue uninterrupted for providers whose termination or non-renewal status is overturned.
- Prior to August 1, 2017, a checklist of the following, along with supporting documentation, as specified, was required. Reconsideration requests filed after this date do not require this additional information.

Applicability	Present in Practice (Yes/No)	Criteria	Documentation Required
PCPs		Patient Center Medical Home (PCMH)	Evidence of participation in a Level 2 or Level 3 PCMH.

Specialists		Patient Centered Medical Practice (PCSP)	Evidence of participation as a PCSP.
All Physicians		Electronic Health Record (EHR)	A copy of the CMS attestation proving EHR stage 1 or stage 2 meaningful use.
All Physicians		E-Prescribing	Identification of the E-prescribing vendor used and the date implemented.
All Physicians		Hierarchical Condition Categories (HCC)	Any evidence of adoption of ePASS® for reporting HCC gap closure to EmblemHealth.
All Physicians		Wellness Programs	Example(s) of any wellness programs administered by the practice to EmblemHealth members. Please include any improved outcomes demonstrated by these wellness programs.
All Physicians		Electronic Lab Results	Any evidence of the practice's adoption of Care360®, a free tool used to order lab tests and obtain results from Quest Diagnostics, EmblemHealth's preferred diagnostic testing laboratory.
All Physicians		Other info	Any documentation supporting specified criteria.

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Chapter 27: Vision Services

The EmblemHealth Vision Program, developed with EyeMed, provides routine vision management for all EmblemHealth members that have a routine vision and materials benefit. Please note that not all members have a routine vision benefit.

EyeMed will administer all routine exams (to determine if corrective lenses are required) and the dispensing of hardware such as frames, lenses and contact lenses based on the member's benefit. EyeMed is responsible for the provider network including contracting and credentialing, claims processing and payment, routine vision grievances and claims appeals.*

*Exception: Medicare grievances and claim appeals will continue to be managed by EmblemHealth.

Affected Membership

EyeMed is the vision services provider for all EmblemHealth members with a vision care benefit. This includes ASO members whose vision benefit is managed by EmblemHealth. Please note not every EmblemHealth member has a routine vision benefit. See the member's Benefit Summary on emblemhealth.com or call EyeMed to determine if a member has vision coverage.

Included Membership

1. Medicaid
2. Medicare
3. HIP (including members whose care is managed by Montefiore Medical Group (CMO) or HealthCare Partners (HCP) and members who selected a PCP assigned to a St. Barnabas Hospital System PCP or AdvantageCare Physicians

(ACPNY).)

4. GHI Commercial Groups with Vision Benefits (See the eligibility information on emblemhealth.com or call EyeMed to determine if a GHI member has vision coverage.)

Finding a Participating EyeMed Vision Provider

If your patients previously got their vision benefits from Davis Vision (a.k.a.VisionWorks), GVS, EyeCare Advantage or an independent in-network provider, starting January 1, 2017, they must use an in-network EyeMed provider in order to get covered benefits (in accordance with their benefit plan.

Participating EyeMed providers can logon onto https://www.eyemed.com or contact EyeMed customer Service at 1-888-581-3648 to obtain member eligibility and benefit information.

For help finding an in-network EyeMed provider, and to ask about benefits, please share the following EyeMed Customer Service toll-free numbers with your patients:

1-844-790-3878	Medicare
1-877-324-2791	Medicaid
1-877-324-4063	Commercial (HMO, PPO, POS)
1-877-324-6211	On/Off Individual and Group Exchange and Essential Plans
TTY/TDD:711	

Participation with EyeMed

Information for Vision Service Providers

EyeMed is responsible for the provider network including contracting and credentialing, claims processing and payment, routine vision grievances and claims appeals.*

*Exception: Medicare grievances and claim appeals will continue to be managed by EmblemHealth.

If you are Interested in Joining EyeMed

Complete an online interest form found at https://provider-relations-forms.eyemedonline.com/EyeMed/NewProvider or call EyeMed's provider service department at 1-800-521-3605.

Routine Vision Exam CPT Codes, Materials HCPCS, and Diagnosis Codes

Routine vision exam CPT codes, materials HCPCS, and diagnosis codes that should be billed to EyeMed are listed below. *Claims submitted to EmblemHealth will be denied.*

CPT Code	Description
92002	Intermediate
92004	Comprehensive
92012	Intermediate
92014	Comprehensive
92015	Refraction
V2750	Standard A/R
V2750-21	A/R Tier 3
V2750-22	A/R Tier 1
V2750-25	A/R Tier 2
V2750-TG	Premium A/R
S0500	Disposable Contact Lenses
V2500 –V2503	PMMA
V2510 – V2513	Gas Permeable
V2520 – V2523	Hydrophilic
V2530 – V2531	Scleral
V2599	Other Contact Lenses
V2020-V2025	Deluxe Frame
V2700	Balance Lens, Glass or Plastic
V2702	Edge Treatment (Polish or Roll)
V2702-TG	Faceting
V2710	Slab-Off Prism

V2715, V2715U1, V2715U3, V2715U4	Prism
V2718, V2718U1, V2718U3, V2718U4	Fresnell Prism
V2730	Special Base Curve
V2744, V2744U1, V2744U2	Photochromic plastic (Transitions®)
V2744U5, V2744U6, V2744U7, V2744U8	Photochromic
V2745, V2745UA, V2745UB, V2745UC	Tint, Solid or Gradient
V2755	UV Lens
V2760, V2760-22, V2760-TG	Scratch-Resistant Coating
V2761	Mirror Coating
V2762	Polarization
V2770	Occluder Lens
V2780	Oversize Lens
V2782	Mid-Index (1.56)
V2783, V2783U1, V2783U3, V2783U4	Hi-Index (1.60+)
V2100 – V2118, V2410, V2410-22	Single Vision Lens
V2121, V2221, V2321	Lenticular
V2200 – V2220, V2299, V2430, V2430-22	Bifocal Lens
V2300 – V2320, V2399	Trifocal Lens
V2781	Plans without Fixed Pricing by Tier - Standard Progressive
V2781 S0581	Premium Progressive - Must include modifier
V2781 S0581	Progressive Tier 4 - Must include modifier
V2781-22	Progressive Tier 2
V2781-25	Progressive Tier 3
V2781-TG	Progressive Tier 1
V2784	Polycarbonate Standard
V2784-22	Premium Polycarbonate

ICD 10 CODES	Description
H52	Disorders of Refraction and Accomodation
H.52.0	Hyperopia
H52.00	Hyperopia, unspecfied eye
H52.01	Hyperopia, right eye
H52.02	Hyperopia, left eye
H52.03	Hyperopia, bilateral
H52.1	Myopia
H52.10	Myopia, unspecified eye
H52.11	Myopia, right eye
H52.12	Myopia, left eye
H52.13	Myopia, bilateral
H52.2	Astigmatism
H52.20	Unspecified astigmatism
H52.201	Unspecified astigmatism, right eye
H52.202	Unspecified astigmatism, left eye
H52.203	Unspecified astigmatism, bilateral
H52.209	Unspecified astigmatism, unspecified eye
H52.21	Irregular Astigmatism
H52.211	Irregular Astigmatism, right eye
H52.212	Irregular Astigmatism, left eye
H52.213	Irregular Astigmatism, bilateral
H52.219	Irregular Astigmatism, unsecified eye
H52.22	Regular Astigmatism
H52.221	Regular Astigmatism, right eye
H52.222	Regular Astigmatism, left eye
H52.223	Regular Astigmatism, bilateral

H52.229	Regular Astigmatism, unsecified eye
H52.31	Anisometropia
H52.32	Aniseikonia
H52.4	Presbyopia
H52.51	Internal ophthalmoplegia
H52.511	Internal ophthalmoplegia, right eye
H52.512	Internal ophthalmoplegia, left eye
H52.513	Internal ophthalmoplegia, bilateral
H52.519	Internal ophthalmoplegia, unspecified eye
H52.52	Paresis of accommodation
H52.521	Paresis of accommodation, right eye
H52.522	Paresis of accommodation, left eye
H52.523	Paresis of accommodation, bilateral
H52.529	Paresis of accommodation, unspecified eye
H52.53	Spasm of accommodation
H52.531	Spasm of accommodation-right eye
H52.532	Spasm of accommodation-left eye
H52.533	Spasm of accommodation-bilateral
H52.539	Spasm of accommodation-unspecified eye
H52.6	Other disorders of refraction
H52.7	Unspecified disorders of refraction
H53.0	Ambyopia
H53.00	Unspecified amblyopia
H53.001	Unspecified amblyopia, right eye
H53.002	Unspecified amblyopia, left eye
H53.003	Unspecified amblyopia, bilateral

H53.009	Unspecified amblyopia, unspecified eye
H53.01	Deprivation amblyopia
H53.011	Deprivation amblyopia, right eye
H53.012	Deprivation amblyopia, left eye
H53.013	Deprivation amblyopia, bilateral
H53.019	Deprivation amblyopia, unspecified eye
H53.02	Refractive amblyopia
H53.021	Refractive amblyopia, right eye
H53.022	Refractive amblyopia, left eye
H53.023	Refractive amblyopia, bilateral
H53.029	Refractive amblyopia, unspecified eye
H53.03	Strabismic amblyopia
H53.031	Strabismic amblyopia-right eye
H53.032	Strabismic amblyopia-left eye
H53.033	Strabismic amblyopia-bilateral
H53.039	Strabismic amblyopia-unspecified eye
H53.10	Unspecified subjective visual disturbances
H53.14	Visual Discomfort
H53.141	Visual Discomfort, right eye
H53.142	Visual Discomfort, left eye
H53.143	Visual Discomfort, bilateral
H53.149	Visual Discomfort, unspecified eye

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Chapter 36: Fraud and Abuse

This chapter includes information on identifying and preventing fraudulent claims.

Fraud and Abuse Overview

Unscrupulous medical professionals, small-time criminals and even members of organized crime siphon as much as $100 billion a year from the nation's health care system. Although fewer than five percent of practitioners in the U.S. commit such violations, health care fraud remains a powerful contributor to the skyrocketing cost of medical care. Federal lawmakers have passed numerous important acts, including The Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act of 1996, to address issues of fraud and abuse.

EmblemHealth's Special Investigations Unit (SIU) was established to meet regulatory requirements while addressing concerns about the cost of fraud and abuse to members and practitioners. The SIU monitors, reviews and investigates potential cases involving fraud, abuse or improper billing. Additionally, the SIU ensures proper payment has been requested and reimbursed. Our SIU respects the partnership we have with our network providers and works with our providers to curb fraud and abuse.

We ask each of our medical professionals to be a part of our fraud fighting team by working together to prevent and identify inappropriate and potentially fraudulent billings through the following procedures:

- Monitoring of claims submitted for compliance with billing and CPT coding guidelines
- Adherence by providers and facilities to Standard Medical Record Guidelines
- Education of all staff members responsible for dealing with medical records and/or billings
- Referral of suspected fraud and abuse cases to EmblemHealth's Special Investigations Unit

The SIU conducts audits by any of the following methods:

- Data analysis of filed claims
- Review of medical records and filed claims
- On-site visits

If improper or fraudulent billings are identified, the SIU will send written documentation to the provider outlining its findings. If and when necessary, the SIU will hold meetings to address providers' concerns and arrange repayment of amounts paid on identified fraudulent claims.

Fraud is defined as obtaining, or attempting to obtain, services or payments by dishonest means with knowledge, willingness or intent. The Federal False Claims Act (accessed at http://www.cms.hhs.gov/smdl/downloads/SMD032207Att2.pdf) widens the definition to also include reckless conduct, "deliberate ignorance" of the truth or falsification of information, and "reckless disregard" of the truth or falsity of the information.

Examples of Fraud

- False or fabricated filings of claims.
- Billing for goods and services that were never delivered or rendered. This includes billing for no shows or cancelled appointments.
- Billing for more services than were actually provided. This includes, but is not limited to, billing for new or premium durable medical equipment, prosthetics/orthotics or supplies while substituting substandard or inexpensive DME.
- Billing at doctor rates for work that was actually conducted by a nurse, resident intern or physician assistant (i.e., up-coding), unless permitted by your contract agreement, state laws and regulations, and/or CMS guidelines.
- Billing for services performed by a lesser-qualified person, unless permitted by your contract agreement, state laws and regulations, and/or CMS guidelines.
- Billing for services under a provider's name for services actually rendered by another provider.
- Misrepresentation of services rendered (CPT codes), diagnosis, place of services, date of services and/or providers of services in order to justify reimbursement.
- Billing for non-covered services as covered services.
- Medical documentation that does not support, or is inconsistent with, the service being billed.
- Falsifying certificates of medical necessity, plans of treatment and medical records to justify payment. This includes fabrication and recreation of medical records to justify the billing and payment.
- Double billing in an attempt to gain duplicate payment (i.e., billing multiple claims to EmblemHealth and/or another insurer without proper disclosure of any COB or payment information, or EOB from another carrier).
- Altering of claim form to obtain higher payment amount.
- Billing separately for a panel of tests when a single panel test was requested (i.e., unbundling).
- Billing procedures over a period of days or weeks when the actual treatment occurred during a single visit (i.e., split billing).
- Improper coding practices (misuse of CPT codes).
- The acceptance of, or failure to return, monies paid on claims known to be false, fabricated or received in error.
- Kickbacks or participating in schemes that involve collusion between a provider and a member.
- Members providing false information for potential gain.
- Billing a planned hospital admission service as if it were an emergency admission and/or urgent care admission.

Abuse or improper billing is defined as any provider or member practice that is inconsistent with sound or established fiscal, business, insurance or medical practices and results in an unnecessary cost to any EmblemHealth

benefit program, including, but not limited to, reimbursement for services that are not medically necessary or treatments that fail to meet professionally recognized standards. Each incident need not be intentional to be considered abuse. Consistent patterns of abuse may be indicative of fraud.

Examples of Abuse or Improper Billing

- Inappropriate balance billing
- Inadequate resolution of overpayment
- Failure to collect deductibles, coinsurances and copays
- High utilization of procedures or tests that are not medically necessary
- Providing services that are experimental or services that do not meet professionally recognized standards
- Coding a service at a higher level than warranted (i.e., up-coding)
- Inappropriate documentation of services rendered
- Unbundling of services or charges
- Requesting prior approval under a network location and billing under an out-of-network location

An entity performing such acts may include a provider, a hospital, an agency, an organization, another institutional provider, an employee or employees of a provider or group of providers, a billing service, a member or any person in a position to file a claim for health benefits.

To report suspicious activity, please contact EmblemHealth's Special Investigations Unit in one of the following ways:

- E-mail: KOfraud@emblemhealth.com
- Toll-free hotline: 1-888-4KO-FRAUD (1-888-456-3728)
- Mail:
  EmblemHealth
  Attention: Special Investigations Unit
  441 Ninth Avenue
  New York, NY 10001

A trained investigator will discuss the nature of the concern. The informant may remain anonymous.

False Claims Act and Medicaid Fraud Programs

The Deficit Reduction Act of 2005 requires health care entities to educate contractors and agents, including providers, about the False Claims Act. In addition, New York State requires Medicaid providers to develop and implement compliance programs aimed at detecting fraud, waste and abuse in the Medicaid program. Providers should ensure that their personnel are familiar with the requirements below.

False Claims Act

Neither EmblemHealth nor our providers may submit false or fraudulent claims to the Federal government. The Federal False Claims Act makes it illegal to:

"Knowingly" includes acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the facts. To impose liability, it is not necessary for the court to find a specific intent to defraud. Simply presenting a false claim is a violation, even if the claim has not been paid and no money has been expended.

The federal government may impose fines of up to $10,000 per claim and treble damages (i.e., three times the amount of actual damages) for False Claims Act violations.

In addition to the Federal False Claims Act, New York State (NYS) and New York City (NYC) have each enacted a False Claims Act. All three prohibit the items set forth above and all three can impose treble damages for each violation. A civil penalty of between $6,000 and $12,000 may be imposed for each violation of the NYS False Claims Act and a penalty of between $5,000 and $15,000 may be imposed for each violation of the NYC False Claims Act. In each instance, the court is authorized to reduce the fine to two times the amount of damages if the alleged violator (i) provided full information to the Commissioner of Investigation, or the investigating agency or official(s), within 30 days of receiving the information; (ii) cooperated with any subsequent government investigation; and (iii) at the time the individual provided information about the violation, no action had commenced with respect to the violation and the individual did not have any actual knowledge that an investigation was underway. It should be noted that the NYS False Claims Act does not apply to claims, records or statements made under the tax law.

Whistleblower Protections under the False Claims Act

The Federal False Claims Act provides that private parties, known as "qui tam relators," may bring an action on behalf of the United States. The Act provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Federal False Claims Act. Remedies include reinstatement with seniority comparable with what the individual would have had but for the discrimination, two times the amount of any back pay, interest on any back pay and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

Under New York's Labor Law, employers are prevented from taking any retaliatory actions (i.e. discharge, suspension or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment) against an employee who discloses or threatens to disclose to a supervisor or a public body an activity, policy or practice of the employer that is in violation of a law, rule or regulation the violation of which creates and presents a substantial and specific danger to public health or safety or which constitutes health care fraud. An employee who has been the subject of a retaliatory personnel action may institute a civil action for relief within one year after the alleged retaliatory personnel action was taken.

New York State Medicaid Fraud Detection

Chapter 442 of the Laws of 2006, which established the New York State Office of the Medicaid Inspector General (OMIG), also created a new Social Services Law § 363-d which requires that Medicaid providers develop and implement compliance programs aimed at detecting fraud, waste and abuse in the Medicaid program. Each provider covered by the requirements must develop and adopt an effective compliance program based on a set of minimum core requirements. Provider compliance programs shall, at a minimum, be applicable to billings to and payments from the medical assistance program, but need not be confined to such matters. The law contains only the minimum requirements for such plans and, effective January 1, 2007, the OMIG, in consultation with the DOH, is authorized to

impose additional requirements for compliance plans beyond the basic statutory requirements.

Additional requirements, minimum standards, etc., may be found at the Office of the Medicaid Inspector General Web site at www.omig.state.ny.us. In addition, a new Part 521, entitled "Provider Compliance Programs," is added to Title 18 of the Codes, Rules and Regulations of the State of New York.

- Knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government.
- 1. Knowingly make, use or cause to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government.
- 2. Conspire to defraud the government by getting a false or fraudulent claim allowed or paid.
- 3. Have possession, custody or control of property or money used or to be used by the government and, intending to defraud the government, either willfully conceal the property or deliver or cause to be delivered less property than the amount for which the person receives a certificate or receipt.
- 4. Authorize the making or delivering of a document which certifies receipt of property used or to be used by the government and, intending to defraud the government, make or deliver the receipt without completely knowing that the information on the receipt is true.
- 5. Knowingly buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the government or member of the Armed Forces who may not lawfully sell or pledge the property.
- 6. Knowingly make, use or cause to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government.

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Chapter 37: Required Provisions to Network Provider Agreements

In this chapter, you will find mandatory contract language required by the State of New York and the Centers for Medicare & Medicaid Services, including the Managed Care Law of 2009, the NYSDOH Standard Clauses, the Special Provisions Related to Medicaid Members and the Medicare Advantage Addendum.

- Managed Care Law of 2009
- Medicare Advantage/Medicare-Medicaid Required Provisions
- NYSDOH Standard Clauses for Managed Care Provider/IPA Contracts Appendix Effective: April 1, 2017
- Provision Related to Medicaid, Managed Long Term Care and Family Health Plus Members
- Special Provisions Related to Medicaid, CHP & HARP Members
- Medicare Advantage Addendum

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Chapter 28: Quality Improvement

This chapter summarizes our quality improvement programs established to improve the medical and behavioral health care outcomes of our members.

Goals and Objectives

In line with EmblemHealth's Corporate Mission, as a quality-driven organization, EmblemHealth has adopted Continuous Quality Improvement in medical (including pharmaceutical and dental) and behavioral health care and service provided to a complex, culturally and language diverse membership as a core business strategy. Our Executive and Management teams use data-driven, decision-making methodologies in the strategic planning process. EmblemHealth has adopted the Institute for Healthcare Improvement (IHI) and the Centers for Medicare & Medicaid Services (CMS) Triple-Aim for Healthcare Improvement. We strive to simultaneously improve the health status of our members, improve each member's experience of care, and reduce the per capita cost of health care. As a result of this ongoing improvement and monitoring process, EmblemHealth will better serve the needs of members, including all demographic groups and those with special needs, as well as employers, employees, participating practitioners, providers, accounts, service partners, brokers, consultants, and regulatory and accreditation bodies. Toward this end, the goals and objectives of the Quality Improvement Program are to:

- Improve the health status of our members.
- Improve the member/provider experience of health care and services.
- Reduce the per capita cost of health care.
- Address members' complex needs (medical and behavioral health) through quality of care, coordination of care, disease management, and case management initiatives.
- Address specific monitoring requirements related to special populations, such as Medically Fragile Children, to ensure benefits and services are appropriately delivered.

All goals and objectives are in alignment with applicable regulatory and accreditation requirements.

Scope of Activities

The scope of activities within the Quality Improvement Program provides a framework to monitor and evaluate significant aspects of care and service provided to health plan members and their service delivery systems.

EmblemHealth takes an active position in helping its members stay healthy, get better quickly, and live effectively with illness. Measures for monitoring important aspects of medical care, behavioral health care, and quality of service, including patient safety, have been developed and implemented. These activities include:

- Quality of Care
- Quality of Service
- Patient Safety
- Utilization Management
- Member and Physician Satisfaction
- Accessibility
- Availability
- Delegation
- Member Complaints, Grievances and Appeals
- Member Decision Support Tools
- Cultural Diversity
- Care for the Family Caregiver

Authority and Responsibilities

The Quality Improvement Committee (QIC) is responsible for policy decisions, planning, designing, implementing, coordinating, analyzing, and evaluating QI activities, instituting needed actions and ensuring follow up as appropriate. The QIC also ensures practitioner participation in the QIP through planning, design, implementation, committee participation, and review. Various committees and subcommittees support the functions of the QIP and report their activities to the QIC at least quarterly. Network practitioners, including behavioral health care practitioners and consumers, participate in the following committees that advise the QIC:

- Quality Improvement Committee
- Behavioral Health QualityManagement Subcommittee
- Care Management Committee
  - Medical Policy Committee
  - Behavioral Health Utulization Management Subsommittee
- Credentialing/Re-credentialing Committee
- Delegation Oversight Committee
- Pharmacy & Therapeutics Committee
- HARP Medicaid BH Advisory Subcommittee
- Children’s Medicaid Health and Behavioral Health Advisory Committee
  - Committee Structure

A main aspect of the Children’s Health and Behavioral Health Benefit is the expansion of existing Quality Management committees and Behavioral Health Quality Management sub-committee functions to ensure they meet the quality requirements and standards for the populations, benefits, and services for children under 21 years of age, including those in the following subpopulations: Medically Fragile Children with physical, emotional, or developmental disabilities diagnosis; behavioral health diagnosis(es); and children in voluntary foster care agencies. This includes expanding the membership of the Behavioral Health Quality Management sub-committee to include in an advisory

capacity: members, family members, youth and family peer support specialists, and child-serving providers. The Behavioral Health Quality Management sub-committee is responsible for carrying out the planned quality activities for the children's membership with behavioral health conditions, including those in the following subgroups: seriously emotionally disturbed children and children with diagnoses across multiple HCBS categories who access behavioral health benefits and/or HCBS services.

A detailed chart of the QIC Structure can be found at the end of this chapter.

Activities and Performance Indicators

EmblemHealth uses appropriate processes and methodology for conducting and evaluating quality improvement activities through appropriate study design that includes baseline measurement, root cause analysis, development and implementation of appropriate interventions, and re-measurement to determine the impact of the interventions, utilizing appropriate statistical analyses. Sampling methodology is developed and the frequency of data collection is determined based on the nature of the quality indicators and/or committee recommendations. Studying aspects of care and service includes setting goals, comparing indicators to benchmarks, establishing thresholds for the outcomes of required actions, and tracking measures over time. Performance indicators are established and measured periodically to monitor multiple dimensions of performance. These indicators correlate directly to the scope of the program and are developed based on scientific evidence or are adopted from authoritative sources.

The responsibility for monitoring and managing the improvement of these rates has been assigned to the Quality Management Department.

Data Sources and Resources

The data sources used for quality improvement measurement, analysis of barriers, and determining appropriate interventions include, but are not limited to, encounters, claims, utilization review, pharmacy, laboratory, enrollment, behavioral health, medical records, and appeals data. Additionally, provider and member complaints, applicable case management and disease management databases, and telephone response data are also utilized. Other sources of data include HEDIS®/QARR data, Quality Compass®, national and regional epidemiological, demographic, and census data about EmblemHealth's membership, and practitioner, provider and member surveys. Provider surveys include, but are not limited to, provider satisfaction surveys, GeoAccess studies, and Access and Availability surveys. Member surveys include, but are not limited to, the following: CAHPS®, EES, Health Outcomes Survey (HOS), new member surveys, member satisfaction with and assessment regarding the network, member loyalty surveys, disease management surveys, and case management surveys.

Integrated data systems collect member, practitioner and provider information, utilization, population-based and/or specific member information, and practitioner/provider specific information. Software includes, but is not limited to, claims systems, NCQA-approved HEDIS® software, credentialing and re-credentialing software, Microsoft products, and other systems to support both clinical and service interventions.

CMS Stars Ratings Data Sources: EmblemHealth complies with the annual Medicare HEDIS®, HOS, and CAHPS® reporting requirements, and other administrative measures required by CMS. This information forms the basis of the CMS Star Ratings used to assess the quality of Medicare Advantage plans.

HEDIS® Reporting Requirements

EmblemHealth submits audited summary-level HEDIS® data to NCQA and to the Centers for Medicare & Medicaid

Services-designated contractor. The data collection methodologies are either administrative or hybrid types. The administrative method is from transactional data for the eligible populations, and the hybrid method is from medical record or electronic medical record and transactional data for the sample.

Because of the critical importance of ensuring accurate data, EmblemHealth is required to participate in an external audit of the HEDIS® measures before public reporting. EmblemHealth contracts with an NCQA-licensed organization for the Compliance Audit. Following receipt of the Final Audit Report, EmblemHealth makes available a copy of the complete final report to CMS.

Medicare HOS Survey Process Requirements

EmblemHealth is required to report results for a baseline HOS and a follow-up survey. EmblemHealth contracts with an NCQA-certified vendor for administration of both the baseline and follow-up surveys. Each year, baseline cohorts are drawn and the CMS identifies a number of randomly selected members per contract to be surveyed. Additionally, each year the cohort measured two years previously at baseline is resurveyed. The results of this re-measurement are used to calculate a change score for the physical health and emotional well-being of each respondent.

Individual member level data is not provided to EmblemHealth until approximately a year after the entire baseline/followup cohort study is completed. CMS provides EmblemHealth with a HOS Baseline Report and HOS Performance Measurement Report and Data containing the results of the follow-up survey. The survey vendor provides EmblemHealth with details of the survey administration.

Medicare CAHPS® Requirements

EmblemHealth is required to report results of the CAHPS® Survey. EmblemHealth contracts with an approved MA & PDP CAHPS® vendor for survey administration. This vendor adheres to CMS requirements for fielding, collecting, and reporting CAHPS® data, thereby ensuring valid and reliable results.

Children's Health and Behavioral Health Medicaid Benefit

The Plan's Children's Health and Behavioral Health Medicaid Benefit integrates physical health and behavioral health for children under 21 years of age to create better quality of care and lay the groundwork for better health outcomes for adults. This includes addressing the needs of Medically Fragile Children, children with behavioral health diagnosis(es), and children in Foster Care (FC) with developmental disabilities. This benefit also includes Home and Community Based Services to address the membership's complex needs.

Reporting Requirements for Children's Health and Behavioral Health Medicaid Benefit:

- Children's Consumer Perception Survey
  - The Plan will participate in a consumer perception survey for the children's population under 21 years of age, including those in the following subpopulations: Medically Fragile Children with physical, emotional, or developmental disabilities diagnosis; behavioral health diagnosis(es), and children in voluntary foster agencies in adherence to New York State guidance. The Plan will also report results according to New York State guidance.

- Home and Community Based Services (HCBS)
  - The Plan will comply with the federal HCBS quality assurance performance measure reporting requirements for children under 21 years of age receiving HCBS as defined by New York State.

- Outcome Measures
  - The Plan will report on required outcome measures for the children's population under 21 years of age, including those in the following subpopulations: Medically Fragile Children with physical, emotional, or developmental disabilities diagnosis; behavioral health diagnosis(es); and children in voluntary foster agencies, as specified by New York State.

Performance Improvement Project

- - The Plan will participate in an internal performance improvement project as defined by New York State on a topic affecting the children's population under 21 years of age, including those in the following subpopulations: Medically Fragile Children with physical, emotional, or developmental disabilities diagnosis; behavioral health diagnosis(es); and children in voluntary foster agencies.

- Quality Assurance Reporting Requirements (QARR)
  - The Plan will continue to submit reports to New York State as specified in the Quality Assurance Reporting Requirements (QARR) within the time frames provided by the Medicaid Managed Care Model Contract.

Monitoring and Evaluation

Quality Improvement Program Description

The Quality Improvement Program Description is reviewed annually and amended as necessary. The review process incorporates input from the Quality Improvement Committee and final approval by the Quality Improvement Committee and the Quality Improvement Committee of the Boards and Quality Assurance Committee of the Board—the governing bodies. The timeline for completing the review process is set forth in the annual Quality Improvement Work Plan. Information about the Quality Improvement Program is published on EmblemHealth's website

The Annual Quality Improvement Program Work Plan (QIPWP)

The Quality Improvement Work Plan encompasses quality and performance improvement activities that EmblemHealth will initiate, continue, complete, or terminate for all lines of business. The development of this review requires the cooperation of multiple departments, including, but not limited to: QualityManagement, Accreditation, Care Management, Utilization Management, Delegation, Behavioral Health, Customer Service, Claims, Enrollment, Marketing and Communications and Grievances and Appeals. This dynamic work plan reflects and integrates planned quality improvement activities throughout the year for all lines of business from all areas of the organization (clinical and administrative), and includes requirements for external reporting. The Quality Improvement Program Work Plan includes the following elements:

- Yearly planned quality improvement activities and objectives for improving:
  - Quality of clinical and behavioral health care
  - Safety of clinical and behavioral health care
  - Quality of service
  - Members' experience
- Time frame for each quality improvement activity's completion.
- Staff member(s) responsible for implementation and management, initiation of the time frame, and the targeted completion date for each activity.
- Planned monitoring and follow-up activities of previously identified issues.
- Calendar of :
  - QI Committee Meeting Schedule
  - Presentation schedule for Quality Improvement Program documents
  - Presentation schedule for Utilization Management Program documents
  - Delegated activities reporting
  - Reports and documents to the Quality Improvement Committee and the Board of Directors.

The status of the work plan items are updated quarterly and reviewed by the Quality Improvement Committee. The

Quality Improvement Work Plan and its activities are subject to ongoing revisions and updates throughout the year as needed to meet changing priorities, regulatory requirements, and identified areas for improvement. Subsequent revisions and updates will be reviewed and approved by the Quality Improvement Committee.

The Annual Quality Improvement Program Evaluation

The Quality Management Assistant Vice President, Quality Improvement manager, and other applicable staff as identified, in collaboration with all relevant departments, prepare the annual Quality Improvement Program Evaluation, which:

- Acknowledges the Quality Committee of the Boards' oversight and evaluation of the Quality Improvement Committee, the effectiveness of the Quality Improvement Committee structure and organizational structures that support implementation.
- Describes and evaluates completed and ongoing quality improvement activities that address quality and safety of clinical care, quality of service, and members' experience.
- Tracks the trending of measures such as HEDIS®, CAHPS®, and organization-specific key performance indicators, to assess performance in the quality and safety of clinical care and quality of service.
- Analyzes and evaluates the impact, results, and effectiveness of quality improvement activities described within the program and work plan and of its progress toward influencing network-wide safe clinical practices. Focus includes, but is not limited to, delegated functions, SNP quality improvement projects, and the Chronic Care Improvement programs implemented during the year.
- Identifies the limitations and barriers to improvement; analyses of barriers include staff who had direct experience with the processes and have presented barriers to improvement.
- Identifies opportunities for improvement, including adequacy of resources, committee structure, practitioner participation, and leadership involvement in the Quality Improvement Program.
- Recommends upcoming year's activities, including those that will carry over into the next year.

The Quality Improvement Program Evaluation is presented to the Quality Improvement Committee and the Quality Improvement Committee of the Boards for feedback and final approval, in accordance with the Quality Improvement Program Work Plan. Members, practitioners, providers, and employees are annually informed of EmblemHealth's Quality Improvement Program results through EmblemHealth's website.

Confidentiality

EmblemHealth requires that each employee and committee member sign a Confidentiality Agreement to ensure that information regarding its members and practitioners/providers is held to confidentiality standards. Confidentiality standards are governed by written policies and procedures and are applicable to oral and written confidential information, including member, practitioner/provider, and company proprietary information. In addition, key departments have internal privacy and confidentiality policies and procedures specific to their function. It is the responsibility of department management to review these policies and procedures annually with each of their employees. The Corporate Compliance Committee has oversight responsibility for development and implementation of privacy and confidentiality policies.

All quality assessment and improvement data, committee minutes, reports, recommendations, and actions are kept strictly confidential and under the auspices of the Quality Improvement Committee. Information pertaining to a member and his/her family will not be released to any third party without the expressed written authorization of the member or his/her legal guardian except as required or permitted by law or with a bona fide legal demand. All medical information utilized to study the general quality and effectiveness of medical services provided to members shall be presented in de-identified form, excluding all individual patient information.

Provider, and practitioner-specific quality assessment and improvement information is maintained in each provider

and practitioner's file with restricted access. Documents and information obtained through the Quality Improvement Program are regarded as confidential and protected under Quality Assurance and Peer Review processes.

EmblemHealth is responsible for developing, compiling, evaluating, and reporting certain measures and other information to CMS, its enrollees, and the general public. EmblemHealth safeguards the confidentiality of the doctor-patient relationship, and reports to CMS in the manner required for cost of operations, patterns of utilization of services, and availability, accessibility, and acceptability of Medicare-approved and covered services. All documentation required by regulatory and accrediting bodies, including CMS, is made available in the format required by the regulatory and accrediting bodies, upon request. This includes, but is not limited to, the Quality Improvement Program Description, Work Plan, Evaluation, Policies, Operational Processes, Quality Improvement Activities, etc.

Delegation Oversight

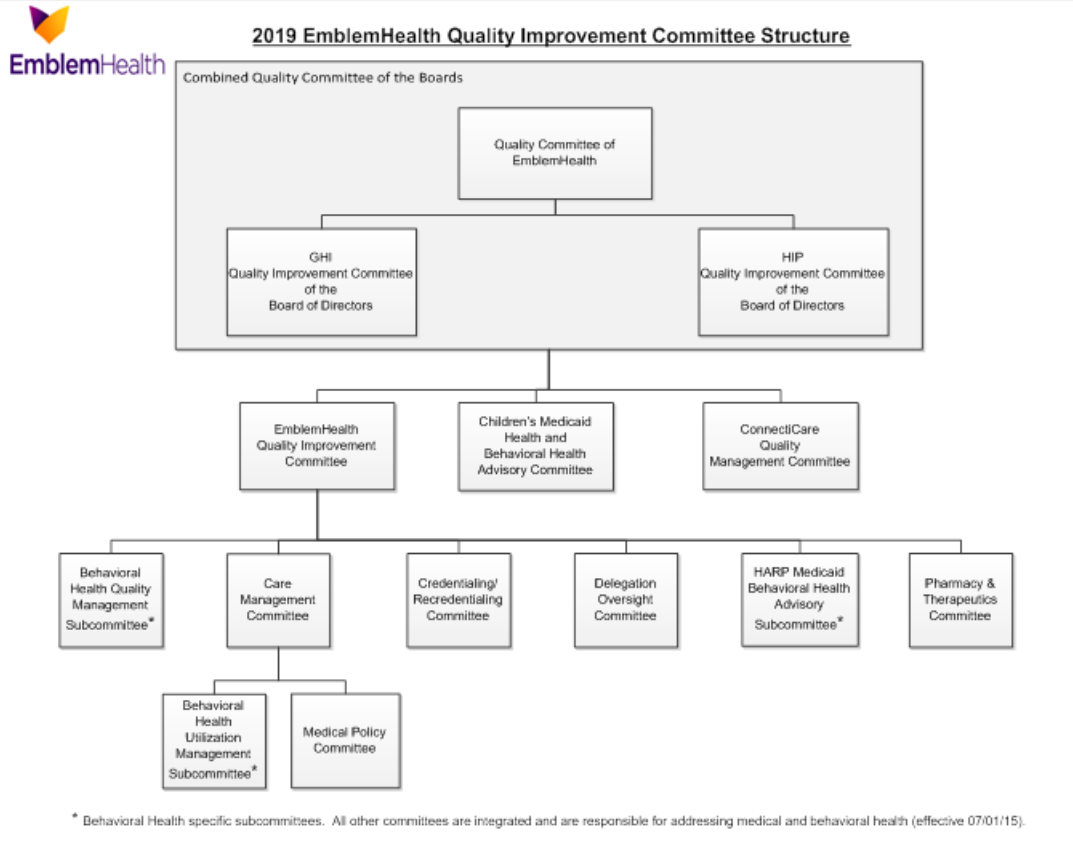
Delegation Oversight Committee

Purpose: The Delegation Oversight Committee assesses and oversees all delegated activities performed by contracted delegates. The Delegation Oversight Committee monitors the delegates' compliance with EmblemHealth's policies and procedures, accreditation standards, and applicable laws, rules, regulations and stipulations, thereby ensuring that all members receive equitable access to care and services.

Responsibilities: The responsibilities of the Delegation Oversight Committee include but are not limited to:

- Responding to and addressing the concerns of the EmblemHealth operational departments in a process-oriented manner as it relates to the performance/non-performance of delegated entities.
- Using objective criteria/metrics to evaluate the measures/processes of performance of the delegated entities against EmblemHealth's and the health care industry's standards and benchmarks to identify areas of success and areas in need of improvement. Metrics help to ensure that the Delegation Oversight Committee's decisions concerning delegated activities and processes are based on objectively measured outcomes and results. It is the Delegation Oversight Committee's responsibility to provide oversight of the audit tools and metrics used to measure delegate performance in the context of frequently changing regulatory and accreditation requirements and changes in industry practice. Audit tools are reviewed and, if applicable, revised on a periodic basis to assure the tools remain sensitive and specific to assess delegate compliance.
- Reviewing all applicable pre-delegation materials and annual audit materials against established protocols.
- Making recommendations to the Quality Improvement Committee regarding delegation activities including, but not limited to, a potential delegate being approved as a delegate, adding functions and/or lines of business to an established delegate, rescinding the delegate status of delegate to that of a vendor, rescinding the contract of a delegate and/or pursuing recommendations that impact the delegate.
- Establishing time frames and protocols for auditing and reporting the functionality of delegated entities to the Delegation Oversight Committee. Delegation audits are completed as frequently as necessary to evaluate compliance, but no less than annually, started and completed within 10 months to 14 months of the prior year's audit.
- Recommending the decisions regarding the delegates to the Quality Improvement Committee in a manner that allows the Quality Improvement Committee to act within timely and appropriate time frames. The Delegation Oversight Committee communicates with all affected and concerned customers in a confidential manner.
- Overseeing statements of deficiencies and improvement action plans to ensure completion of recognized deficiencies and compliance with CMS, NYS, the NYC Department of Health, and other state and federal regulatory and accreditation bodies. If serious problems cannot be corrected, the Relationship Manager and Subject Matter Experts present the unresolved issues to the Delegation Oversight Committee. The Delegation Oversight Committee may recommend to the Quality Improvement Committee partial or full revocation of delegated activities.

2019 EmblemHealth Quality Improvement Committee Structure



EmblemHealth

Provider Manual

Chapter 29: Medical Record Guidelines

In this chapter, you will find policies on how to maintain member medical records including medical record standards and contractual requirements regarding retention and disclosure of information

Medical Record Guidelines

EmblemHealth requires its practitioners to maintain accurate medical records.

The medical record contains information about each member, identifies the patient's complaints/symptoms or lack thereof, contains the diagnosis and basis for the diagnosis, the communication and discussion of treatment options, side effects, decisions made and treatments rendered. The primary purpose of the record is to document the course of the member's health or illness and treatments and serve as a mode of communication between physicians and other professionals participating in the care rendered. The entire medical record of an active member must remain in the primary care physician's office and must be consistent with all relevant local, state and federal laws, rules and regulations.

The following guidelines assist EmblemHealth in assuring the appropriate exchange and retention of member medical data and are used to perform clinical audits in conjunction with ongoing quality assurance activities.

Please note that EmblemHealth may request a copy of, or make an on-site visit to review, your medical records for internal and regulatory chart audits.

Access to medical records

A member has the right to review, copy and request amendments to his or her medical record. Any member or qualified person who desires a copy of the medical record may obtain one by submitting a written request to his or her participating practitioner or facility.

Our member handbook tells members how to give consent to the collection, use and release of personal health information, how to obtain access to their medical records and what we do to protect access to their personal information.

A member or qualified person may challenge the accuracy of the information in the medical record. In addition, he or she may require that a statement describing the challenge be added to the record.

Access by a member or qualified person to information in the medical record may be denied, but only if the participating provider or facility determines that:

Access can reasonably be expected to cause substantial harm to the member or to others; or

Access would have a detrimental effect on the participating practitioner's or facility's professional relationship with

the member, or on their ability to provide treatment.

Medical Record Content and Format

Each member should have a unique medical record, which contains at least the following information:

PCP Coordinates Care

Where the member's plan requires PCP assignment, the record verifies that the PCP coordinates and manages the member's care.

Personal

- Name
- EmblemHealth ID number
- Date of birth
- Address and phone number
- Employer's name, address and phone number
- Marital status
- Benefit plan participation and copayment (if applicable)
- Name of the primary care physician (PCP)
- List of allergies and/or adverse reactions, or "No Known Allergies" (NKA)

Medical

- Biographical information
- Comprehensive baseline history and physical (see details below)
- Diagnostic test results
- Consult reports
- Progress notes
- Medication records
- Problem list
- Allergy documentation
- Telephone/communication log
- Immunization records
- Preventive health screening records
- Inpatient/ER discharge summary reports, if applicable**
- Operative reports, if applicable

** The PCP must also clearly document any follow up on the member's ER visit and/or hospitalization, whether an office visit, written correspondence, or telephone conversation.

The comprehensive baseline history and physical must include a review of:

- Subjective and objective complaints/problems
- Family history
- Social history (i.e., occupation, education, living situation, risk behaviors)
- Significant accidents, surgeries, illnesses and mental health issues
- Complete and comprehensive review of systems (including patient's presenting complaint, as applicable)
- Prenatal care and birth information (baseline, 18 years and younger only) in cases where the member has both a PCP and an OB/GYN, they must coordinate to ensure there is a centralized medical record for the provision of prenatal care and all other services.

Periodic history and physicals review should be repeated in accordance with age appropriate preventive care guidelines.

Within the record jacket, reports of similar type (i.e., progress notes, laboratory reports) should be filed together in chronological or reverse chronological order permitting easy retrieval of information and initialed by the physician to indicate they have been read. Each progress note filed should be legibly written or typed, signed and dated by the author, and contain at least the following items:

- The reason for visit as stated by the member
- The duration of the problem
- Findings on physical examination
- Laboratory and X-ray results, if any
- Diagnosis or assessment of the member's condition
- Therapeutic or preventive services prescribed, if any
- Dosage, duration and side effect information of any prescription given, with medication allergies and adverse reactions noted prominently (updated during a physical, when a prescription is written, or annually, whichever comes soonest)
- Follow-up plan (including self-care training) or that no follow up is required

Reports generated as a result of a request for a test or consultation must be filed immediately in the medical record with the member's name, ID number and date of birth on each document page.

Test results should be reported to the member within a reasonable time after physician receipt and review and filed with a progress note indicating when the member was notified, by whom, and the next steps in the treatment plan.

Provider Signature Attestation

The Centers for Medicare and Medicaid Services (CMS) requires each date of service in a member's medical record to be accompanied by a legible provider signature and credentials. Some examples of appropriate credentials are MD, DO and Ph.D. In general, for your medical records to be deemed compliant, you must authenticate each note for which services were provided. Acceptable physician authentication includes handwritten and electronic signatures or signature stamps. Please review the tables that follow for examples of acceptable and unacceptable signatures and credentials.

ACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

Signature Type	Acceptable

Handwritten signature or initials, including credentials	- Mary C. Smith, MD or John J. Smith, DO or, for initialing MCS, MD or JJS, DO
Signature stamp, including credentials	- Must comply with state regulations for signature stamp authorization

Electronic signature, including credentials	- Must be password protected and used exclusively by the individual physician
	- Requires authentication by the responsible physician, statements including but not limited to:
	  - Approved by
	  - Signed by
	  - Electronically signed by

UNNACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS WITH CORRECTIVES

Signature Type	Unacceptable Unless
Provider signature without credentials	- Name is linked to provider credentials or name on physician stationary
Typed name	- Name is authenticated by the provider
Signed by a non-physician or a non-physician extender (e.g., medical student)	- Signature is co-signed by responsible physician

Auditing Primary Care Physician (PCP) Medical Records

The Quality Review Operations department conducts ongoing audits, based on randomly selected charts, of a PCP's medical record documentation procedures. We inform PCPs of their results at the time of the audit.

Those PCPs who do not score at least 90 percent are offered a means of correcting a deficiency immediately after review and are enrolled in one-year of monitoring, during which EmblemHealth will educate and provide practitioners with record-keeping aids. A nurse reviewer will then re-audit by viewing at least three records seen by the PCP during the monitoring period.

Accessing Medical Records

Responsibility for maintaining and securely storing a member's medical record lies with the office of the Primary Care Physician. An active member's record should be available for review both at the time of the member's appointment and when requested by EmblemHealth, the NYSDOH, CMS (and LDSS for Medicaid only) or other authorized entity for utilization review and for quality and other applicable audits.

Practitioners are responsible for maintaining a patient's original medical records for six years (or 10 years for Medicare members) after either the last date of service rendered or the date the member no longer seeks care from that provider. In the case of a minor, the records shall be retained for three years after the member reaches the age of majority or six years after the date of service, whichever is later. This timeline applies even if the patient has terminated his/her EmblemHealth coverage.

All practitioners must observe applicable state and federal laws, rules and regulations concerning the confidentiality of medical records.

Release of Information to Members

Members are entitled access to or copies of records concerning their health care. All or part of the medical record may be released to the member or other "qualified persons" with written authorization from the member and in accordance with applicable state and federal law.

"Qualified persons" are appointed by members or the court to handle specific areas of concern on the member's behalf. Examples of "qualified persons" include, but are not limited to:

- Court appointed committee for an incompetent
- Parent of a minor
- Court appointed guardian of a minor
- Other legally appointed guardian

The Authorization to Use or Disclose Protected Health Information form should be completed in order to provide authorization. If this form is not used, the written consent must include the following information:

- Name of the physician from whom the information is requested
- Name and address of the institution, agency or individual that is to receive the information
- Member's full name, address, date of birth and EmblemHealth ID number
- The extent or nature of the information to be released, including dates of treatment
- Date of initiation of authorization
- Signature of the member or qualified person

Member requests should be honored within 10 days of the receive date of the written authorization.

A member or qualified person may challenge the accuracy of information in the medical record and may require that a statement describing the challenge be included in the record.

Access to member information may be denied only if the provider determines that access can reasonably be expected to cause substantial harm to the member or others, or would have a detrimental effect on the provider's professional relationship with the patient or his or her ability to provide treatment.

The physician may place reasonable limitations on the time, place and frequency of any inspections of the patient information. Personal notes or observations may be excluded from any disclosure based on the provider's reasonable judgment.

Special authorizations, forms and procedures are required for HIV-related testing (both before and after the test is performed) and for release of any HIV-related information from the medical record. In order to release confidential HIV-related information, consent forms created or approved by the New York State Department of Health (NYSDOH) must be used. All authorizations requesting the release of behavioral health records must specify that the information requested concerns behavioral health treatment.

We recommended that providers consult legal counsel with regards to records disclosure issues.

Advance Directives

Advance directives are written instructions, recognized under state law, which relate to the provision of health care when the individual is incapacitated and unable to communicate his/her desires. Examples include such documents as a living will, durable power of attorney for health care, health care proxy or do not resuscitate (DNR) request.

EmblemHealth counts on its practitioners to honor a member's request regarding the type of care stipulated under an advance directive.

Upon enrollment, and consistent with relevant federal and state laws, each member receives the following:

- "Planning in Advance for Your Medical Treatment," a NYSDOH article which describes an individual's rights in New York State with respect to health care decision making.
- "Appointing Your Health Care Agent - New York State's Proxy Law," a NYSDOH article which provides information and a sample form to be used to appoint a "health care agent."
- A letter describing EmblemHealth's policy implementing the requirements under the law and regulations.

Our practitioners should discuss advance directives with their patients (as appropriate) and file a copy of any advance directive document in the medical record. Each medical record that contains an advance directive should clearly indicate that said document is included.

Telephonic Medicine

Telephonic medicine includes, but is not limited to, diagnosis, treatment, advice and instruction given to patients over the phone. EmblemHealth does not pay for telephonic consultations as a separate billable service.

We expect the highest quality of care, including face-to-face interaction between the patient and provider whenever possible. To reduce liability and the risk of medical errors made possible by telephonic consultations, we require practitioners to adhere to the following procedures:

- Document every phone call in the patient's medical record.
- Base notes on the same principles of documentation as during face-to-face interaction.
- Whenever practical, have the patient's medical records available when telephone interaction is conducted from the practitioner's office.
- All covering physicians should provide the attending physician's office with clearly labeled notes of telephonic interactions.
- Office staff who interact with patients telephonically regarding medical issues including, but not limited to, appointment reminders, refills and diagnostic reports should also document these interactions in the medical record.

Patient-Clinician Electronic Mail Policy

We expect the highest quality of care, including face-to-face interaction between the patient and provider whenever possible. To reduce liability and the risk of medical errors made possible by electronic mail consultations, EmblemHealth has adopted the following guidelines set forth by the American Medical Association:

Communication Guidelines:

- Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- Inform patient about privacy issues.
- Patients should know who, besides addressee, processes messages during addressee's usual business hours and during addressee's vacation or illness.
- Whenever possible and appropriate, retain electronic and/or paper copies of e-mails communications with patients.
- Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
- Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
- Request that patients put their name and patient identification number in the body of the message.
- Configure automatic reply to acknowledge receipt of messages.
- Send a new message to inform patient of completion of request.
- Request that patients use auto-reply feature to acknowledge reading clinician's message.
- Develop archival and retrieval mechanisms.
- Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
- Avoid anger, sarcasm, harsh criticism and libelous references to third parties in messages.
- Append a standard block of text to the end of e-mail messages to patients which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
- Explain to patients that their messages should be concise.
- When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
- Remind patients when they do not adhere to the guidelines.
- For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Legal and Administrative Guidelines:

Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:

- Communication guidelines (stated above).
- Instructions for when and how to convert to phone calls and office visits.

- Clauses which hold harmless the health care institution for information loss due to technical failures.
- Waivers of the encryption requirement, if any, at patient's insistence.
- Descriptions of security mechanisms in place, including:
  - Using a password-protected screen saver for all desktop workstations in the office, hospital and at home.
  - Never forwarding patient-identifiable information to a third party without the patient's express permission (in writing).
  - Never using patient's e-mail address in a marketing scheme.
  - Not sharing professional e-mail accounts with family members.
  - Not using unencrypted wireless communications with patient-identifiable information.
  - Double-checking all "To" fields prior to sending messages.
  - Performing at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
  - Commit policy decisions to writing and electronic form.

The policies and procedures for e-mail should be conveyed to all patients who wish to communicate electronically.

The policies and procedures for e-mail should be applied to facsimile communications, where appropriate.

EmblemHealth-Adopted Medical Record Review Tools

Medical record review tools can help ensure that your medical records adhere to our standards. The medical record tools approved by EmblemHealth are at www.emblemhealth.com and are listed below. We ask our providers to check our website periodically for updates.

- Adult Medical Record Review Tool
- Maternity Medical Record Review Tool
- Pediatric and Adolescent Medical Record Review Tool

Contractual Obligations

The following text outlines the legal agreement between the Practitioner and EmblemHealth with regards to the above information.

The term "Practitioner" hereunder shall refer to any contracted primary care physician, specialist, hospital facility and physician practicing within a physicians' group or hospital facility, unless otherwise noted.

Records and Reports

Practitioner shall document all Covered Services provided to Members in a format which is easily retrievable and which conforms with federal, state and local laws and regulations applicable to medical records. Practitioner shall permit the Plan's representative(s) access on-site at Practitioner's practice, upon reasonable prior notice and during regular business hours, to inspect and copy all medical, billing, and financial and statistical records relating to the provision of Covered Services to Members in accordance with all applicable laws and regulations and usual policies

and procedures for the maintenance of such records.

Practitioner shall make Members' medical records available to the Plan or its designated representative(s) for, among other purposes, conducting utilization review and assessing quality of care and the Medical Necessity and appropriateness of care provided to Members. Practitioner shall comply with all federal, state and local laws and regulations applicable to the confidentiality, privacy, and maintenance of patient records, including requirements for maintaining such records for six (6) years (10 years for Medicare members) from the last date of treatment or, in the case of a minor, for six (6) years after the minor reaches the age of majority, or for such period of time as required by law, whichever is longer. Record maintenance and audit access shall survive the termination of this Agreement regardless of the cause giving rise to such termination.

Practitioner shall, no later than ten (10) business days after receipt of written request, provide a copy of a Member's medical records, encounter data or financial and statistical records relating to services rendered to Members to the Plan, NYSDOH, and to any other federal, state or local governmental agency, e.g., CMS or LDSS (for Medicaid only), involved in assessing the quality of care or investigating Member grievances or complaints, including the Comptroller General of the State of New York, the Department of Health and Human Services and the Comptroller General of the United States and their authorized representatives. Upon such request from any federal, state, or local government, Practitioner shall provide written notice of such request to the Plan within four (4) business days of such request. All requests for records shall be supplied to the Plan at Practitioner's expense. This provision shall survive termination of this Agreement regardless of the cause giving rise to such termination.

In the event that a Member transfers to another Participating Provider, Practitioner shall, within ten (10) days of a Member's authorization, provide a copy of the Member's medical records to the Member's new Participating Provider without charge. Moreover, Members shall be provided with a copy of their medical records, upon appropriate request, without charge from Practitioner. This procedure will ensure that the new PCP will have a continuous medical record of the member and that there should not be a lapse in continuity or treatment.

Non-Emergent Medical Record Transfer

Upon any change of PCP, the member should be asked to sign a Request for Medical Information. Dates of treatment would be inclusive of current and outstanding laboratory and/or x-ray reports. The Request for Medical Information will be sent to the previous PCP, and the copy of records will be forwarded to the new PCP's office as soon as possible.

Emergent Medical Record Transfer

In the event of a change in PCP in an emergency situation, the Plan may call the previous PCP office directly and request, by phone, that a copy of the medical records be forwarded to the new PCP. A written request would follow by mail within 24 hours of the initial phone contact.

Practitioner shall maintain and provide any other records the Plan may request for regulatory compliance or program management purposes and shall cooperate with the Plan in all fiscal and medical audits, site inspections, peer review, Utilization Management, credentialing and recredentialing and any other monitoring required by federal, state or local regulatory or accreditation agencies, including Utilization Review Accreditation Commission ("URAC") and the National Committee for Quality Assurance ("NCQA"). Any record required by a regulatory or accreditation agency shall, at Practitioner's expense, be delivered to the Plan within the time frame requested by the requesting agency, but in no event more than four (4) business days of its request. Practitioner shall promptly comply with all directives and recommendations issued as a result of any such inspection or audit. Practitioner shall retain all financial and administrative records relating to this Agreement for seven (7) years after the termination of this Agreement, or for such period of time as required by law, whichever is longer. This provision shall survive termination of this Agreement regardless of the cause giving rise to such termination.

Providing Access to Medical Records

Within ten days of a written request, a health care provider must provide an opportunity, for an individual to inspect any patient information (in the provider's possession) relating to the examination or treatment of an individual. The

request may come from any qualified person. A "qualified person" means any properly identified subject, or an appointed guardian under article 81 of the mental hygiene law, a parent of an infant, a guardian of an infant appointed pursuant to article 17 of the surrogate's court procedure act (or other legally appointed guardian of an infant who may be entitled to request access to a clinical record) or an attorney representing or acting on behalf of the individual or the individual's estate.

A parent or guardian is not entitled to inspect or make copies of any patient information concerning the care and treatment of an infant where the health care provider determines that access to the information requested by the parent or guardian would have a detrimental effect on the provider's professional relationship with the infant, or on the care and treatment of the infant, or on the infant's relationship with his or her parents or guardian.

Note that a provider may refuse to provide access to information if the provider believes that (i) "review of the requested information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right to access to the information, or (ii) the material requested is personal notes and observations, or the information requested would have a detrimental effect as defined by law".

Providers should be familiar with Public Health Law sections 17 and 18 which further define when providers must provide access, timeframes, frequency, when charges may be imposed, etc.

EmblemHealth

Provider Manual

Chapter 30: Claims

In this chapter you will find EmblemHealth's policies and procedures for submitting your claims. Information includes recent managed care laws, electronic claims submission and where to file claims or documentation for plan members.

Claims Submission

Please see the following page for our Claim Submission for Unlisted Procedure or Service Code Special Report form.

Electronic Claims Submission

Today, thousands of health care practitioners have eliminated paper claims and are submitting electronic claims to EmblemHealth in HIPAA-compliant professional provider (837P), institutional provider (837I) and dental provider (837D) EDI claims transaction formats.

Helpful Tips For Proper Setup of Electronic Billing Systems

- When billing electronically, please allow a reasonable amount of time to complete your account receivable reconciliation process. Ensure that your billing system is not set up to automatically re-bill every 30 days.
- Many times the payment for the original claim was applied to the copay or the service was denied for medical necessity, eligibility or another reason. Please make sure that your automated billing system accurately posts patient responsibility data and claims settlement messages.
- Ensure that your billing system does not automatically generate a paper claim. This duplicate billing practice is costly and delays processing.

Some Advantages of Electronic Claim Submission

- Quicker claims submission, which means faster reimbursement to you
- No paper claims to stock and complete
- Simplified record keeping by eliminating lost claims paperwork
- Reduced clerical time and the costs to process and mail paper claims

Pathways For Electronic Claim Submission To EmblemHealth

Providers, both institutional and professional, may use practice management system vendors, billing services or clearinghouses to submit claims and other EDI transactions to EmblemHealth.

Note: Practice management system vendors and billing services offer a variety of EDI solutions to the health care community and charge fees and/or transaction costs for their services. EmblemHealth does not specifically recommend or endorse any vendor or billing service.

Clean non-Medicare claims submitted electronically will be processed within 30 days; paper or facsimile clean non-Medicare claims will be processed within 45 days in accordance with the New York State law for prompt payment of claims. All claims submissions must include the TIN and NPI of the rendering and billing provider(s).

Important Requirement for Electronic Claims Submission

National Provider Identifier

Please contact your practice management system vendor to ensure your software is capturing and correctly populating your National Provider Identifier (NPI) in your electronic claims or your claims will be rejected by EmblemHealth. Please note the following NPI requirements for electronic health care claim submissions:

Professional Provider Claim (837P) NPI Requirements

- Billing Provider 2010AA: An NPI is required for health care providers in the United States or its territories.
- Pay-To Address 2010AB: There is no NPI in the Pay-To Address loop. The purpose of Loop ID-2010AB has changed from previous versions. Loop ID-2010AB only contains address information when different from the Billing Provider Address.
- Rendering Provider 2310B: Only required when the Rendering Provider information is different from the information carried in Billing Provider Loop 2010AA. If this loop is sent, an NPI is required.
- Rendering Provider 2420A: Only required when the Rendering Provider information is different from the information carried in the 2310B or 2010AA loops. If this loop is sent, an NPI is required.

Institutional Claim (837I) NPI Requirements

- Billing Provider 2010AA: An NPI is required for health care providers in the United States or its territories.
- Pay-To Address 2010AB: There is no NPI in the Pay-To Address loop. The purpose of Loop ID-2010AB has changed from previous versions. Loop ID-2010AB only contains address information when different from the Billing Provider Address.

Dental Provider Claim (837D) NPI Requirements

- Billing Provider 2010AA: An NPI is required for health care providers in the United States or its territories.
- Pay-To Address 2010AB: There is no NPI in the Pay-To Address loop. The purpose of Loop ID-2010AB has changed from previous versions. Loop ID-2010AB only contains address information when different from the Billing Provider Address.
- Rendering Provider 2310B: Only required when the Rendering Provider information is different from the information carried in Billing Provider Loop 2010AA. If this loop is sent, an NPI is required.

Payor ID Numbers

Plan	Payer ID

GHI HMO	25531
GHI PPO	13551
HIP	55247
Vytra	22264
CCI VIP Medicare Advantage	78375

Avoiding Duplicate Claims Submissions

When duplicate claims are submitted, you potentially delay claims processing and create confusion for the member. You may read more about how to avoid duplicate claims submissions at Claims Corner.

Electronic Claim Attachments

Attachments cannot be submitted electronically at this time. However, most claims should be submitted electronically. If supporting documentation is required for the settlement of your claim, we will request it. One common request is for the Unlisted Procedure or Service Code Form.

Note: We will be enhancing our technology to support an electronic attachment capability for professional practitioners. We will notify you when we are ready to accept attachments electronically.

Claims Submission for Unlisted Procedure or Service Codes
In accordance with American Medical Association Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) reporting guidelines, please use the Unlisted Procedure or Service Code Form to submit claims for unpublished procedure or service codes. This information will be used to determine appropriate payment and claim adjudication in conjunction with the member's benefit plan.

Electronic Coordination of Benefits Claims

At this time, commercial electronic coordination of benefits claims are not accepted electronically. We are currently enhancing our technology to support this functionality. We anticipate that commercial COB claim acceptance/processing will be available late fourth quarter 2014. We will notify you when it's available.

EmblemHealth PPO and HMO participate in the National Coordination of Benefits Agreement (COBA) program for the receipt and processing of Medicare Part A and Part B supplemental crossover claims.

Electronic Funds Transfer and Electronic Remittance Advice for EmblemHealth Claims

EmblemHealth offers PNC Remittance Advantage, a no-cost online payment solution that helps your office reduce payment processing expenses and improve cash flow.

With PNC Remittance Advantage, you can receive direct deposits to your bank accounts (electronic funds transfer) and view or download your remittances online (electronic remittance advice). Electronic transactions are fast, convenient and reduce the risk of lost or stolen payments. Electronic funds transfer and electronic remittance advice are the standards for receiving EmblemHealth payments and remittance advice.

The registration process is simple and secure and takes just moments to complete:

- Step 1: Have available a recent EmblemHealth Explanation of Benefits (EOB) and either a voided check or a letter from your bank listing the account name, account number, account type and bank routing number for each of your practice's bank accounts used to receive electronic payments.

- Step 2: Go to PNC Remittance Advantage at https://rad.pnc.com.
- Step 3: Select the "Register for Portal and Online Payment Services" link on the upper left side of your screen.
- Step 4: Register for the website with your email address, your practice's tax identification number and your Provider ID, found on your EmblemHealth EOB.
- Step 5: For larger practices, add all of your practice's payees and organize them according to bank account, location, personnel or whatever is appropriate for your practice.
- Step 6: Enter your bank account information and upload a scanned image of your voided check or bank letter.
- Step 7: Associate each payee group with a bank account, and then submit your enrollment form online.
- Step 8: Allow two weeks to validate the bank account information before receiving electronic payments and remittance advices.

If you need help with the registration process, please call the PNC Remittance Advantage Help Line at 1-877-597-5489, option 1, Monday through Friday, from 8:30 am to 8:30 pm (ET).

Real Time Eligibility Benefit Inquiry and Response (270-271)

The ASCX12N 270/271 health care eligibility benefit inquiry and response transaction function is available for use. This functionality is designed as a secure electronic tool to verify member health coverage, benefits and member responsibilities such as deductibles, coinsurance and copays. Transactions work for both single members and for batches of members.

Enrolling to use the 270/271 eligibility benefit inquiry and response transaction is easy. Simply contact your billing vendor or clearinghouse. Inform them you would like to use the CAQH HIPAA-compliant 270/271 eligibility benefit inquiry and response transaction.

Health Care Claim Status Request and Response (276-277)

You may use the ASC X12N 276/277 (005010X212E2) health care claim status request and response transaction function. This functionality is designed as a secure electronic tool to look up the claim status for a single member or for batches of members.

Enrolling to use the EDI HIPAA/CAQH 276/277 health care claim status request and response is easy. Simply contact your vendor or clearinghouse. Inform them you would like to begin receiving the CAQH HIPAA-compliant 276/277 health care claim status request and response transaction.

EDI-Related Help Desk Support

Please call our Provider Call Center at 866-447-9717, Monday through Friday, from 8 a.m. to 6 p.m. and a Customer Service representative will be happy to assist you.

CMS 1500 And UB04 Forms

To obtain UB04 and CMS 1500 forms, sign in to Health Forms and Systems, Inc. at www.health-forms.com or the Centers for Medicare & Medicaid Services at www.cms.hhs.gov/CMSForms/CMSForms/list.asp. UB04 and CMS 1500 forms are also available in Claims Corner.

Hard copy forms can be requested by calling the U.S. Government Printing Office at 1-800-869-6590 or 1-202-512-1800.

Timely Submission

Appropriate Timely Submissions When GHI Is Primary Carrier:

- For claims received for dates of service on or after Nov. 14, 2019, 120 days unless the participation agreement

states an alternative time frame to be applied.

- For claims received for dates of service prior to Nov. 14, 2019:
  - In-network claims: 365 days from date of service
  - Out-of-network claims: 18 months from date of service

Appropriate Timely Submissions When GHI Is Secondary Carrier:

- For claims received for dates of service on or after Nov. 14, 2019: 120 days from the primary carrier's EOB voucher date unless the participation agreement states an alternative time frame to be applied.
- For claims received for dates of services prior to Nov 14, 2019: 365 days from the primary carrier's EOB voucher date.

Appropriate Timely Submissions When HIP Is Primary Carrier:

- For claims received on or after April 1, 2019, 120 days unless the participation agreement states an alternative time frame to be applied.
- For claims received prior to April 1, 2019:
  - In-network claims: 365 days from date of service
  - Out-of-network claims: 365 days from date of service

Appropriate Timely Submissions When HIP Is Secondary Carrier:

- For claims received on or after April 1, 2019: 120 days from the primary carrier's EOB voucher date unless the participation agreement states an alternative time frame to be applied.
- For claims received prior to April 1, 2019: 365 days from the primary carrier's EOB voucher date.

EmblemHealth will apply the timely filing provisions found in each Participation Agreement with HIP Network Services IPA, Health Insurance Plan of Greater New York and HIP Insurance Company of New York for HIP members.

Claims Processing and Payment

Clean non-Medicare claims submitted electronically will be processed within 30 days; paper or facsimile clean non-Medicare claims will be processed within 45 days in accordance with the New York State law for prompt payment of claims. All claims submissions must include the TIN and NPI of the rendering and billing provider(s).

For all Medicare claims, EmblemHealth adheres to the Centers for Medicare & Medicaid Services (CMS) rules and regulations for prompt claims payment. That is, 95 percent of clean claims will be processed within 30 days, and all other claims will be processed within 60 days. For clean claims that are not processed within 30 days, interest will be paid at the prevailing rate under Medicare regulations.

EmblemHealth will not reimburse any claim submitted more than 365 days after the service date. Providers who wish to contest a claim that was denied for untimely filing should follow the provider grievance process set out in the applicable Dispute Resolution chapters for Commercial, Medicaid or Medicare. The reimbursement paid on late claims submissions may be reduced by an amount up to 25 percent. Participating practitioners may not bill the patient for services that EmblemHealth has denied because of late claims submission.

Duplicate claims should not be submitted. Providers may check the status of a prior claim submission by going to the EmblemHealth website, www.emblemhealth.com/home/providers, or calling a Provider Customer Care Advocate.

Claims that include a substitute physician should be submitted by the regular EmblemHealth-contracted practitioner, as substitute physicians are not required to enroll with the health plan and should not bill the health plan directly. See the Submitting Claims for Non-Credentialed Practitioner in a Group Arrangement or for a Non-Par Substitute Practitioner section later for more information on how to submit claims for substitute/non-contracted physicians at a contracted medical group service location.

Submitting Claims for Non-Credentialed Practitioner in a Group Arrangement or for a Non-Credentialed Substitute Practitioner

All providers who are part of an EmblemHealth-contracted medical group – and individually credentialed providers who have a non-contracted provider as part of their group and share a TIN, NPI, specialty/taxonomy code – are considered contracted providers for the purposes of claim payments and are considered "Substitute Practitioners". Claims for Substitute Practitioner services should be billed by the medical group or by the regular participating practitioner and will be reimbursed at the regular participating practitioner's contracted fee schedule.

Substitute Practitioners are not required to enroll with the health plan and should not bill the health plan directly.

Please note the following to ensure your claims for the Substitute Practitioner's services are documented correctly:

- Claims that include services provided by a Substitute Practitioner or must include the credentialed provider's billing name, address and national provider identifier (NPI) in Block 33 of the claim form.
- The name and mailing address of the Substitute Practitioner must be documented in Block 19, not Block 33.
- When billing for a service provided by a Substitute Practitioner physician, the modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the Substitute Practitioner.

Claims From a Network Hospital Associated With a Non-Network Health Care Provider

EmblemHealth will not summarily process claims from a network hospital as out of network solely on the basis that a health care provider who is not participating with EmblemHealth treated the member.

Claims From a Network Health Care Provider Associated With a Non-Network Hospital

EmblemHealth will not arbitrarily process claims from network health care providers as out of network solely because the hospital is not participating with EmblemHealth.

Coordination of Benefits

EmblemHealth will not deny a claim, in whole or in part, on the basis that it is coordinating benefits and the member

has other health insurance coverage, unless we have a reasonable basis to believe that the member has other health insurance coverage that is primary for the claimed benefit. If EmblemHealth requests and does not receive information regarding other coverage from the member within 45, then we will adjudicate the claim.

Billing the Member or Secondary Payor

Network providers, in agreeing to accept EmblemHealth's reimbursement schedule for services rendered, shall not bill or seek payment from the member for any additional expenses (except for applicable copayments, co-insurance or permitted deductibles) including, but not limited to:

- The difference between the charge amount and the EmblemHealth fee schedule or the difference between the member's copay amount and fee schedule if the copay amount is greater than the fee schedule.
- Reimbursement for any claim denied for late submission, inaccurate coding, unauthorized service or as deemed not medically necessary.
- Reimbursement for any claim pending review.

Any provider attempting to collect such payment from the member does so in breach of the contractual provisions between the provider and EmblemHealth.

The provider is responsible for collecting members' copayments at the time of service not to exceed the fee schedule amount. Copayments may not be charge for preventive care services as indicated in the Your Plan Members chapter.

Because member liability is determined after a claim is processed, the EOB will clearly state the member's payment responsibility. If any coinsurance or deductible remains, you can then bill your patient directly for the balance.

EmblemHealth is not responsible for payment of noncovered services. Before rendering a noncovered service, the network provider must notify the member in writing that the service is not covered by our plan, notify the member of the cost of the service and receive the member's written consent to receive such service. Only then may the provider collect payment for the noncovered service(s) directly from the members.

The member may sign an agreement with a provider whereby the member accepts responsibility for payment for noncovered services only.

Medicare Dual Eligible Members

Individuals with both Medicare and Medicaid coverage are called "dual eligibles." Depending on their category of Medicaid coverage, a dual eligible may receive state Medicaid plan assistance to cover their Medicare Part B premium, Medicare Parts A and B cost-share and certain benefits not covered by Medicare.

Centers for Medicare & Medicaid Services (CMS) guidelines stipulate that dual eligibles who qualify to have their Medicare parts A and B cost-share covered by their state Medicaid plan are not responsible for paying their Medicare Advantage plan cost-shares for covered services. Providers may not balance bill for these amounts.

To comply with this CMS requirement, providers treating dual eligibles enrolled in an EmblemHealth Medicare Advantage plan must do the following for these members:

- Bill the Managing Entity as primary payor and the state Medicaid plan as secondary payor
- Accept the Medicaid payment as payment in full and not collect any cost-share from the member if they participate with their state Medicaid program
- Prior to providing services, notify the member if they do not accept the state Medicaid as payment in full

Effective January 1, 2016, Medicaid will no longer reimburse partial Medicare Part B coinsurance amounts when the Medicare payment exceeds the Medicaid fee or rate for that service. If the Medicare payment is greater than the Medicaid fee, no additional Medicaid payment will be made.

Effective July 1, 2016, Medicaid will no longer pay the full copayment or coinsurance amounts for Medicare Part C claims. Medicaid will reimburse at the rate of 85 percent of the Medicare Part C copayment or coinsurance amount.

These changes also apply to pharmacy claims for medications and supplies. There is no change to the current reimbursement methodology of Medicare Part B coinsurance or Part C copayment/coinsurance for ambulance providers, psychologists, or Federally Qualified Health Centers (FQHCs). These providers will continue to be paid the full Medicare Part B coinsurance and Part C copayment/coinsurance amounts.

Look Back Periods To Reconcile Overpayments

Applies to all plans

To ensure fair and accurate claims payment, EmblemHealth conducts audits of previously adjudicated claims. The time period for these audits is referred to as the "Look Back Period." Claims may be audited based on the settlement or paid/check date, not the date(s) of service. The date range for each audit is primarily determined by regulatory requirements and varies with the member's plan type. The Look Back Periods are summarized in the table below (and may be modified as needed to reflect statutory, regulatory changes and exceptions).

Plans	Look Back Period
Commercial Plans	2 years
FEHB Plans and Medicaid Reclamation Claims	3 years
Medicare Advantage Plans	Pre-American Taxpayer Relief Act of 2012 Within one year for any reason and 3 years after the year in which payment was made for good cause (new and material evidence has come to light) Post-American Taxpayer Relief Act of 2012 Within one year for any reason and 5 years after the year in which payment was made for good cause (new and material evidence has come to light)
Medicaid, Child Health Plus and Veterans Administration (VA) Facilities Claims*	6 years

*No unilateral offset permitted. If an overpayment is identified, notices and requests for repayment will be sent to the provider. The notices will provide a detailed explanation of the erroneous payment, as well as instructions for repayment options and how to dispute the repayment request. The provider may challenge an overpayment recovery by following the Provider Grievance process set out in the applicable Dispute Resolution chapter of the Provider Manual: Commercial/CHP, Medicaid or Medicare. If the overpayment is not returned within the requested time frame or the dispute of overpayment is not submitted in a timely manner, EmblemHealth will withhold funds from future payment(s) to the provider up to the amount of the identified overpayment.

Note: These time frame limitations do not apply to:

- Claims that fall under the False Claims Act
- Duplicate claims
- Fraudulent or abusive billing claims
- Claims of self-funded members
- Claims of members enrolled in coverage provided by the state or a municipality to its employees
- Claims subject to specifically negotiated contract terms between an EmblemHealth company and a provider (contractual time frames will apply)

Also important to note:

Commercial Plans

- Section 3224-b of the Insurance Law limits recovery of overpayments to 24 months.
- Notice must be sent to provider specifying the patient name, service date, payment amount, proposed adjustment and a reasonably specific explanation of the proposed adjustment.
- The 24-month limitation does not apply to: (i) claims that are fraudulent or abusive billing; (ii) claims of self-funded plan members; (iii) claims of members enrolled in a state or federal government program; or (iv) claims of members enrolled in coverage provided by the state or a municipality to its employees.

FEHB Plans

- 30/60/90-day interval notices must be sent to provider; offset may occur if debt remains unpaid and undisputed for 120 days after first provider notice.
- The 3-year look back limitation does not apply to False Claims Act claims.
- Provider Notice must provide: (a) an explanation of when and how the erroneous payment occurred; (b) the appropriate contractual benefit provision (if applicable); (c) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, etc.); (d) a request for payment of the debt in full; (e) an explanation of what may occur should the debt not be paid, including possible offset to future benefits; (f) offer installment options; and (g) provide the provider with an opportunity to dispute the existence and amount of the debt.

Medicaid Reclamation Claims

- NYS has the right to recoup payments from EmblemHealth that Medicaid fee-for-service paid on behalf of a patient who has commercial insurance.

Medicaid and Child Health Plus

- Required by Model Contract with SDOH.

Claims Corner

EmblemHealth has developed Claims Corner, an online claims information resource, in order to provide useful information to aid in submitting clean claims for speedy processing. More information can be found in the Provider section of our Web site.

Adolescent Mental Health Checkup Reimbursement

Providers will be reimbursed for administering a mental health checkup during a well-child exam or a routine office visit by using the codes noted in the chart below. The codes must indicate that a separately identifiable evaluation and management service was performed.

Reimbursement Codes* for All EmblemHealth Networks and Plans

Well-Child Visit Reimbursement Codes for Mental Health Screening

CPT Codes for Well-Child Visit		CPT Codes (E/M Codes Based on Time)		Modifier	Developmental Screening Code
99393	5-11 est. patient	99211	5 minutes, est. patient		
99394	12-17 est. patient	99212	10 minutes, est. patient		
99395	18 + est. patient	99213	15 minutes, est. patient		
99383	5-11 new patient	99214	25 minutes, est. patient		
99384	12-17 new patient	99215	40 minutes, est. patient	25 Note - Modifier 25 should append the E/M codes and not the developmental screening code.	96110
99385	18 + new patient	99201	10 minutes, new patient		

These well-child codes may be used in conjunction with mental health screenings.	99202	20 minutes, new patient		
	99203	30 minutes, new patient		
	99204	45 minutes, new patient		
	99205	60 minutes, new patient		

ICD Codes:

V20.2 - well-child/ preventive health visits

V79.8 - special screening exam for mental disorders and developmental handicaps (negative screening

V40.0 - mental and behavioral health problems (positive screening)

*Providers must refer to their provider contract for office visit reimbursement rates.

Coverage Denied for Never Events

Beginning January 1, 2010, EmblemHealth will deny or adjust Medicare and Medicaid claims submitted for never events (defined as surgical or other invasive procedures performed in error by a practitioner or group of practitioners).

Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are cut into or an instrument is introduced through a natural body orifice. Procedures range from the minimally invasive to major surgeries. This applies to all procedures found in the surgery section of the Current Procedural Terminology (CPT) coding. It does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

In general, never event errors include, but are not limited to:

- Performing a different procedure altogether
  Any procedure that is not consistent with the correctly documented informed consent for the patient.

- Performing the correct procedure on the wrong body part
  Any procedure that is not consistent with the correctly documented informed consent for the patient. This includes surgery on the appropriate body part, but in the wrong place (for example, operating on the left arm versus the right or on the left kidney not the right, or at the wrong level (spine).
- Performing the correct procedure on the wrong patient
  Any procedure that is not consistent with the correctly documented informed consent for that patient.

All related services provided during the same hospitalization in which the error occurred are not covered. Medicare will also not cover other services related to these noncovered procedures as defined in the Medicare Benefit Policy Manual (BPM):

-
  - All services provided in the operating room when such an error occurs
  - Services rendered by any and all practitioners in the operating room when the error takes place who could bill individually for their services

Performance of the correct procedure after the never event has occurred is not considered a related service.

Note: Emergent situations that change the plan in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under the CMS ruling. This also includes the discovery of new pathologies near the surgery site, if the risk of a second surgery outweighs the benefit of patient consultation or the discovery of an unusual physical configuration (e.g., adhesions, extra vertebrae, etc.)

More information regarding Medicare never events and the latest rulings may be found on the CMS website at www.cms.gov.

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Medicaid Never Events

The 13 avoidable hospital conditions that the New York State Department of Health has identified as non-reimbursable are:

1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient
3. Wrong surgical procedure performed on a patient
4. Patient disability associated with a medication error
5. Patient disability associated with use of contaminated drugs, devices, biologics provided by a health care facility
6. Patient disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
7. Patient disability associated with an electric shock while being cared for in a health care facility
8. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance
9. Patient disability associated with a burn incurred from any source while being cared for in a health care facility
10. Patient disability associated with the use of restraints or bedrails while being cared for in a health care facility
11. Retention of a foreign object in a patient after surgery or other procedure
12. Patient disability associated with a reaction to administration of ABO-incompatible blood or blood products
13. Patient disability associated with intravascular air embolism that occurs while being cared for in a health care facility

The Department of Health will continually review this list, which will be modified and expanded over time.

For those Medicaid cases where a serious adverse event occurs and the hospital anticipates at least partial payment

for the admission, the hospital will follow a two-step process for billing the admission:

1. The hospital will first submit their claim for the entire stay in the usual manner, using the appropriate rate code (i.e., rate code 2946 for DRG claims or the appropriate exempt unit per diem rate code such as 2852 for psychiatric care, etc.). That claim will be processed in the normal manner and the provider will receive full payment for the case.
2. Once remittance for the initial claim is received, it will be necessary for the hospital to then submit an adjustment transaction to the original paid claim using one of the following two new rate codes associated with identification of claims with serious adverse events:
   - 2591 (DRG with serious adverse events), or
   - 2592 (Per Diem with serious adverse events)

All claims identified as never events will be reviewed on a case by case basis.

Facility Claims Requirements

Ambulatory Patient Group (APG) Rate Codes

EmblemHealth pays claims billed with ambulatory patient group (APG) rate codes (and their corresponding CPT codes) for services covered by APG reimbursement. The APG system is the New York State-mandated payment methodology for most Medicaid outpatient services. APGs will be paid for outpatient clinic, ambulatory surgery and emergency department services when the service is reimbursed at the Medicaid rate. APGs will not be used for services that are carved out of Medicaid managed care.

To facilitate APG claims processing, please:

- Submit APG and non-APG services on separate claims
- Report a value code of 24 and an appropriate rate code
- Report CPT codes for all revenue lines

Claims without proper coding will be returned to you for correction prior to adjudication.

More information on APGs can be found at the New York State Department of Health's website at www.health.state.ny.us/health_care/medicaid/rates/apg/, as well as the DOH's Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual at www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_provider_manual.

For documentation on known APG issues and HIPAA APG requirements, go to eMedNY's website at www.emedny.org/apg_known_issues.pdf and at www.emedny.org/HIPAA/index.html.

"Present on Admission" Indicator for Hospitals

The Deficit Reduction Act of 2005 requires hospitals to report the secondary diagnoses (if present) for Medicare and Medicaid patients. To comply with this government program, EmblemHealth requires a "present on admission" (POA) indicator for the following claims:

- Acute care hospital admissions for Medicare members
- All medical inpatient services
- Substance abuse treatment
- Mental health admissions

Note: Patients considered exempt by Medicare must also have POA indicators noted. If the diagnosis is exempt, enter a value of "1."

A POA indicator is not needed for Medicare member claims in the following hospitals:

- Critical access hospitals
- Inpatient rehabilitation facilities
- Inpatient psychiatric facilities
- Maryland waiver hospitals
- Long term care hospitals
- Cancer hospitals
- Children's hospitals
- Hospitals paid under any type of prospective payment system (PPS) other than the acute care hospital PPS

A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the ICD-9-CM Official Guidelines for Coding and Reporting, by the Centers for Medicare & Medicaid Services [CMS] and the National Center for Health Statistics [DHHS]) and the external cause of injury. CMS does not require a POA indicator for the external cause of injury unless it is being reported as an "other" diagnosis.

If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA indicator would not be reported.

Present on Admission (POA) Indicator List

Code	Description
Y	Yes. The condition was present at the time of inpatient admission.
N	No. The condition was not present at the time of inpatient admission.
U	Unknown. The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.
1	Unreported/not used, exempt from POA reporting. This code is the equivalent code of a blank on the UB-04. However, it was determined that blanks were undesirable when submitting this data via the 4010A.

Issues related to inconsistent, missing, conflicting or unclear documentation must be resolved by the practitioner.

More information and coding instructions, including the POA Fact Sheet, can be found on the CMS website at www.cms.gov/MLNMattersArticles/downloads/MM5499.pdf and at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/wPOAFactSheet.pdf.

Claims Review Software

EmblemHealth uses multiple types of commercially available claims review software to support the correct coding of claims that result in fair, widely recognized and transparent payment policies.

To avoid any payment adjustments, we recommend you carefully document each service provided, according to CMS guidelines: Documentation Guidelines for Evaluation and Management. Complete medical record documentation is the foundation of every patient's health record and can significantly affect claims coding and adjudication. Accurate coding translates clinical documentation into uniform diagnostic and procedural data sets and provides the evidence that the services billed were rendered to the patient.

In addition to the above, EmblemHealth utilizes the services of several organizations for claim editing services as indicated below:

Cotiviti, Inc.

The Cotiviti, Inc. Payment Policy Management software provides EmblemHealth with correct coding and payment policy for EmblemHealth to administer and pay claims in a manner consistent with relevant policy sources. Policy sources include, but are not limited to, the requirements of CMS, AMA and other specialty academies' policies and procedures. Examples of claims editing software rule recommendations include, but are not limited to: A) Implementation of industry standard and vendor recommended updates; B) Systematic revisions to ensure correct administration of EmblemHealth benefit plans; C) Correction of diagnoses and procedure inconsistencies, procedure and setting inconsistencies and incorrect/coding of multiple services.

McKesson Health Solutions ClaimsXten

ClaimsXten is an ICD-9- and ICD-10-compliant software solution that assesses claims information, including CPT/HCPCS procedure codes, to detect coding irregularities and conflicts or errors, and makes recommendations for correction for both professional and facility claims1. ClaimsXten coding rules come preconfigured in Knowledge Packs and are based on a compilation of guidance from AMA and CPT publications, CMS, specialty societies, and McKesson’s clinical physician teams. The auditing logic evaluates modifiers in a correct, hierarchical fashion when multiple modifiers are reported per claim line. All rules, codes, edits sources and edit clarification are updated quarterly. Preconfigured ClaimsXten clinical rules may be revised by Senior EmblemHealth Medical Directors to align with EmblemHealth clinical policies.

Montefiore CMO Claims Review Software

Montefiore CMO (the management services organization for Montefiore IPA) uses a series of claims rules that encompass CMS National Correct Coding Initiative edits, specialty edits, commercial edits and unique, code-specific edits. For Montefiore CMO claims inquiries, contact 1-877-447-6888.

TriZetto® QNXT (version 3.0.200.0)

QNXT is a comprehensive payer solution developed by TriZetto to administer all lines of medical business and efficiently manage all relationships between HIP, members and practitioners. QNXT manages complex reimbursement capabilities, flexible benefit plan design functions and complex contract modeling capabilities.

HealthCare Partners Claims Review Software (HCPIPA)

HCPIPA claims review follow EmblemHealth, Current Procedural Terminology (CPT), American Medical Association (AMA) and ASA claims processing guidelines and apply CMS coding initiative guidelines. For HCPIPA claims inquiries, contact 1-800-877-7587 or use the EZ-Net system on the HCPIPA website at www.hcpipa.com. A valid username and password are required.

EZCAP (version 4.6)

EZCAP collects and stores provider profiles, health plan benefit and member eligibility data, specialist treatment authorizations, procedure and diagnosis codes, case management and customer service information. EZCAP also stores and processes professional and facility claims and calculates member months and capitation payments.

Palladian Muscular Skeletal Health Claims Review Software

Palladian currently uses Health Solutions Plus (HSP). This software is a modular system providing claims payment, member eligibility, provider credentialing, repricing and internal and external reporting.

QicLink System (version 3.30.60.00)

The QicLink System is a suite of applications providing claims payment, member eligibility and utilization management, provider credentialing, repricing and internal and external reporting services. Claims and authorizations are subject to member eligibility and practitioner contractual agreements before being paid or authorized. This system also integrates with other software programs such as ProviderNet, PUMA and DataPiction.

Taxonomy Codes: Definition and Claims Use

Taxonomy codes are administrative codes set for identifying the practitioner type and area of specialization for health care practitioners. Each taxonomy code is a unique ten character alphanumeric code that enables practitioners to identify their specialty at the claim level. Taxonomy codes are assigned at both the individual practitioner and organizational practitioner level.

Taxonomy codes have three distinct levels: Level I is the practitioner type, Level II is Classification, and Level III is the

Area of Specialization. A complete list of taxonomy codes can be found within the Health Insurance Portability and Accountability Act (HIPAA).

Taxonomy codes are self-reported, both by registering with the National Plan and Provider Enumeration System(NPPES) and by electronic and paper claims submission.

Taxonomy Codes registered with NPPES at the time of NPI application are reflected on the confirmation notice document received from NPPES with the provider's assigned NPI number. Current taxonomy codes registered, including any subsequent changes, may be obtained on an inquiry basis by visiting the NPI Registry website.

A practitioner can have more than one taxonomy code, due to training, board certifications etc. It is critical to register all applicable taxonomy codes with NPPES and to use the correct taxonomy code to represent the specific specialty when filing claims. This will assist EmblemHealth in more accurate and timely processing of claims.

Please provide Taxonomy codes on all EmblemHealth claims, the absence of these codes may result in incorrect payment.

Taxonomy codes on electronic claim submissions with the ASC X12N 837P and 837I format are placed in segment PRV03 and loop 2000A for the billing level and segment PRV03 and loop 2420A for the rendering level. For paper CMS-1500 professional claims, the taxonomy code should be identified with the qualifier "ZZ" in the shaded portion of box 24i. The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the "ZZ" qualifier for the billing level.

The Importance of Accurate Taxonomy Codes

Taxonomy codes are administrative codes that identify your provider type and area of specialization. It is a unique ten character alphanumeric code that enables you to identify your specialty at the claim level. We want to make sure you know how this will affect you and your EmblemHealth patients.

What is happening
Starting on September 11, 2018, if your taxonomy code is invalid or your taxonomy indicates you do not have the right to prescribe certain drugs, pharmacies using Express Scripts, Inc. (ESI)—our primary pharmacy network—will not fill your patients' prescriptions, even if it is a refill of a previous prescription.

Why this is happening
Express Scripts, Inc. is following New York prescriptive authority logic, which compares the drugs being prescribed with a prescriber's taxonomy in the National Plan and Provider Enumeration System (NPPES).

To avoid getting calls from upset patients and multiple pharmacies, update your taxonomy codes. Don't let your patients get turned away at the pharmacy.

What you need to do

- Review the Medicare taxonomy crosswalk to see which taxonomies are eligible to prescribe.
  - Go to cms.gov and search "Crosswalk Medicare Provider/Supplier to Healthcare Provider Taxonomy."

- Update your taxonomy code(s), if necessary.
  - Go to npiregistry.cms.hhs.gov.
  - Enter your National Provider Identifier (NPI) in the National Plan and Provider Enumeration System (NPPES).
  - Click on the NPI number. Scroll to the bottom of the record to see your taxonomies.
  - If the taxonomy is not a valid CMS taxonomy, go to nppes.cm.hhs.gov/#/. Enter your username and password in the individual NPI portion of the site and update the taxonomy code as needed. Please make sure you select

a taxonomy that belongs to an individual provider, not an entity.

Refer to the example below to learn more about how to make sure your taxonomy code accurately reflects what you do. For more information:

- Go to cms.gov.
- Click on the Medicare tab at the top of the page.
- Scroll to the Provider Enrollment & Certification section.
- Click on Medicare Provider-Supplier Enrollment.
- Scroll to the bottom.
- Click on Taxonomy in the left navigation.

Tip for Selecting the Correct Taxonomy Code

Avoid General Codes

We strongly encourage physicians and other prescribers to avoid choosing the very general taxonomy codes below. They may inappropriately identify the prescriber as someone who cannot write prescriptions for patients, resulting in a rejected prescription.

- Specialist
- Contractor
- Hospital
- Clinic

Individuals should avoid choosing a taxonomy that represents a facility. Instead, select the taxonomy for your actual specialty.

For Nurses

If you are a nurse and have an advanced practice degree, we urge you to avoid selecting “Registered Nurse” as a taxonomy for the same reason stated above. Your taxonomy code should reflect that you have an advanced practice nursing degree to ensure accurate identification of what you do and to avoid unnecessary rejects.

Unlisted Procedure or Service Code Form

Please see the following page for our Claim Submission for Unlisted Procedure or Service Code Special Report form.

EmblemHealth

Provider Manual

Chapter 31: Podiatry

This chapter contains information about the special reimbursement program for podiatry services provided by designated providers. In addition to applicable members/benefit plans, you will find information on policies and procedures, payment, reimbursement and claims.

Market Share Payment Program For Podiatry Services Overview

Retired as of November 1, 2018

In order to streamline the payment system, all podiatrists participating in this program are reimbursed under the Market Share Payment (MSP) program methodology.

The MSP methodology affords numerous advantages, such as:

- Monthly payments that normalize cash flow
- Simplified billing based on global payments for new patient referrals
- Increased opportunities for improved efficiencies

Under MSP, practitioners receive a point each month for each new member referral (as identified by submitted claims) which translates to a global payment covering six months of professional services rendered. This covers the initial visit, as well as any subsequent procedures performed by the podiatrist for the same member. If, at the end of six months, the practitioner is still treating the member, the cycle starts over and the practitioner receives another point and another six-month payment for that member.

All professional services rendered are covered under MSP, including, but not limited to, diagnostic tests, surgery, in-patient care, surgical follow-ups, office care and office procedures.

Policies and Procedures

Retired as of November 1, 2018

Even though we register podiatry patients and administer payments differently under the alternate MSP program, standard EmblemHealth policy shall apply with regards to the following areas:

- Referrals*

- Prior approvals
- Claims submissions
- Benefit coverage
- On-call coverage
- Non-covered services
- Collection of copayments and coinsurance
- Checking member ID cards

* Note that podiatry specialists cannot refer directly to other podiatry specialists. Patients who require a referral to another podiatrist must be directed back to their PCP for evaluation and additional referral. This requirement includes referrals for second opinions.

Please refer to your participating provider contract, and the Care Management and Your Plan Members chapters of this manual for more details.

Identification of High-Severity Patients

Retired as of November 1, 2018

Podiatry claims are reviewed monthly to determine if a member is, or has become, a high-severity patient. A high-severity patient is one for whom, during the time period of a valid contact point, a singular procedure was performed, among others, and such single service equals or exceeds 11.72 relative value units (RVUs) as defined by Medicare and geographically adjusted to New York City.

Payment for High Severity Patients

Retired as of November 1, 2018

Should a member be deemed a high-severity patient, additional points will be awarded to the participating podiatrist once during each member's six-month period and shall be reported on the monthly EmblemHealth remittance advice. If high-severity service occurs after the first month of payment, a payment adjustment will be made during the month the qualifying claim is processed.

The additional points schedule is subject to change with notification to participating podiatrists. As of January 2009, the Market Share Payment program's schedule is:

Highest Single Procedure RVUs	
0-11.71	1 Contact Point
11.72 or more	5 Contact Points Case Maximum

Requests for Exceptional Case Review

Retired as of November 1, 2018

Exceptional cases are members whose podiatric services present a high degree of severity or complexity and/or require significant frequency of service or volume of care within their respective six-month periods. Payments must have been previously adjudicated under the Market Share Payment (MSP) program in order to be reviewed and reclassified as exceptional.

MSP participating podiatrists who wish to have a case reviewed for this determination must submit the following supporting documentation:

- Cover letter providing detail to support adjustment request
- Copy of previously submitted claim form
- Clinical notes
- Radiological and operative reports

The above information may be sent to:

EmblemHealth
Edward Saxer
Co-Chairman, Podiatry Professional Advisory Committee
55 Water Street
New York, NY 10041-8190

The Podiatry Professional Advisory Committee (PAC), a panel composed of professional EmblemHealth staff and practitioners from the New York podiatric community, will review qualifying cases during each of the committee's quarterly meetings. Podiatrists will be told the outcome of their request within a reasonable timeframe thereafter.

Claims Submission Guidelines

Retired as of November 1, 2018

Practitioners should continue submitting ALL claims, as usual, on the standard CMS 1500 form in the current electronic or paper format. Claims are still required for payment under the Market Share Payment program and, if applicable, for any services paid on a fee-for-service basis. In addition, it is necessary to continue submitting all claims data to ensure additional consideration is given for high-severity patients and general program monitoring.

For more information regarding standard claims submission guidelines, including electronic submission and coding, please refer to the Claims chapter of this manual and/or your participating provider agreement.

Claims Submission Time Period and Payment Turnaround

Retired as of November 1, 2018

Participating practitioners will receive payments for Market Share Points on or near the 25th of each month for claims processed by the end of the prior month. Claims processed after the last day of the month will be included in the

following month, provided they are submitted within the contractual timeframes.

The initial date of service on a submitted claim will determine when the time period begins for the Market Share Payment episode of care, regardless of the EmblemHealth processing date.

Posting Procedure for Participating Practitioners

Retired as of November 1, 2018

Please note that the following posting procedures for your accounts receivable are recommended for your use. Actual accounting policies for each practitioner's office may differ.

Collection of Patient Liabilities (Copayments, Coinsurance Amounts)

Under the Market Share Payment program, office staff should collect any copayment, coinsurance and other applicable fees for service payments from patients. In addition, any coordination of benefits information should be collected from the patient. Office staff will need to post the amounts collected from the patient.

Upon Receipt of Remittance Advice

A remittance advice is a financial statement that EmblemHealth sends to practitioners to reconcile accounts, explain approved charges, and review claims disbursements and member payment responsibilities. Each advice statement should be reviewed in order to determine that all submitted claims have been processed and that action has been taken on these claims.

For patients generating Market Share Program payments, a remittance advice will be sent showing the amount paid and the original claim that generated the creation of a Market Share Point. Adjustments made to these payment amounts after the original payment processing will be included on a new remittance advice.

When Services Are Provided to Patients Under a Market Share Payment Contact Point

All patient service claims provided during each member's Market Share Payment program six-month time period will generate a remittance advice from EmblemHealth indicating that the patient services were compensated under a previous contact point and will reference the claim that generated the original Market Share Payment. The participating podiatrist, as previously paid in full, should write off these subsequent services.

Reimbursement Calculations

Retired as of November 1, 2018

NOTE: The examples hereunder are for illustrative purposes only. Actual numbers will differ and will vary by month.

Determination of the Professional Podiatry Care Fund Amount

Each month, EmblemHealth determines the amount of the Professional Podiatry Care Fund (PPCF) for all lines of business based on a number of financial variables.

Current Month Pool Funding

Medicare Budget	$2.40

Number of Enrollees	50,000
Gross Fund Amount (Monthly)	$120,000
Deductions from Fund (Illustrative Only)	
- Non-Par*	$15,000
Total Deductions	$15,000
Current Month Net Available for Distribution	$105,000

* Services provided by non-participating podiatrists will be deducted from the Market Share Payment pool.

Determination of the Market Share Payment Value

Market Share Payment values are determined by the historical average costs for all unique patient cases within a specialty. Adjustments may be made to the average case cost for fee-for-service exclusions and other situations. For example:

$2,200,000	Annual Total Podiatry Cost
$500,000	Nonparticipating Provider Costs
$500,000	Other Medical Costs
$1,200,000	Net Annual Historical Podiatry Costs

* Illustrative Only

If there were 12,000 unique patient cases reported by all podiatry providers in the previous 12 months, then the average patient case would cost $100 ($1.2M divided by 12,000 cases).

Note: The Net Annual Historical Podiatry Cost and number of unique patient cases (reported by all practitioners) are calculated on a 12-month rolling average basis. As such, the average patient case cost (in this example, $100) will go up or down depending on the cost and case activity of the previous rolling 12 months. Any differences in the patient case cost will be reflected as an adjustment to the next month's payment.

Determination of Individual Physician Payment

For illustration purposes:

1. Each month, a point is assigned to the podiatrist each time a unique patient is seen by the podiatrist. In January, Dr. Health saw three new patients.
   3 New Patient Cases = 3 Points for Dr. Health
   1,000 New Patient Cases for all participating podiatrists during the month of January
2. Each month, EmblemHealth determines the amount of the Professional Podiatry Care Fund (PPCF) for all lines of business. For this example, let's say the pool has been allocated $100,000 in January.
3. The amount paid to the podiatrist each month is based on the practitioner's individual points divided by the total points of all practitioners and multiplied by the available dollars in the pool. Dr. Health's payment for January would look something like this:

Practitioner's Points	/	Total Points (All Practitioners)	x	Total Pool	=	Total Practitioner Payment
3	/	1,000	x	$100,000	=	$300 Total Market Share Payment

In months where the practitioner serves unique patients in addition to previously treated patients, the payment structure may look something like this. For example, let's say Dr. Health takes on one new case in February while still treating his three January patients:

February

	January	February	Period-to-Date
(1) Total Pool	$100,000	$100,000	$200,000
(2) New Patient Cases (All Practitioners)	1,000	950	1,950
(3) Dr. Health's New Patient Cases	3	1	4
(4) Market Share Payment Value	$100	$105.26	$102.63 (avg to date)

Practitioner	Patient	(a) January Points	(b) New February Points	(c) Period-to-Date Points (=a+b)	(d) Period-to-Date Patient Value (=4, average)	(e) Compensation through Prior Period*	(f) Net Due February (=d-e)
Dr. Health							
	Patient 1	1.0	0.0	1.0	$102.63	$100.00	$2.63
	Patient 2	0.0	1.0	1.0	$102.63	$0.00	$102.63
	Patient 3	1.0	0.0	1.0	$102.63	$100.00	$2.63
	Patient 4	1.0	0.0	1.0	$102.63	$100.00	$2.63
	Total Dr. H	3.0	1.0	4.0	$410.52	$300.00	$110.52

Quality Management

Retired as of November 1, 2018

To ensure appropriate patient care management, EmblemHealth performs periodic quality assurance reviews which may include practice pattern review, review of medical records, monitoring of referrals, review of specific clinical indicators, monitoring for over/under utilization and outliers, peer review, and other measures as determined by the EmblemHealth medical management committees and the Podiatry Professional Advisory Committee.

EmblemHealth will also generate monthly reports profiling utilization by a podiatrist to ensure proper treatment of patients. We encourage practitioners to discuss their utilization information with our Medical Director, as well as with appropriate representatives from the Podiatry Professional Advisory Committee.

For additional information regarding the Quality Management Program, please refer to the Quality Improvement chapter of this manual.

Role of the Podiatry Professional Advisory Committee

Retired as of November 1, 2018

EmblemHealth works with participating specialists to ensure the fairness and integrity of the Market Share Payment program. To provide an appropriate forum for practitioner input, we have established the Podiatry Professional Advisory Committee (PAC), a panel composed of professional EmblemHealth staff members, as well as peers from the New York podiatric community. The PAC supports the EmblemHealth Quality Improvement Department and Medical Director. The PAC's responsibilities include:

- Reviewing the clinical results of the program
- Recommending process improvement initiatives
- Providing unbiased explanation of program to peers
- Encouraging dialogue between EmblemHealth and practitioners
- Facilitating practitioner education
- Establishing appropriate community standards of care
- Creating a functioning peer review process
- Encouraging and helping the development of clinical quality indicators
- Monitoring specialty-specific quality metrics
- Reviewing specific cases to determine if they meet exceptional case criteria

EmblemHealth Market Share Payment Remittance Advice Field Explanations

Retired as of November 1, 2018

Provider Name	The "pay to" provider's name. Box 33 of the CMS 1500.
Remit	Remit number (number assigned to remittance statement).
Check Number	Check number.
Check Date	Check date.
Servicing Provider	Practitioner rendering the service. Box 31 of the CMS 1500.

Provider License Number	EmblemHealth provider ID.
Patient Name	Member name on claim (patient name).
ID	Member ID.
Subscriber	Name of member (policy holder).
Case Number	The number assigned to the first claim submitted.
Initial Contact Date	Date that triggers contact period. (Same as initial date of service.)
Contact Point	Point assignment for new patient encounter. Can include additional points earned for high-intensity patients even if those services are performed in subsequent months. This field is located between contact point and case amount field.
Case Amount	Initial case payment.
Claim Number	Claim number of submitted claim.
Begin DOS	Date of service on submitted claim.
Procedure code	CPT code.
Modifier	CPT modifier.

Current Case Payment	Amount reflected in check, which could be initial case payment, adjustments due to point value changes and/or adjustments due to additional RVU points assigned to a case.
Prior Case Payment	All payments excluding current case payment and initial case payment.
Net Case Payment	Current value of case payment. (Will also reflect payment deductions due to voided claims.)
Provider Total	Accumulation of all current case payments for each servicing provider.
Affiliate Total	Accumulation of all current case payments for each tax ID. Several servicing practitioner totals may make up the affiliate total.
Page Totals	Sum of current case payments on each page.
Begin Recoupment Balance	Starting balance of negative adjustments.
Amount Recouped This Cycle	Recoupment of negative adjustments for present cycle.
New Recoupment Balance	Outstanding balance after recoupment of present cycle.
Amount Processed Current Cycle	Sum of current case payments.
Amount Recouped This Cycle	Recoupment of balance from previous cycle.

Check Amount	Net dollar amount reflected in check.

Termination from the Program

Retired as of November 1, 2018

If the podiatrist discontinues patient care prior to the expiration of the six-month care period, the podiatrist still receives the full MSP. If there is a pattern of discontinuation of care, EmblemHealth may determine a reduced reimbursement amount for the practitioner.

Podiatrists who do not wish to participate under MSP shall have the option of terminating their agreement with HIP upon 180 days written notice or as otherwise described in their provider agreement. Upon notice to EmblemHealth of intent to terminate, practitioners should no longer accept new members who are covered under this program and will be expected to provide ongoing care for existing patients until the completion of their current treatment plan. After termination, these practitioners should desist from rendering service to HIP members except for continuity of care requirements as outlined in the provider agreement.

For more information about the Market Share Payment program, please contact the Physician Contracting hotline at 1-866-447-9717.

EmblemHealth

Provider Manual

Chapter 35: Regulatory Mandatory Reporting

In order to track conditions that affect the public health at large, agencies within New York State, the New York State Department of Health and the New York City Department of Health and Mental Hygiene have enacted laws that require practitioners to follow in order to ensure public safety. Our practitioners are required to participate in these government reporting procedures.

Regulatory Mandated Reporting

New York State has a number of rules, regulations and laws that require regular reporting. For more information, visit the New York State Department of Health (NYSDOH) website at www.health.ny.gov and search for "Rules, Regulations and Laws".

Further, physicians are required to report communicable diseases, including cases, suspected cases and certain carriers, to local health departments. For mandatory physician reporting of patient information, visit the NYSDOH website at www.health.ny.gov and search for "Infection Control Reporting Requirements".

New York City-Specific Reporting Requirements

For Medicaid/CHPlus members, EmblemHealth and our participating practitioners are also required to provide data exchange services to support the Citywide Immunization Registry (CIR) and Lead Poisoning Prevention Program (LPPP).

New York City Resources

The *Compendium of Public Health Requirements and Recommendations: For Health Care Providers Working with Managed Care Organizations*, published by the New York City Department of Health and Mental Hygiene (NYCDOHMH), contains public health requirements focusing on two areas:

- Reporting requirements for communicable diseases and injuries, immunizations, lead test results, termination of pregnancy and school health
- Guidelines for prevention, diagnosis and management focusing on the following topics: communicable diseases, immunizations, emergency preparedness, child development, breast-feeding, child safety, adolescent health, domestic violence, reproductive health, oral health, chronic diseases and chronic health problems

For additional guidelines and information, visit the New York City Web site at www.nyc.gov.

Agencies

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

- Centers for Disease Control and Prevention (CDC)
- Food and Drug Administration (FDA)
- New York City Department of Health and Mental Hygiene (NYCDOHMH)
- New York State Cancer Registry (NYSCR)
- New York State Central Register (SCR) of Child Abuse and Maltreatment
- New York State Department of Health (NYSDOH)
- New York State Immunization Information System (NYSIIS)
- New York State Penal Code
- New York State Pesticide Poisoning Registry
- New York State Rules and Regulations on Controlled Substances-Public Health Law
- NYCDOHMH Citywide Immunization Registry (CIR)
- NYCDOHMH Lead Poisoning Prevention Program (LPPP)
- NYSDOH Alzheimer's Disease and Other Dementias Registry
- NYSDOH Bureau of Communicable Disease Control
- NYSDOH Bureau of Occupational Health - Occupational Lung Disease Registry
- NYSDOH Center for Environmental Health
- NYSDOH Congenital Malformations Registry
- NYSDOH Division of Quality and Surveillance for Nursing Homes and ICFs/MR (DQS)
- NYSDOH Hospital Complaints
- NYSDOH Office of Professional Medical Conduct

Home Care Worker Wage Parity Law

This law establishes a minimum wage requirement for home care aides who perform Medicaid-reimbursed work (including partial payment for dual-eligible Medicaid and Medicare plans) for certified home health agencies (CHHAs), long-term home health care programs (LTHHCPs), licensed home care service agencies (LHCSAs), limited licensed home care service agencies (LLHCSAs) and other organizations that employ home care aides in New York City or in Nassau, Suffolk or Westchester County. This law is in effect in New York City for services provided on or

after March 1, 2012, and in Nassau, Suffolk and Westchester counties for services provided on or after March 1, 2013.

If your organization, hospital or hospital system is a contracted entity providing home care services for EmblemHealth Medicaid or Managed Long Term Care (MLTC) members in New York City or Nassau, Suffolk or Westchester County, you are required to provide EmblemHealth with quarterly written certification of your organization's or hospital's compliance with the minimum wage requirements of the Home Care Worker Wage Parity — Public Health Law of §3614-c. This certification must also be sent to the New York State Department of Health (NYSDOH) annually.

Certified Home Health Agencies (CHHAs)
Contracted CHHAs providing home care services to EmblemHealth Medicaid, Partial Capitated MLTC and/or MAP MLTC members in New York City or in Nassau, Suffolk and/or Westchester counties are required to provide EmblemHealth with annual written certification of their organization's or hospital's compliance with the minimum wage requirements of the Home Care Worker Parity law. Certifications must be made using the approved NYSDOH certification form.

Licensed Home Care Services Agencies (LHCSAs)
Contracted LHCSAs providing home care services to EmblemHealth Medicaid, Partial Capitated MLTC and/or MAP MLTC members in New York City or in Nassau, Suffolk and/or Westchester counties are required to provide EmblemHealth with quarterly written certification of their organization's compliance with the minimum wage requirements of the Home Care Worker Wage Parity law. Certifications must be made using the approved NYSDOH certification form.

Note: Entities that are or have a CHHA or LTHHCP that contracts with LHCSAs or other third parties are required to submit an annual certification to the NYSDOH and obtain quarterly written certification from the contracted entities, attesting those contracted entities are also in compliance with this provision.

Submitting Your Certifications to EmblemHealth

Quarterly certifications are due to EmblemHealth on March 1, June 1, September 1 and December 1 of each year. Annual certifications are due to the NYSDOH by March 1 of each year.

Please fax the certification (and subcontractor list, if applicable) to EmblemHealth's Provider Network Operations department at 1-212-510-5330.

Consequences of Noncompliance

EmblemHealth is required to annually certify that all of its contracted CHHAs, LTHHCPs and LHCSAs are in compliance with the Home Care Worker Wage Parity law. Therefore, any CHHA, LTHHCP or LHCSA that fails to certify will inhibit EmblemHealth's ability to accurately comply with its certification requirement. As such, noncompliance with the certification requirements detailed herein may result in termination of our agreement with your organization.

Required Record Keeping

All providers must maintain records of compliance for at least 10 years. These records must be made available to the NYSDOH upon request. If you have any questions about complying with this request, please contact your EmblemHealth provider representative.

More Information

For more information about the Home Care Worker Wage Parity provision and its implementation, please send an email to homecare@health.state.ny.us with "Home Care Worker Parity" in the subject line.

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Provider Manual

Chapter 37: Required Provisions to Network Provider Agreements

In this chapter, you will find mandatory contract language required by the State of New York and the Centers for Medicare & Medicaid Services, including the Managed Care Law of 2009, the NYSDOH Standard Clauses, the Special Provisions Related to Medicaid Members and the Medicare Advantage Addendum.

- Managed Care Law of 2009
- Medicare Advantage/Medicare-Medicaid Required Provisions
- NYSDOH Standard Clauses for Managed Care Provider/IPA Contracts Appendix Effective: April 1, 2017
- Provision Related to Medicaid, Managed Long Term Care and Family Health Plus Members
- Special Provisions Related to Medicaid, CHP & HARP Members
- Medicare Advantage Addendum

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Provider Manual

Chapter 39: Forms, Brochures & More

To view the provider toolkit, click here.