EmblemHealth

Chapter 8: Access to Care and Delivery System

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Chapter Summary

This chapter outlines EmblemHealth policies and procedures for the provision of medical care to members, including provider participation requirements, roles and responsibilities, and termination procedures.

Note: “provider” and “practitioner” are used interchangeably within this manual.

Accessibility and Timeliness of Care

All EmblemHealth plan members are entitled to:

- An initial assessment of their health care status performed by their provider 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)

See the **Member Policies and Rights** chapter for more information.

Telephone Response

Member telephone calls should be handled by the practitioner or designated office staff as appropriate to the situation in line with the following guidelines:

- Emergency conditions: respond immediately
- Urgent conditions: respond within four hours
- Semi-urgent conditions: respond during the same day
- Routine conditions: respond within two working days
  After-hours calls where the urgency is unclear: respond within 30 minutes

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- 24/7 availability for direct calls or through voice coverage services

Appointment and Access Standards

Appointment Availability Standards

Practitioner offices must schedule appointments in a timely and efficient manner. Providers are expected to follow EmblemHealth's **Appointment Availability Standards During Office Hours & After Office Hours Access Standards** , which are based on industry, Centers for Medicare & Medicaid Services (CMS), New York State Department of Health (NYSDOH), and NCQA health plan accreditation access standards. See applicable standards for:

- Primary care practitioners
- OB/GYNs
- Oncologists
- Specialists
- Mental health and substance abuse practitioners
- Medicaid children's health and behavioral health benefits

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

Availability of care means a member must be able to contact their provider's office and secure an appointment within the established time frames based upon their need (urgent, non-urgent, routine, initial follow-up care, etc.), or be directed to the appropriate emergency services.

EmblemHealth conducts annual surveys for appointment availability by calling practitioner offices during office hours to determine the next available appointment for a given type of service. We also verify 24-hour access by calling after-hours telephone numbers. These surveys ensure compliance with these standards, as required by regulators and accreditation bureaus, as part of our Quality Management program.

Practitioners who fail one or more components of the survey are notified by mail and automatically included in the next survey. Practitioners who are not compliant with the standards and fail the re-survey are forwarded to EmblemHealth's Credentialing/Recredentialing Committee (CRC) for review and action.

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

Urgent Care Access

For urgent, non-emergent conditions, EmblemHealth maintains a network of urgent care centers for all plan members. To access a list of participating urgent care centers, go to emblemhealth.com/find-a-doctor.

Update Your Practice Records

Your practice information appears in our network directories, including our online **Find a Doctor** tool. Keeping your information updated helps patients and physicians find your practice and helps us accurately process your claims. You must report updates to your practice information if any of the following changes occur:

- Ability to accept new members
- Age-range limitations applicable to the health care professional
- Add or delete a provider from your practice
- Board certifications
- Current and valid state (NJ, NY, CT, MA) licenses
- DEA or CDS certificate
- Email address
- Ethnicity
- Fax number
- Gender
- Hospital affiliations
- NYS Patient-Centered Medical Home (PCMH) or NCQA PCMH certifications
- IRS taxpayer identification number (TIN)
- Languages spoken by you or within your office
- Medicaid number is assigned
- Medical group affiliation
- Medicare number is assigned
- National Provider Identifier (NPI) number is assigned
- OB/GYN opts to see GYN-only patients
- Office hours
- Opening or closing a primary care panel
- Practice addresses
- Practice phone numbers used for scheduling patient appointments
- Billing information
- Specialties
- Taxonomy codes
- Wheelchair accessibility at a practice location

Providers and their staff can sign in to **emblemhealth.com/providers** to update their practice records under the Provider Profile tab unless the provider is **part of a group** with arrangements to send changes via a spreadsheet/dataset process. For changes that cannot be processed online, mail or fax your changes to EmblemHealth's 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 no later than five business days after any change to office address, telephone number, office hours, specialty, languages spoken, hospital affiliation, or addition/termination of an individual provider in a medical group. Updates to your practice information will be posted to the EmblemHealth website within 15 days. 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 does not affect previously submitted claims. EmblemHealth processes claims for a location with a date of service on or before the provider's termination date.

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 EmblemHealth's directories for accuracy and may impose fines and/or penalties for inaccurate information. Any fines/penalties or negative financial impact incurred by EmblemHealth due to a practitioner's failure to notify us of any required change listed above are charged to the practitioner in an amount equal to the fine/penalty.

Providers in our Enhanced Care Prime Network for Medicaid, HARP, and Essential Plans, must notify the New York State Department of Health of any change of address, telephone number, or other pertinent information within 15 days of the change. To update provider addresses and telephone information, providers must complete their designated **Change of Address** form. Each **Change of Address** form contains detailed instructions for submission based on provider type and license/registration address.

With respect to participation in Federal Employees Health Benefits (FEHB), providers and facilities must have in place business processes to ensure the timely provision of provider directory information to EmblemHealth:

1. when the provider or facility begins a network agreement with EmblemHealth,
2. when the provider or facility terminates a network agreement with EmblemHealth,
3. when there are material changes to the content of provider directory information,
4. upon request by EmblemHealth and
5. at any other time determined appropriate by the provider, facility or U.S. Department of Health and Human Services.

Change of Ownership

A change of ownership cannot be performed online; it is treated like a new enrollment. Providers must contact EmblemHealth when a change in ownership occurs. The appropriate contact information is located in the **EmblemHealth Contact Information** section of the **Directory** chapter.

Know Your Network Participation

The online **Find a Doctor** lists your network affiliations. We recommend you periodically review the information we have on file for you. We also encourage you to regularly share your network participation and any changes with your staff. If the network information on the member's ID card matches your network affiliations, then you are in-network for the member's benefit plan. See the **2025 Summary of Companies, Lines of Business, Networks, and Benefit Plans** and **2024 Summary of Companies, Lines of Business, Networks & Benefit Plans** in our Toolkit for a listing of all networks and plans.

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

Ask to see a member's ID card at each appointment, emergency visit, or inpatient stay for basic plan information. Providers should also verify member eligibility by signing in to **emblemhealth.com/providers** and using the Eligibility drop-down under the Member Management tab. A member ID card does not guarantee eligibility or payment.

Provider Data Validation

New York State and federal regulations require EmblemHealth to maintain the accuracy of its provider file data and ensure its Provider Directories meet basic information requirements. EmblemHealth validates the accuracy of a provider's service location data during both credentialing and recredentialing by reviewing the provider's data in CAQH Provider Data Portal. Providers are also contractually obligated to update their information with EmblemHealth. For additional guidance, please click **here**.

Note: Let us know if you stopped practicing obstetrics less than two years ago and we will update our records accordingly.

Medical Care Delivery System

EmblemHealth contracts with an extensive array of facilities and ancillary clinicians, including a network of prestigious teaching and community hospitals, skilled nursing facilities, and freestanding ambulatory care centers. EmblemHealth members have access to a network of thousands of contracted practitioners (including multi-specialty practices) who provide care in medical centers, their own community offices, and via telehealth.

EmblemHealth maintains a robust network of practitioners to meet the comprehensive and diverse health needs of its members. Practitioners are selected based on meeting criteria for credentialing, geographic standards for accessibility, compliance with the Americans with Disability Act, and cultural and linguistic competency.

In the event 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 arranges and authorizes, when appropriate, the use of a nonparticipating practitioner at no additional out-of-pocket expense to the member.

Additionally, coordination and continuity of care are provided for new EmblemHealth members and when physicians retire or are no longer able to provide the care needed for EmblemHealth members.

Contracted Vendors and Reporting Responsibilities

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

Medicaid and Child Health Plus Responsibilities to Government Agencies

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

All subcontractors, including practitioners, will perform all work and render all services in accordance with the terms of the agreement between EmblemHealth, NYSDOH, CMS, and accreditation agencies. Practitioners agree to comply with and be bound by the confidentiality provisions set forth in the above-referenced agreements. Any obligations and duties imposed on subcontractors, including participating practitioners, do not impair any rights accorded to Local Departments of Health (LDSS), NYSDOH, New York City Department of Health and Mental Hygiene (NYCDOHMH), U.S. Department of Health and Human Services (DHHS), CMS, or accreditation agencies.

Primary Care Practitioner/Primary Caregiver

It is important for primary care practitioners (PCPs) to establish a meaningful, professional, and lasting relationship with their patients. EmblemHealth encourages new members to contact their PCPs for an initial evaluation within 90 days of enrollment. If the initial contact with the practitioner is for an acute visit, the practitioner should recommend 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. If the member's benefit design requires a referral, the PCP must enter it into the provider portal. If the PCP or primary caregiver anticipates the need to refer a member for **services requiring a preauthorization**, including the use of a non-participating provider, the request must be approved by EmblemHealth in advance for consideration of payment for the care. A PCP may refer members with chronic, disabling, or degenerative conditions or diseases to a specialist for a set number of visits within a specified time. An EmblemHealth or managing entity medical director must approve standing referrals via the preauthorization process.

Credentialed advanced nurse practitioners (ANPs) may act as primary caregivers, maintaining their own panels 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 has the same coverage arrangement for hospital admissions at an EmblemHealth-contracted hospital. ANPs may submit to EmblemHealth either a written collaborative agreement or the **Advanced Nurse Practitioner Requesting Additional Status as Primary Caregiver** form.

For more information on how to become credentialed with EmblemHealth as a primary caregiver, see the **Credentialing** chapter.

Primary Care Practitioner Responsibilities

EmblemHealth-contracted PCPs are responsible for providing primary care services and managing all medically necessary health care services for their assigned members. PCPs help members stay healthy by supervising and coordinating all care with medical and behavioral health practitioners, and by 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, including but not limited to:
  - Routine preventive health screenings
  - Health counseling and advice
  - Physical examinations
  - Baseline and periodic 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 screenings (as appropriate) and referral to and coordination with appropriate services
  - Routine/urgent/emergent office visits for illnesses or injuries
  - Diagnosis and treatment of conditions not requiring the services of a specialist
  - Clinical management of chronic conditions not requiring a specialist
  - Hospital medical visits (when applicable)
  - Coordination of care
- Maintain appropriate coverage for members 24 hours a day, 7 days a week, 365 days a year as noted in the above section on 24-hour access.
- Maintain office hours not less than two (2) days per week, eight hours per day, at each primary care office.
- Maintain a current medical record for each patient.
- 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.
- Refer all members for services in accordance with EmblemHealth's referral policies and procedures. See the **Utilization and Care Management** chapter of this manual for more details.
- Provide services by 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.
- Arrange timely inpatient care, specialist consults, and diagnostics, including, but not limited to, laboratory/radiological services when medically necessary.
- 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 members and appropriate specialists.
- Coordinate the findings of consultants and laboratories and interpret such findings for the member/member's family subject to the HIPAA Privacy Rule.
- Consult and coordinate with members regarding specialist and behavioral health recommendations.
- Comply with the New York State **"Vaccines for Children Program,"** as appropriate, and with New York State and New York City requirements for reporting communicable diseases.
- Share information with members, addressing their goals, treatment options, and follow-up.

Primary Care Practitioner Selection, Assignment and Change Policy

When EmblemHealth members first enroll, they choose where they want to receive medical care. Members whose benefit design requires the selection of a PCP can choose any participating PCP with an open panel. A member can also be attributed to a group if a claim shows they have been cared for by a PCP in your practice. 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. A PCP cannot be his/her own or his/her family's primary care practitioner.

Medicaid members were previously automatically assigned to select provider groups. To be consistent with state policy, Medicaid members will now be automatically assigned to provider groups based on demographic and location needs beginning in 2024.

Members who fail to select a PCP within a given time frame 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 EmblemHealth's Customer Service departments or by logging on to **emblemhealth.com/members**. PCP changes take effect immediately upon request.

For those members who have obtained services from your practice but did not actively choose you as their PCP, the following process applies:

- EmblemHealth will run a monthly claims utilization report for members in all HMO lines of business with no assigned PCP to check for preventive visits, other evaluation and management (E&M) PCP visits, lab services referred by PCP, and prescriptions written by a PCP. If they have utilization with any of your PCPs, EmblemHealth will assign that member to your group as of the first of the month.
- EmblemHealth will run a quarterly claims utilization report to check utilization for all HMO members currently assigned to PCPs for all lines of business.
  - If a member continues to use PCPs in your practice, then they will remain attributed to your practice.
  - If a member previously cared for by a PCP in your practice receives care from a different practice, they will be assigned to that practice starting on the date of the first PCP visit with that other practice.
  - If a member does not have utilization with any PCP in your practice, they will no longer be attributed to your practice at the end of the quarter.

- Capitation payments will be impacted by these changes, and recoupments and additional payments may be initiated, as applicable.

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

Medicaid and Child Health Plus PCP Panel Size Limits

Practitioners treating members enrolled in Medicaid or Child Health Plus (CHPlus) have a maximum capacity limit of 1,500 members on their panel, or 2,400 members for a physician practicing in combination with a registered physician assistant or certified nurse practitioner. Advanced nurse practitioners credentialed as primary caregivers will have no more than 1,000 members on their panel. These member-to-practitioner ratios assume 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.

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 provider no longer participates in the network.
- Other circumstances exist that make it necessary to change providers.

The practitioner should provide at least 90 days prior written notice to **Provider Customer Service** indicating he/she will not continue as the member's practitioner. Provider Customer Service will coordinate with Member Services to notify the member.

Restricted Recipient Program (RRP) – Changing PCPs

Medicaid members in the Restricted Recipient Program (RRP) are limited as to when they can change PCPs. They may change PCPs for good-cause reasons such as:

- Provider no longer wishes to be the RRP member's provider.
- Provider closed servicing location or moved to a location not convenient to the RRP member.
- Provider no longer participates in the network.
- Member moved beyond 30 minutes or 30 miles from the RRP provider.
- Other circumstances exist that make it necessary to change providers.

Requesting Information for Continuity of Care

The member's new PCP should request all pertinent medical records from any other health practitioner providing care for the member. The following information should 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 if none were indicated
- Dosage and duration information regarding any prescription given
- Follow-up plan, as needed
- Childhood immunization records

Transitional Care When Practitioners Leave the Network

When a practitioner is terminated, EmblemHealth will:

- Notify affected members of a practitioner's termination:
  - Medicaid/HARP and CHPlus: At least 15 days from the date we become aware of the change in status.
  - Commercial: At least 30 days prior to the effective date.
  - Medicare: Beginning in 2024: At least 45 calendar days before the termination effective date for contract terminations that involve a primary care or behavioral health provider. For contract terminations that involve specialty types other than primary care or behavioral health, at least 30 calendar days before termination effective date.
- Provide the affected practitioner with a written notice explaining the reasons for the termination or suspension, as well as the right to request a hearing (see the Termination and Appeal section of the **Credentialing** chapter).
- Provide members with a transitional care period of 90 days from either the date of the notice or the effective date of termination, whichever is later, if the member is in an ongoing course of treatment; or for pregnant members, continuity of care will be provided for the duration of the pregnancy and for postpartum care directly related to delivery.

We make every effort to assist members when their practitioners terminate participation with one of our plans. Members who wish to continue an ongoing course of treatment with their current health care providers for a limited time must contact, or have their provider contact, their plan/managing entity. For more information on transitional care, see the Continuity of Care with Out-of-Network Providers - When Providers Leave the Network subsection of the **Utilization and Care Management** chapter.

If the practitioner is a primary care provider (PCP) and the member chooses to stay with the PCP during the 90-day transition period, the member must notify Customer Service of the new PCP who will manage their care after the transition. If the practitioner leaving the network is a specialist and the member chooses to stay with the specialist for the 90-day transition period, the member should choose a new specialist for care following the 90-day transition period or after the postpartum period.

Medical Specialists

EmblemHealth-contracted specialist physicians agree to see members referred by a participating PCP, except when members are seeking services to which they are permitted to self-refer, or when a member's benefit design does not require the selection of a PCP. (See the Direct Access (Self-Referral) Services section of this chapter.)

Specialists should make note of the scope of the referral and refer the member back to the referring PCP for continuation of care. 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 is referred to a specialist, the specialist is responsible for diagnosing the member's clinical condition and/or managing treatment of the condition, up to the number of visits identified on the referral authorization. The scope of services rendered is limited to those related to the clinical condition for which the PCP refers the member.

When providing specialty care, the practitioner must:

- Keep the PCP informed of the member's general condition through 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/her designee) and emergency care
- Deliver all medical health care services available to members with self-referral benefits

OB/GYN specialists may see members without referral or prior approval 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 Preauthorization Procedures section in the **Utilization and Care Management** chapter.

Nurse Practitioner and Physician Assistant Services

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 is made to the NP 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.

NP Covered Services

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

- Considered physician's services otherwise 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 an MD/DO
- Not otherwise precluded from coverage because of statutory exclusions

NPs 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.

NP 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, 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.

Physician Assistant Services

The professional services of a Physician Assistant (PA) may be covered in-network if they are contracted, meet qualification for PAs, and 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 is made to the PA 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.

PA 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

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 involving an independent evaluation or treatment of the patient's condition.

PA 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 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.

PA 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.

Direct Access (Self-Referral) Services

EmblemHealth Members

EmblemHealth members can self-refer to network providers for the following services 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, and acute gynecological condition
- At least 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/care 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.)
- 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, including:

- Annual mammography screening
- Annual routine eye exam
- Colorectal cancer screening
- Glaucoma screening, if at high risk
- HIV screening
- Influenza and pneumococcal vaccine
- Initial chiropractic assessment
- Outpatient mental health visits
- Nutrition therapy services
- 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.

Medicaid and Child Health Plus Members (CHPlus)

In addition to the above services to which all EmblemHealth members have direct access, there are some services that members in state-sponsored programs (Medicaid and CHPlus) may also self-refer. Unless otherwise indicated, members in all state-sponsored programs may self-refer to the services outlined in in **Section 10.15 of the Medicaid Managed Care Model Contract**:

1. Mental Health and Chemical Dependence Services
2. Vision Services
3. Diagnosis and Treatment of Tuberculosis
4. Family Planning and Reproductive Health Services
   Note: **Federal regulations** require patient consent forms and paper claims for hysterectomy and sterilization procedures for Medicaid members. For more details, see **Claims Corner** at **emblemhealth.com**.
5. Article 28 Clinics Operated by Academic Dental Centers

Routine Voluntary HIV Testing

In New York State, voluntary HIV testing is part of routine medical care. Additionally, New York State public healthlaw 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 non-life-threatening condition, whether in a hospital, emergencyroom, or primary care setting such as a doctor's office or outpatient clinic. For a summary of changes in the law, see **HIV Testing, Reporting and Confidentiality in New York State 2017-18 Update**. (Current as of Feb. 19, 2020)

Informed Consent

Patients must be provided information about HIV either orally, in writing, or through other means. The patient must be informed that HIV testing will be conducted. The patient can decline the HIV test, which must be noted in the patient's medical record. The law no longer requires patients to give written or verbal informed consent for a HIV test. The practitioner must counsel the patient on **important points to know about HIV testing** .

Treating HIV/AIDS

Visit the **Clinical Corner** at **emblemhealth.com** for clinical practice guidelines for the treatment of HIV/AIDS.

Hepatitis C Testing

A hepatitis C screening test must be offered by PCPs regardless of the setting and without regard to board certification. This includes physicians, physician assistants, and nurse practitioners. Emergency Departments are not required by law to offer hepatitis C testing but are encouraged to do so. Every individual born between 1945 and 1965 must be offered a hepatitis C test.

If the test is reactive, the provider must offer follow-up health care, or refer to a provider who can provide follow-up care. Follow-up care must include a hepatitis C diagnostic test (HCV RNA).

For more information on hepatitis C, visit the **New York State Department of Health** website.

Newborn Access to Care

EmblemHealth Medicaid Newborns

Newborn children of mothers enrolled in EmblemHealth's Medicaid plans are automatically enrolled in the mother's plan. These newborns receive all benefits and services of the plan beginning on their date of birth. All members should call EmblemHealth's Customer Service department to provide their newborn's name, sex, date of birth, birth weight, and birth hospital so we can complete the enrollment process. Once enrolled, the newborn is issued a member ID card.

Note: Enrollment could be delayed for several reasons. Therefore, if a newborn presents for care without an ID card, but the mother is an active Medicaid member on the date of the baby's birth, care must be rendered. Practitioners should call EmblemHealth's **Provider Customer Service** to verify eligibility.

EmblemHealth Child Health Plus

If a CHPlus member gives birth, the parent must complete an application for the newborn. There is no automatic enrollment in CHPlus. 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 with expertise in caring for medically fragile children. This ensures children with co-occurring developmental disabilities receive services from appropriate providers. Network providers refer to appropriate network community and facility providers to meet the needs of the child or seek authorization for out-of-network providers when participating providers cannot meet the child's needs. For more information, see the Preauthorization Procedures section of the **Utilization and Care Management** chapter.

Telehealth Services

Telehealth is the use of electronic information and communication technologies by a health care provider to deliver health care services to an insured individual who is located at a site different than where the health care provider is located. Covered evaluation and management services in a face-to-face setting are equally covered when the same services are delivered using telehealth and are in accordance with the member's benefits. For more information, see the **Telehealth Medical Policy**.

Telehealth Monitoring

EmblemHealth members enrolled in either a Medicaid or Medicare-Medicaid plan can access telehealth services from approved home health care agencies if the members are assessed and meet specific criteria. Only home care agencies approved by Medicaid as providers of telehealth are authorized to provide telehealth monitoring.

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 to obtain prior approval to provide telehealth services as a covered benefit. EmblemHealth covers 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 evaluation may include a review of the original assessment or we may request a new assessment.

The home health care agency may 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 documents the following about 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, medication side effect, ormedication adverse effect
- 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

EmblemHealth Neighborhood Care

EmblemHealth Neighborhood Care offers our plan members and other community members a place to receive the personalized, one-on-one support of experts in clinical, benefit, and health management solutions. Neighborhood Care does not provide medical services. Instead, they help practitioners manage patient care by supporting the primary practitioner-patient relationship. Both in-person and telephonic contact is available at multiple locations, many of which are located with the ACPNY practice sites. For more information, visit **emblemhealth.com/Neighborhood**.

Disclosure

EmblemHealth will not prohibit or restrict any practitioner from disclosing to any member, patient, or designated representative any information the practitioner deems appropriate regarding a member's condition or course of treatment, including the availability of other therapies, tests, medications, etc., regardless of benefit coverage limitations. EmblemHealth will 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 will not be prohibited from discussing the risks, benefits, and consequences of treatment (or absence of treatment) with the member, patient, or designated representative. Patients will have the opportunity to refuse treatment and to express preferences about future treatment decisions.