EmblemHealth

Chapter 17: Utilization and Care Management

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Chapter Summary

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

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

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

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

Who Conducts Utilization Management

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

- Those who have full responsibility for managing a population of members are called Managing Entities. EmblemHealth itself (also referred to as HIP and EmblemHealth Plan, Inc. formerly GHI) and its affiliated ConnectiCare companies are Managing Entities as well as the organizations we have authorized to manage our member's care. The current Managing Entities include:
  - ConnectiCare
  - EmblemHealth (also referred to as HIP or EmblemHealth Plan, Inc. formerly GHI))
  - Health Care Partners (HCP)
  - SOMOS
- The applicable Managing Entities information can be found:
  - On member ID cards: Logos for our Managing Entity partners are shown on the bottom left-hand corner of the front of the Member ID cards. Their contact information may be found on the back of the

card. See the **Member Identification Card** chapter of this manual for sample cards.
  - In the secure **provider portal** under the Member Management tab and Eligibility drop-down, or under the Preauthorization tab and Preauthorization Lookup Tool drop-down.
- Delegated vendors for special Utilization Management programs. These vendors have partnered with us to oversee a certain set of services for all or a sub-set of our members. Please see the applicable guide or manual chapter for details on members and services covered and processes for requesting pre- and post-service reviews.
  - Carelon Behavioral Health
    - **Behavioral Health Services**
  - Prime Therapeutics
    - **Pharmacy Utilization**
  - eviCore
    - **Cardiology Imaging Program**
    - **Durable Medical Equipment**
    - **Radiation Therapy Program**
    - **Radiology Program**
  - OrthoNet
    - **Spine Surgery and Pain Management Therapies Program**

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

Utilization Management Policy & Clinical Criteria

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

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

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

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

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

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

Medical Appropriateness Review
The purpose of medical appropriateness review is to ensure:

- All inpatient and outpatient care is medically necessary
- All care occurs in the appropriate setting
- Services and treatment are ordered and provided, whenever possible, by network providers

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

Types of Utilization Reviews & Determination Time Frames

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

Preauthorization

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

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

If a service is not medically necessary or appropriate based on a review of the clinical findings, the medical director may make the decision to deny coverage of a service for the episode of care.

The requesting physician is notified by telephone when we decide to deny coverage of a service or further service for an episode of care. The treating physician is given the opportunity to complete a peer-to-peer review with the medical director regarding the denial.

In addition to the phone calls and letters, providers can access the status of a preauthorization request, and the determination made, when they sign in to **emblemhealth.com/providers** and use the Search Preauthorization drop-down under the Preauthorization tab.

Concurrent

We must make a determination if a concurrent approval is warranted and notify the member and provider by phone and in writing. The determination must be made within one (1) business day of receipt of the necessary information. In addition to the phone calls and letters, providers can access the status of a case when they sign in to **emblemhealth.com/providers** and use the Concurrent Review Status Report drop-down under the Preauthorization tab.

If the review does not meet medical necessity criteria, the concurrent review nurse reviews the case with an EmblemHealth medical director who renders a decision. Whether the stay is approved or denied as not medically necessary, the concurrent review nurse notifies all applicable parties (i.e., the attending physician, the facility, and the member) by telephone and in writing (which may include secure email) within one (1) business day of receipt of all necessary information of a determination.

If a service, or continued use of a service, is not medically necessary or appropriate based on a review of the clinical findings, the medical director may make the decision to deny coverage of a service or further service for the episode of care.

We also notify the facility of a determination that results in a denial of coverage or of a further service for an episode of care. The facility is also given the opportunity to complete a peer-to-peer discussion with the medical director about the denial.

Retrospective

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

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

If a service or continued use of a service is not medically necessary or appropriate based on a review of the clinical findings, the medical director may make the decision to deny coverage of a service or further service for the episode of care.

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

Reconsideration/Peer-to-Peer Process

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

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

Note: This process applies to Medicare members ONLY when the requested service denied was in a participating inpatient acute facility and the denial was issued concurrently or retrospectively. All Medicare pre-service denials

and all Medicare out-of-network denials, as well as any Medicare denials for other places of service, remain excluded from this process. The member/provider must continue to file an appeal or request a Medicare Reopen. An actual appeal must be submitted for Medicare members or a request for a Medicare Reopening. See the Medicare Reopening subsection of the **Dispute Resolution for Medicare Plans** chapter for more information.

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

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

Referral Procedures - Practitioners

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

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

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

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

How to Make a Referral

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

OB/GYNs Referring to Specialists

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

- Diagnostic mammography (Screening mammography does not require a referral or preauthorization. *)
- Diagnostic radiology and imaging (includes diagnostic imaging, diagnostic radiology, radiology, and magnetic resonance imaging**)

- Gynecologic oncology
- General surgery
- Infertility specialists
- Lamaze (No referral is necessary for Medicaid members.)
- Maternal and fetal medicine
- Neonatal/perinatal medicine
- Pediatric cardiology for fetal studies
- Radiation oncology (includes diagnostic radiological physics, radiation oncology and therapeutic radiology)
- Reproductive endocrinology

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

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

Specialists Referring to Specialists

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

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

*See the **Radiology Related Programs** in Clinical Corner.

Referral Duration

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

REFERRAL DURATION		
REFERRAL TYPE	**MAXIMUM # UNITS/VISITS**	**DURATION**
EmblemHealth Medicare HMO and HIP Plans		
Allergy Testing	12	90 days*
Chemotherapy	20	90 days*
Consultation	1	180 days
Consultation, Follow-up, Testing	6	180 days
Consultation, Follow-up, Testing, Treatment	6	180 days
Consultation, Follow-up, Treatment	6	180 days
Diagnostic Lab/X-Ray	1	45 days*
Radiation Therapy (see the **Radiology Related Program** chapter for more information)	Varies by treatment	Varies by treatment
Speech Therapy	10	10 visits within 30 days
HIP Plans		
Chiropractic Services	1	1 visit within 30 days
HIP Plans		
Rehabilitation (Outpatient PT/OT)	8	8 visits within 90 days

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

Consultation Reports

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

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

- **If emergent:** A consultation report is issued immediately following the visit by means of telephone or fax communication, with the written summary mailed to the referring physician within 24 hours of the visit.
- **If urgent:** A consultation report is issued within 24 hours of the visit.
- **If routine:** A consultation report is issued within five (5) to seven (7) business days after the visit.

All consultation reports contain at least the following information:

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

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

Second Opinions

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

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

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

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

Continuity of Care: Special Situations Requiring Preauthorization

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

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

Standing Referrals

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

Specialists as PCPs

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

Specialty Care Centers

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

Use of Out-of-Network Providers

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

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

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

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

- Medicaid Managed Care Model Contract
- OHIP Principles for Medically Fragile Children
- EPSDT, HCBS, and CFCO rules; and with consideration for extended discharge planning
- Child Teen Health Program (CTHP)
- Office of Children and family services (OCFS)

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

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

Services Requiring Preauthorization

- Pre-service reviews (preauthorizations) are administered by the Managing Entity on the member ID card or by the vendor managing a utilization program on our behalf.
  - See the Clinical Corner at **emblemhealth.com/providers** for the **Preauthorization Lists** and a

Preauthorization Check Tool.

- For children placed in foster care, preauthorization requirements are currently being reviewed for several services including the services provided by the **29-I Health Facilities**. It is anticipated that by 07/01/2021, the list will reflect that no preauthorization will be required for these services.
- Specifically, for “Other Limited Health -Related Services” such as Neuropsychological testing as of 04/01/2021 and any mandated assessments will be auto-approved so no preauthorization will be required. Additionally, Core Limited Health Related Services will not require preauthorization.

- Preauthorization is not required for emergency admissions.
  - However, EmblemHealth and the Managing Entities must be notified within 24 hours of the admission.
  - Services are reviewed for medical necessity following notification and submission of clinical information.
  - See **Emergency Admission Procedures** under **Hospital and Facilities** section of this **chapter**.

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

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

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

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

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

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

Preauthorization for Anticipated Care of Maternity Patients

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

Preauthorization for Infertility Services

EmblemHealth provides coverage for infertility services in accordance with New York State law and the member’s benefits. For more information, visit Medical Policies. and use the **Infertility Treatment Form.**

Preauthorization for Midwifery Services

The services of a midwife are covered for all our benefit plans. Preauthorization is required for all HIP members.

For GHI members, preauthorization is only required if the midwife is not a network participant.

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

Additional Preauthorization Procedures for GHI Practitioners

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

- Patient characteristics such as age, gender, height, weight, vital signs or other historical and physical findings pertinent to the condition proposed for treatment
- Precise information confirming the diagnosis or indication for the proposed medical service
- Details of treatment for the index condition, or any related condition, including names, doses, and duration of treatment for pharmacotherapy, and/or detailed surgical notes for surgical therapy
- Appropriate laboratory or radiology results
- Office or consultation notes related to the proposed medical service
- Peer-reviewed medical literature, national guidelines, or consensus statements of relevant expert panels
- Applicable CPT-4 and ICD diagnosis codes
- Complete facility and service information

Continuity of Care With Out-of-Area Providers

Continuity/Transition of Care - New Members

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

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

If the member has entered her second or third trimester of pregnancy, she may continue to see the nonparticipating practitioner through delivery, and postpartum care for up to 12 months, for care related to the delivery.

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

1. A condition during ongoing course of treatment with an out-of-network provider
2. Member is pregnant (up to 12 months postpartum)

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

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

1. Accept our reimbursement rates as payment in full
2. Adhere to our **Quality Improvement Program**
3. Provide medical information related to the enrollee's care
4. Otherwise adhere to our policies and procedures including those regarding referrals and obtaining preauthorizations and a treatment plan approved by our applicable preuthorization department (see the **Who to Contact for Preauthorization** section in the **Directory** chapter)
5. Continue treatment for an appropriate period (based on transition plan goals)
6. Share information about the treatment plan with the organization
7. Continue to follow the organization's UM policies and procedures
8. Charge only the required copayment

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

Continuity of Care - Medicaid Children

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

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

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

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

Management, or the delegate. Utilization Management contacts Care Management to review POC deviations and discuss any adjustments to either service delivery or the POC.

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

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

Continuity of Care Children in Foster Care

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

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

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

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

Continuity of Care for Long-Term Services and Support Services (LTSS)

For enrollees transitioning from Medicaid fee-for-service and were already receiving LTSS, EmblemHealth continues to authorize covered services in accordance with the most recent POC for at least 90 days. Service frequency, scope, level, quantity, and existing providers at the time of the transition remain unchanged (unless such changes are requested by the enrollee, or the provider refuses to work with EmblemHealth) for no less than 90 days.

EmblemHealth care management ensures there are no lapses in authorizations and to continue an ongoing course of treatment by the provider during a transitional period of up to ninety (90) days. For enrollees where a medical order is needed but cannot be obtained, EmblemHealth care management will work with the provider agency to arrange safe discharge, which may be to a higher level of care. During the 90-day transitional period, EmblemHealth care management must obtain needed documentation (physician's order, M11Q, etc.) and arrange for appropriate assessments so that a new care plan can be established, and service authorizations can be issued.

Once the 90-day transitional period has ended, based on a new assessment, care management will issue a new service authorization determination. Should there be any changes to the frequency, scope, level, and quantity of services authorized, at least a 10-day notice will be provided by care management before the effective date (on a

non-working day) of any reduction or termination of services, regardless of the end of the original authorization period.

Continuity/Transition of Care - Benefits Exhausted or Ended

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

Continuity of Care - When Providers Leave the Network

When a member's health care practitioner leaves the EmblemHealth network, the member is given the option of continuing an ongoing course of treatment with their current practitioner for a transitional period of up to 90 days from either the date of the termination notice or the effective date of termination, whichever is later, if the member is in an ongoing course of treatment; If the member is pregnant, they may be able to continue to receive care from their current PCP or specialist through the duration of the pregnancy and postpartum care directly related to delivery.
Members who wish to continue seeing their current health care practitioner for a limited time must contact, or have their provider or practitioner contact, the appropriate preauthorization department (see the **Who to Contact for Preauthorization** section in the **Directory** chapter).
EmblemHealth permits a member to continue with their current practitioner if the reason for leaving is not related to imminent harm to patients, to a determination of fraud, or to a final disciplinary action by a state licensing board that impairs the health professional's ability to practice. The practitioner must agree to all the following:

1. Continue to accept, as payment in full, reimbursement from EmblemHealth (or managing entity) at the rates applicable prior to the start of the transition period and the in-network cost-sharing from the member.
2. Adhere to EmblemHealth's quality assurance requirements and provide us with necessary medical information related to such care.
3. Adhere to our policies and procedures including, but not limited to, procedures for referrals, obtaining preauthorization, and treatment plan approval.
4. Continue treatment for an appropriate period (based on transition plan goals).
5. Share information about the treatment plan with the organization.
6. Continue to follow the organization's utilization management policies and procedures.
7. Charge only the required copayment.

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

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

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

Out-of-Area Students

We recognize the challenges for full-time students when health care needs arise while away at school. Special

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

Laboratory Services

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

In-Office Testing List

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

Members whose care is managed by HealthCare Partners (HCP) may not have their lab tests administered in a practitioner's office, even if the members are in one of the above-listed benefit plans. (To confirm eligibility, check the member's ID or sign in to **emblemhealth.com/providers** and use the Eligibility drop-down under the Member Management tab.)

Hospital and Facility Procedures

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

In-Hospital Services

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

Elective Inpatient Procedures - Admitting Physicians

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

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

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

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

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

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

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

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

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

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

Emergency Admission Procedures

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

1. Contracted hospitals may notify EmblemHealth electronically of all admissions through the emergency room by signing in to **emblemhealth.com/providers** and using the Create ER Notification drop-down under the More tab. Benefits of electronic notifications are:
    - 24/7 access.
    - Automatic date/time-stamped receipt immediately sent back as proof of the notification.
    - Immediate confirmation of member eligibility.
    - Automatic and immediate routing of cases managed by another entity on EmblemHealth's behalf; includes date/time stamp of notification to EmblemHealth.
    - PCP name and contact information provided.
    - Ability to follow status of inpatient case when signing in to **emblemhealth.com/providers** and using the Concurrent Review Status Report drop-down under the Preauthorization tab. As soon as a notification is submitted, an inpatient case is created and assigned the same trace number referenced on the ER Admission Notification Receipt. For HIP-managed members, hospitals may use the trace number to find the inpatient case using the preauthorization inquiry features. All cases appear in a pended status until all necessary information is received and concurrent review is performed.
2. Contracted hospitals may notify EmblemHealth of emergency admissions for HIP and Medicare HMO

members by calling **866-447-9717.**

3. Contracted hospitals may notify EmblemHealth for GHI EPO/PPO and EmblemHealth EPO/PPO plans by calling **800-223-9870.**

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

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

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

Out-of-Network Facility Admissions

Admissions to out-of-network facilities in or out of the service area are monitored by telephonic review on a concurrent basis by the Managing Entity listed on the member's ID card. If the member is stable and needs ongoing care, a transfer may be initiated to facilitate the return of the member to care within the primary delivery system.

Inpatient Transfers Between Hospitals/Acute Care Facilities

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

Managing Entity/Members Phone	Phone	Fax
EmblemHealth for HIP members	**866-447-9717**	
EmblemHealth for Non-City of New York members and GHI retirees	**800-223-9870**	
GHI PPO City of New York members and non-Medicare eligible retirees with GHI PPO benefits, contact Anthem Blue Cross and Blue Shield (formerly known as Empire BCBS)	**800-521-9574**	
HealthCare Partners (HCP)-managed members	**800-877-7587**	**888-746-6433**

When contacting us, have the following information available:

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

- Reason for transfer

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

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

Concurrent Review (Non-DRG Inpatient Stays)

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

Concurrent Review (DRG Inpatient Stays)

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

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

Concurrent Review Status Report

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

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

Commercial/Child Health Plus

When a claim is submitted for an admission through the emergency department without having received timely notification, records are requested from the facility for an initial retrospective clinical review by the Post-Service

Review department. The facility is given 30 days to submit the records. If records are received within 45 calendar days from receipt of request, they are reviewed for medical necessity. A decision is made and communicated to the provider and the member in writing within 15 calendar days of receipt of the requested clinical information. If the case is denied (in whole or in part), appropriate appeal rights are included in the communication.

Medicaid/Medicare

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

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

Retrospective Utilization Review

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

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

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

Discharge Planning

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

Readmission Policy

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

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

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

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

Medicare Outpatient Observation Notice MOON

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

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

All hospitals and CAHs are required to provide this statutorily required notification. Instructions are available at: **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html**

Skilled Nursing Home or Rehabilitation Facility Procedures

For more information, see the **SNF IRF LTAC** chapter.

Prior to Admission

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

For all admissions, the SNF should check member eligibility, benefits and preauthorization. Sign in to **emblemhealth.com/providers** and use the Member Management and Preauthorization tabs, or contact the member's Managing Entity as listed on the back of the member's ID card.

At the Time of Admission

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

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

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

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

Concurrent Review

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

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

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

Treatment Course Extension

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

Benefit Extensions

You may submit a benefit extension request by signing in to **emblemhealth.com/providers** and using the Request Benefit Extension drop-down under the Preauthorization tab.

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

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

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

Permanent Placement Process for Medicaid Members

If a Medicaid member needs long-term residential care, the facility is required to request increased coverage from the Local Department of Social Services (LDSS) within 48 hours of a change in a member's status via submission of the DOH-3559 (or equivalent). The facility must also submit a completed Notice of Permanent Placement Medicaid Managed Care (MAP) form within 60 days of the change in status to the LDSS. The facility must notify EmblemHealth of the change in status. If requested, the facility must submit a copy of the MAP form to EmblemHealth for approval prior to the facility's submission of the MAP form to the LDSS. **Payment for residential care is contingent upon the LDSS' official designation of the member as a Permanent Placement Member.**

Specialist Referrals

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

The care manager responsible for authorizing continued stay can also coordinate specialty and transportation services needed by the member. The HMO member's PCP or the attending physician in the SNF is responsible for coordinating all medical care provided to the member at the SNF. If the PCP is coordinating the care, the SNF staff should keep the PCP informed of the patient's health status. To obtain the PCP's contact information, sign in to

emblemhealth.com/providers and use the Eligibility drop-down under the Member Management tab, or call the member's Managing Entity..

Hospital Transfers

If an emergency occurs, the facility should take all medically appropriate actions to safely transport the member to the nearest hospital, including the use of an ambulance, if necessary. The Managing Entity must be notified when a member temporarily leaves and returns to a SNF, such as when the member is readmitted to the hospital.

Discharge Planning

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

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

If a member appeals the end-of-stay decision through IPRO, the SNF is responsible for sending the medical records to IPRO by the end of the day on which they were requested. IPRO is open seven (7) days a week to take appeal information.

Medicare Member Notices of Non-Coverage

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

Ambulatory Surgery Facility Procedures

Prior to Procedure

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

The facility must confirm a preauthorization has been issued for HIP and Medicare HMO members by signing in to

emblemhealth.com/providers and using the Search Preauthorization drop-down under the Preauthorization tab. For all other members, call **Customer Service** as indicated in the **Directory** chapter. EmblemHealth does not issue a preauthorization and/or case number until the admission or procedure has been reviewed and either approved or denied.

At the Time of Procedure

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

- Member ID number
- Member name
- Procedure date
- Diagnosis
- Clinical information supporting the medical necessity of the procedure
- CPT codes for the requested procedure

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

Ambulatory surgery facilities must verify member eligibility and check the status of a preauthorization request. Sign in to **emblemhealth.com/providers** and use the Member Management and Preauthorization tabs, or call Customer Service as indicated in the **Directory** chapter for EmblemHealth-managed members.

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 care) Medicare fee-for-service. For Medicare members receiving hospice services, EmblemHealth provides benefits for services not related to the terminal illness. Medicare members may revoke their hospice election at any time and return to EmblemHealth to receive care related to their terminal illness.

Electing Hospice

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

Although the treating physician is responsible for arranging hospice services for the patient, EmblemHealth continues to coordinate all non-hospice-related services (i.e., those not related to the terminal illness for the

Commercial, Medicaid, Child Health Plus or Medicare member). To better service our members, we need to have a copy of the signed Hospice Election Form and/or Hospice Revocation Form submitted to EmblemHealth's Care Management department. The form(s) should include the member's name and the plan ID number.

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

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

Preauthorization for Admission to Hospice Agencies or Inpatient Facilities

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

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

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

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

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

Care Provided During Hospice Election Period

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

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

Hospital Transfers

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

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

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

Case Management Process

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

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

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

In-home Palliative Care Services

Aspire Health's in-home palliative care services is one of the interventions we started offering **Jan. 1, 2023**, with no cost-sharing to eligible members.* Aspire Health uses its proprietary algorithm to identify EmblemHealth members with serious illnesses who could benefit from palliative care. Someone from Aspire Health will reach out to the identified members to offer their services. If the offer is accepted, Aspire Health will notify the member's practitioner(s).

Aspire Health will follow the practitioner's preferences and protocols for communicating about their patients and coordinating their care. This way practitioners can focus on addressing the underlying illness while Aspire Health makes the patient comfortable. It has a robust data collection system that allows it to track and report to practitioners their patients' status and quality metrics using a summary of every visit.

Aspire Health's teams include clinicians — doctors, nurse practitioners, nurses — plus social workers, chaplains, and patient care coordinators. They are on-call for patients and their families 24 hours a day, seven days a week. Aspire Health clinicians can prescribe medicines and provide needed support to manage symptoms, such as pain, difficulty breathing, fatigue, nausea, and difficulty sleeping.

Aspire Health's team provides experienced, compassionate "eyes and ears in the home." This can provide useful insight to our practitioners into one of the key factors that influences health – a patient's living situation.

*The following members are excluded from this program:

- Those with Administrative Services Only (ASO) or City of New York PPO plans.
- Members in Dual Eligible Special Needs Plans (Medicare D-SNP).
- Members managed by Health Care Partners and CityBlock.

Case/Care Management Program

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

Care Management Programs

EmblemHealth Care Management programs' overarching goal is to help patients with chronic or complex conditions manage and improve their health. To achieve that aim, our Care Management programs are designed to:

- Increase member satisfaction
- Encourage patient engagement
- Promote more primary care/preventive care visits
- Reduce the use of acute care services, including hospitalization
- Reduce duplication of services and streamline care coordination
- Assist providers in meeting quality goals

Other Health and Wellness

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

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

Experimental/Investigational Services and Medical Technologies

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

We also have a Technologies & Bioethics Committee composed of an interdisciplinary team of medical

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

Delineation of Responsibility

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

Board of Directors

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

Care Management Committee

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

Chief Medical Officer/ Medical Directors

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

Utilization and Care Management Department(s)

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

Clinical Personnel

Qualified health care professionals supervise utilization review decisions using procedures for preauthorization and concurrent review. Licensed nurses and other licensed health care professionals, in conjunction with the

medical directors when appropriate, provide clinical and appropriateness review of referral for patient services based on accepted criteria. Data acquisition and utilization outcomes, trends, quality of care issues, and over and under-utilization statistics are reported to the Care Management Committee.

Maintenance of Records

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

Reporting and Intervention

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

Risk Identification and Management

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

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

Conflict of Interest Policy

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