2018 Plan News & Regulatory Reminders

A message from Karen Ignagni

President and Chief Executive Officer, EmblemHealth

As your partners, we are committed to supporting the work you do every day to keep our members healthy and happy. We know it is you who see our members most often, and it is your guidance in which they place their trust. In short, you are an invaluable member of our team. You are uniquely positioned to positively impact our members' satisfaction, and the quality of their overall care and well-being.

Every year, we focus on achieving high performance in Medicare Star Ratings and the Healthcare Effectiveness Data and Information Set (HEDIS) scores. These surveys include questions about our members' experiences with health care professionals and their health plan. The feedback our members provide on ease of booking an appointment and wait times, for example, impacts these scores.

The most important part of our focus on these scores is that we are continuing to live our mission—creating healthier futures for our customers and communities. Living this mission means meeting our members where they are, and providing an experience that is positive and meaningful. The work we do together is critical to our success.

We look forward to working with you on perfecting the basics, and finding innovative new ways to keep the satisfaction of your patients and our members at the forefront of the changing health care landscape.

Karen Ignagni
President and Chief Executive Officer

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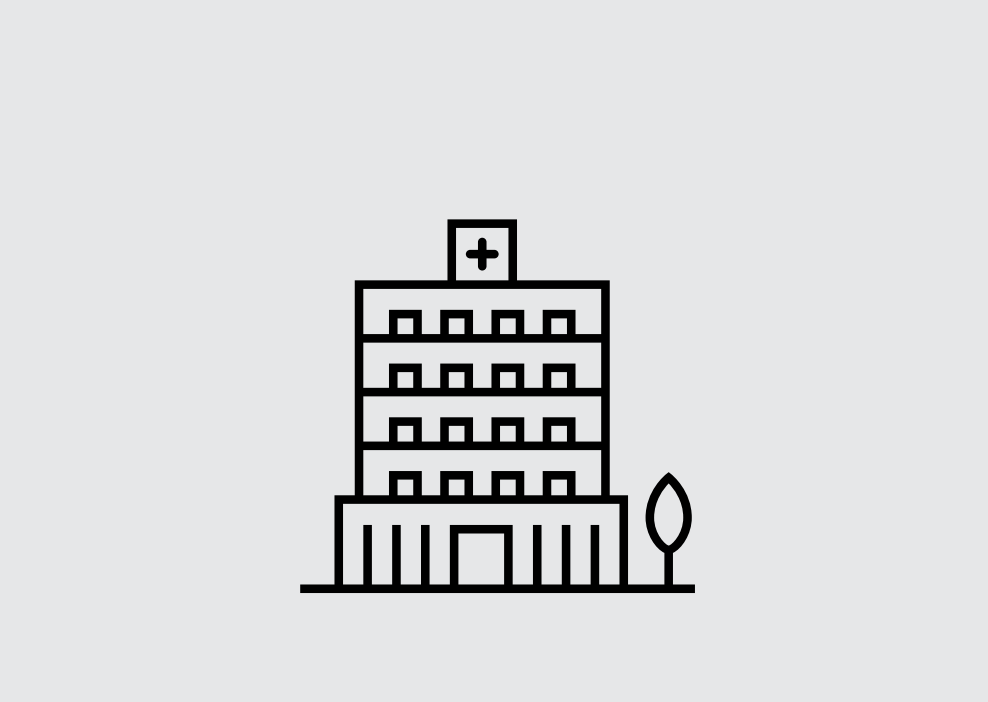
EmblemHealth®

Introducing Centers of Excellence



Hospital for Special Surgery & Memorial Sloan Kettering Cancer Center

EmblemHealth has established new partnerships to offer our members care at our Centers of Excellence.

Members who have serious injuries or illnesses related to cancer or orthopedics (musculoskeletal conditions) will have access to the Hospital for Special Surgery (HSS), the top-ranked orthopedic hospital in the nation, and Memorial Sloan Kettering Cancer Center (MSK), one of the country's leading cancer centers. The National Cancer Institute (NCI) has designated MSK as one of three Comprehensive Cancer Centers in New York State. There are a total of 49 NCI-designated Comprehensive Cancer Centers in the U.S.

We'll share more information with you and our members about how to access these services in the coming months.

Section 1: 2018 Recap and regulatory reminders

Medicaid, HARP, Child Health Plus, and Medicare programs

Medicaid/HARP/Child Health Plus

Provider enrollment in fee-for-service Medicaid program

All Medicaid Managed Care, Health and Recovery Plans (HARP), and Child Health Plus (CHP) providers must enroll with state Medicaid programs. The enrollment requires you to include information such as your name, Social Security number, and state license or certification number.

As a result of this mandate, EmblemHealth has updated its credentialing requirements. All health care professionals who participate in our Enhanced Care Prime Network for Medicaid and HARP members and/or Prime Network for our Child Health Plus members need to enroll with New York State Medicaid.

Medicaid

Support Medicaid recertification

To avoid losing benefits, remind Medicaid members to recertify two months before their Eligibility End Date. Anticipated end dates can be found on the Eligibility Detail screen in the provider portal and on the PCP Roster.

If your Medicaid patients have questions about the renewal process or want help in completing the renewal application, they can call us at **888-432-8026**.

Medicaid (continued)

Medicaid fee schedule updates

EmblemHealth updates its systems with the Medicaid fee schedules released by the New York State Department of Health (NYSDOH) via eMedNY. These updated fee schedules are used to calculate payments to providers who are reimbursed based on the Medicaid fee schedule. Once we receive it, it's our policy to load, test, and make it available to pay claims within 60 days. After the load date, claims received are paid using the updated fee schedule, if applicable. For claims submitted before the load date, no retroactive adjustments will be made.

Statewide Patient-Centered Medical Home incentive payment program — revised incentive payments and billing guidance

Effective May 1, 2018, in accordance with the 2018-2019 enacted state budget, New York State (NYS) Medicaid changed the reimbursement amounts for providers working at practices recognized as a Patient-Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA). The changes outlined in this policy reflect the standards and PCMH incentive payment amounts that were agreed upon as part of the enacted budget. It applies to both Medicaid Managed Care (MMC) and Medicaid Fee-For-Service (FFS). This revised policy is in response to the fiscal constraints of the current Medicaid Global Spending Cap on the PCMH incentive payments, and state efforts to increase participation in the PCMH program.

Given the growth of the PCMH program, NYS Medicaid tries to reward primary care providers (PCPs) who achieve PCMH recognition and provide high-quality care to New York Medicaid members.

Visit Claims Corner at **emblemhealth.com/Providers/Claims-Corner** to see the summary table by provider type and recognition status, the MMC per-member, per-month (PMPM) amounts, and the FFS "add-on" amounts for visits with qualified evaluation and management codes for the period of May 1, 2018 through June 30, 2018.

Restricted breast cancer surgery facilities for Medicaid recipients

NYSDOH policy requires Medicaid recipients to get mastectomy and lumpectomy procedures for a breast cancer diagnosis at high-volume facilities. Prior authorization requests and claims for mastectomies and lumpectomies submitted by low-volume facilities for our Medicaid members will be denied. The list of restricted low-volume facilities is updated annually. To see the current list, visit the NYSDOH website at **health.ny.gov/health_care/medicaid/quality/surgery/cancer/breast/no_contract.htm**.

Revision in Hepatitis C prescriber requirements

In March 2018, Governor Cuomo announced the first state-level strategy to end the hepatitis C virus (HCV) in New York State. This strategy includes efforts to increase access to medications and treatment. The HCV direct-acting antiviral (DAA) prescriber experience and training clinical criteria implemented by the NYSDOH will no longer utilize the Medicaid Hepatitis C Practitioner Information Request Form process and will remove the HCV Approved Practitioners List from the website.

As noted in the NYSDOH AIDS Institute HCV Guideline — Treatment of Chronic HCV Infection with Direct-Acting Antivirals, when prescribing HCV antiviral therapy, clinical experience and appropriate continuing education are important to ensure that HCV medications are prescribed safely and correctly and that all patients receive the highest quality of care. You can read more at **hivguidelines.org/hcv-infection/treatment-with-daa**.

Additionally, providers should refer patients with chronic HCV infection and decompensated liver disease and patients who are pre- or post-transplant to a liver disease specialist. Depending on their level of experience and expertise, providers may also want to refer patients who have coexisting conditions (including HIV) that require treatment with complex drug regimens to a provider with experience in the management of complex patients with HCV infection. Medicaid programs based on past Drug Utilization Review (DUR) Board action will no longer be required.

Medicaid (continued)

Expanded benefits and services for Medicaid members

We're helping Medicaid members with their cell phone costs. Do you have patients who may have trouble paying their monthly cell phone bill? We're offering free or low-cost cell phone service to eligible Medicaid members through SafeLink Wireless. This supports the federally funded Lifeline program. Wireless services can help your eligible patients get access to opportunities like education and jobs. Encourage them to enroll.

Increase in physical therapy benefits for our Medicaid and HARP members

Effective July 1, 2018, the number of physical therapy visits allowed in a calendar year increased from 20 per enrollee to 40. This change applies to physical therapy services provided in practitioner offices, certified hospital outpatient departments, and diagnostic and treatment centers. Please note, the 40-visit limitation does not apply to children (birth up to 21 years of age), individuals with developmental disabilities, and individuals with a traumatic brain injury.

Informed consent required for hysterectomy/sterilization procedures

Federal regulations require patient consent for hysterectomy and sterilization procedures. The patient or their representative must sign the required consent form for the service to be deemed a covered service under the Medicaid plan.

For these procedures, you must submit paper claims AND include the patient's completed and signed consent form.

Go to the NYSDOH website (**health.ny.gov**) and search for "hysterectomy and sterilization consent form" to download the following forms:

FORM NUMBER	FORM TITLE
LDSS-3113	Acknowledgement of Receipt of Hysterectomy Information (English)
LDSS-3113S	Acknowledgement of Receipt of Hysterectomy Information (Spanish)
LDSS-3134	Sterilization Consent Form (English)
LDSS-3134S	Sterilization Consent Form (Spanish)

If you submit an electronic claim for these procedures, it will be put on hold (pended) until you resubmit a paper claim with a completed patient consent form. If a consent form is not received, the claim will be denied.

Educational materials available from the NYS Office of Mental Health

The New York State Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Department of Health (DOH), and the New York City Department of Health and Mental Hygiene (DOHMH) have developed a series of educational materials to inform patients and providers about:

- Medicaid Managed Care Health and Recovery Plans (HARPs) and
- Adult Behavioral Health Home and Community Based Services (BH HCBS).

Additional information can be found in our Provider Toolkit at **emblemhealth.com/providers/Provider-Resources/Provider-Toolkit** under Outreach to Individuals Eligible for HARP and Behavioral Health Home and Community Based Services, or at the OMH Managed Care Consumer Education website at **omh.ny.gov/omhweb/bho/education.html**.

Child Health Plus

Expanded over-the-counter benefits

On Sept. 18, 2017, we began covering Child Health Plus members for products included on the Medicaid over-the-counter drug list. For example, Children's Motrin® and Children's Tylenol® are now covered.

Medicare/Medicaid

Do not bill dual eligible members for any Medicare balance due

Medicare-Medicaid dual eligible individuals who qualify to have their Medicare Parts A and B cost-share covered by their state Medicaid plan are not responsible for paying their Medicare Advantage Plan cost-shares for covered services. Federal and New York State law prohibit providers from balance billing Medicare-Medicaid dual eligible individuals for any Medicare deductibles, coinsurance, or copayments. All Medicare and Medicaid payments, if any, received for services provided to dual eligible individuals must be accepted as payment in full.

To comply with this requirement, providers treating dual eligible individuals enrolled in an EmblemHealth Medicare Advantage Plan must do the following:

- Bill the managing entity as primary payor.
- Bill the state Medicaid plan as secondary payor.
- Accept the Medicaid payment as payment in full and not collect any cost-share from the member.
- Prior to providing services, notify the member if you do not accept the state Medicaid payment as payment in full.

Medicare

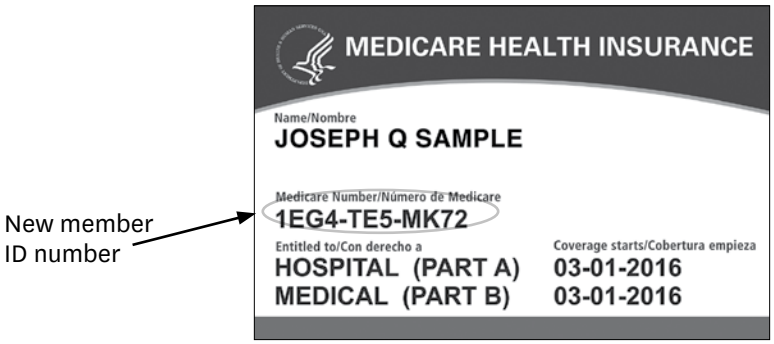
Medicare payment reduction

The Centers for Medicare & Medicaid Services (CMS) reduced premium payments to health plans, providers, and suppliers by 2 percent in 2013 as a result of cuts in federal spending. On Jan. 1, 2018, EmblemHealth began applying this reduction to professional and facility Medicare claims.

New Medicare ID cards

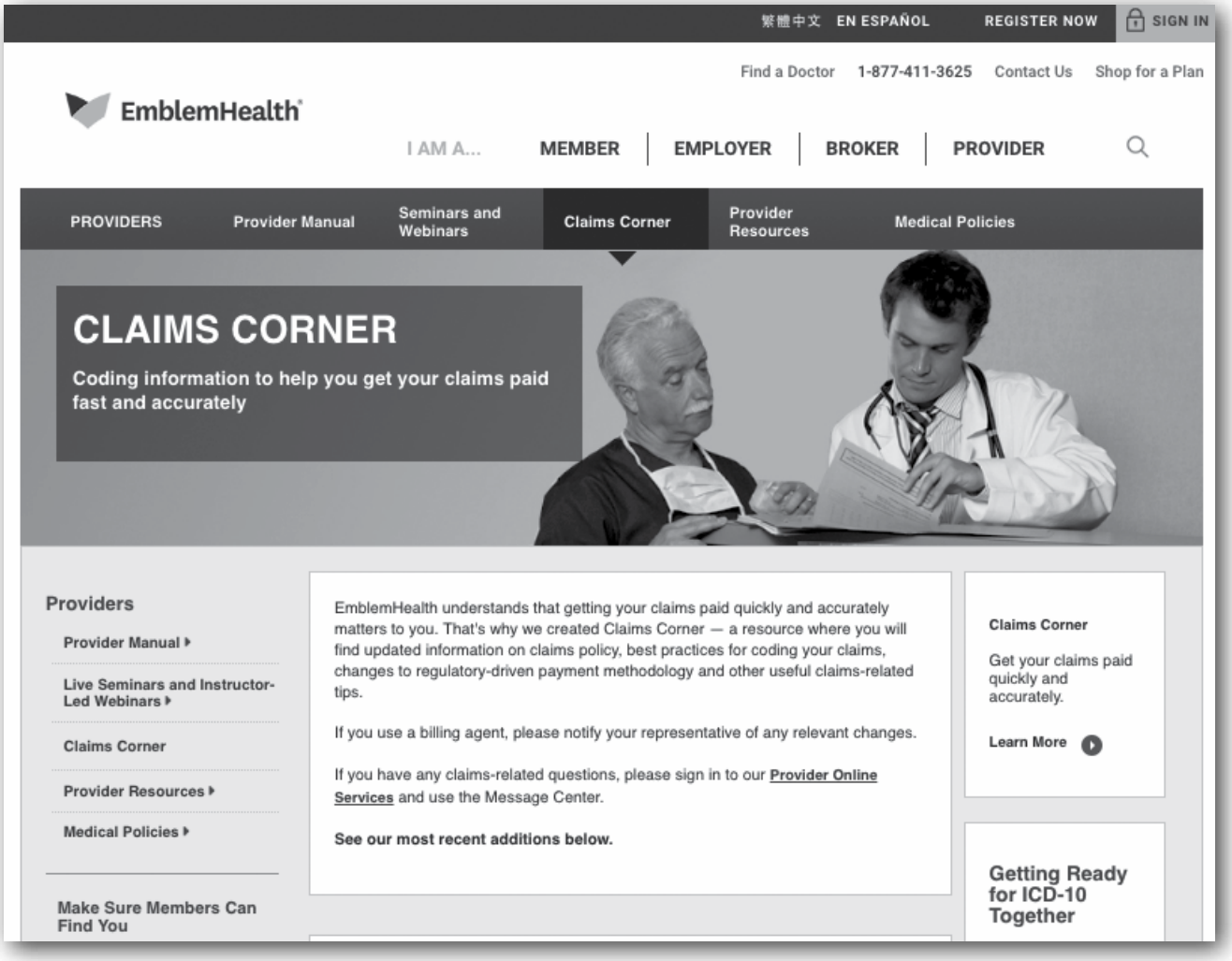
Starting April 2018, CMS began issuing new Medicare cards to beneficiaries, which contain a Member Beneficiary Identifier (MBI) instead of the Social Security number-based Health Insurance Claim Number (HICN). The MBI is different than the HICN; it is 11 characters long and made up only of numbers and uppercase letters (no special characters). To note, EmblemHealth's Medicare Advantage member ID cards do not use or include Social Security numbers.

The new Medicare cards with the MBI are being sent to all individuals with Medicare in phases by location. All new Medicare cards should be issued by Dec. 31, 2019. Individuals who are new to Medicare after April 2018 will only be assigned an MBI.



There should be no impact to our operations during this period. We will maintain a crosswalk of the HICN and MBI for our enrollees.

Providers should update their records with the new MBI as their patients receive their new Medicare cards. Medicare will continue to accept claims with a HICN through Dec. 31, 2019. After Dec. 31, 2019, only the MBI will be used. To learn more about what the new Medicare cards mean for providers, visit **cms.gov/Medicare/New-Medicare-Card/Providers/Providers-and-office-managers.html**.



Claims and payment policy

Claims Corner is your resource

EmblemHealth implemented a number of claims policy and coding guideline changes over the past year. Be sure to check the Claims Corner section of our provider webpage for the latest updates, such as the prior approval requests that now require clinical review. Staying current helps ensure a smooth claims process and can help increase timely payments.

Make note of new addresses

For paper claims for the Emblem Behavioral Health Services Program, use:

Emblem Behavioral Health Services
P.O. Box 1850
Hicksville, NY 11802

For medical record submissions in support of pre-payment review for high-cost outliers, email **prepaymenthco@emblemhealth.com**. For medical records that are too large to email, use:

EmblemHealth Prepayment Review
P.O. Box 3235
New York, NY 10116-3235
Attention: Nancy Newbold

Claims submission changes for radiologists who treat AdvantageCare Physicians members

Starting Oct. 1, 2018, eviCore healthcare (eviCore) began processing claims for radiology services performed by radiologists for AdvantageCare Physicians (ACPNY) members. Claims sent to EmblemHealth after Oct. 1, 2018 will be denied, indicating that the claim should be sent to eviCore.

Claims can be sent to eviCore by electronic submission using Payor Number 14182 or by mail to:

eviCore
400 Buckwalter Place Blvd.
Bluffton, SC 29910

Note: Other specialties that provide radiology services should continue to submit their claims to EmblemHealth.

Payment policy changes

EmblemHealth follows industry standards for coverage guidelines and claims payments that include, but are not limited to, those set by the National Correct Coding Initiative, the American Medical Association (AMA), and CMS. Over the past year, we updated our claims processing system because of guidelines that changed. Visit our Claims Corner webpage at **emblemhealth.com/Providers/Claims-Corner** to see the updates.

Correct coding

Accurate payment is dependent on your claims being coded correctly. EmblemHealth's claims systems are programmed to analyze claims to identify and address common coding errors. We've made changes to our claims systems to address claims coding policy updates, claims coding software edits (ClaimsXten), and changes to match CMS' correct coding guidelines. These include:

- ICD 10 Guidelines – Coding of a sequela requires reporting of the condition or nature of the sequela sequenced first, followed by the sequela (7th character "S") code.
- Coding Antepartum Care by Different Provider Groups – Starting Aug. 28, 2018, when more than one provider group renders a portion of the antepartum care to a pregnant member, the delivering physician should not bill using global obstetrical delivery codes.

Aligning Group Health Incorporated (GHI) with CMS

Beginning Oct. 30, 2018, EmblemHealth applied the following policies to align Group Health Incorporated (GHI) claims processing with CMS policy:

- Canalith Repositioning Therapy – CPT 95992 will be denied when billed without a BPPV diagnosis.
- Tumor Antigen by Immunoassay CA 15-3/CA 27.29 – CPT 86300 is payable when billed with specific ICD-10-CM diagnoses codes. CPT 86300 will be denied in the absence of one of the covered diagnoses identified in the National Coverage Determinations (NCD) coding manual.
- Modifier 25 with Evaluation and Management Services Reported with Procedures – Modifier 25 is used to describe a significant, separately identifiable evaluation and management (E/M) service that was performed at the same time as a procedure. Modifier 25 must not be used within 28 days of a previous face-to-face service.

When coverage will not be provided

EmblemHealth updated the following claims payment policies. In certain circumstances, such as screenings for asymptomatic patients, coverage will no longer be provided.

- Chest x-rays for lung cancer screening in asymptomatic patients.
- Dual-energy x-ray absorptiometry (DXA) bone density screening for males under 70 years old.
- Abdominal ultrasound examination for infectious mononucleosis.
- Ophthalmic ultrasound or high-resolution biomicroscopy is not appropriate for imaging of the anterior chamber except in certain rare glaucoma cases.
- Electrocardiogram (ECG) is not appropriate to screen for coronary disease in asymptomatic adult patients billed in the office setting (POS 11).
- Colonoscopy Procedures – Medicare coverage guidelines allow covered diagnosis codes for medically necessary colonoscopy procedures. These do not affect codes for colorectal cancer screening.
- Extremity venous studies and arterial studies will be denied when billed without a supporting diagnosis for either study. If both types of studies are performed during the same encounter without a supporting diagnosis for the arterial study, the arterial study will be denied.
- Lung Cancer Screening with Low Dose Computed Tomography Frequency should not be performed more than once per patient within a 12-month period.
- Evaluation of cardiovascular function with tilt table testing (CPT code 93660) should only be performed for suspected neurocardiogenic syncope. The test will be denied when billed without a diagnosis of syncope and collapse (ICD-10 code R55).
- Coding for chronic care management (99490) and complex chronic care management services (99487 & 99489) – The patient must have at least two chronic (continuous or episodic) conditions expected to last at least 12 months. The care management service will be denied if billed without both a primary and a secondary diagnosis.

Claims for anesthesia

EmblemHealth updated the following claims policy based on the American Society of Anesthesiologists and the International Spine Intervention Society. Claims for anesthesia and moderate sedation will be denied in certain circumstances.

- Anesthesia and moderate sedation services billed with pain management services for a patient age 18 or older will be denied without the presence of a surgical procedure.

Experimental and investigational procedures

In 2018, the following tests/procedures were classified as experimental and/or investigational as there is insufficient evidence of therapeutic value.

- Phosphatase, Acid; Prostatic – lab testing is not covered.
- CPT code 0184T; no longer covered for Medicaid and Commercial plans.

Appropriate use of modifiers

EmblemHealth follows the AMA coding guidelines and policies in accordance with CMS on the appropriate use of modifiers. EmblemHealth will deny the use of a modifier when outside of these guidelines.

- Modifier 79 – Procedures appended with Modifier 79 will be denied for inappropriate modifier usage if no other procedure has been billed on either the same date of service or in the post-operative period by the same reporting provider.
- Use modifier 25 or 59 to be reimbursed for HCPCS codes G0442, G0443, G0444, G0445, G0446, and G0447.
- Physicians are required to report the appropriate anesthesia modifier when billing for anesthesia. Certified registered nurse anesthetists (CRNAs) also must report the appropriate anesthesia modifier.
- It is not appropriate to bill multiple anesthesia modifiers AA, AD, QK, QX, QY, and QZ on the same claim line. These modifiers are considered mutually exclusive and will be denied.

Allergy, asthma, and immunology

EmblemHealth follows CMS guidelines per the Joint Task Force on Practice Parameters commissioned by the American Academy of Allergy, Asthma & Immunology (AAAAI); the American College of Allergy, Asthma and Immunology (ACAAI); and the Joint Council of Allergy, Asthma and Immunology for the frequency in which certain services or testing should be performed. Tests, units, and/or procedures that exceed established maximums will be denied.

- Frequency of Allergy Studies – establishes the maximum amount of allowable tests.
- Frequency of Preparation and Provision of Antigen Doses – includes the reporting, supervision of preparation, and provision of single or multiple antigen doses.
- Daily Max Units Regardless of Modifier – Where applicable, if the units of service billed are greater than one, the units will be adjusted to allow only one unit per date of service and all subsequent units will be denied.

Frequency and time frames

EmblemHealth follows CMS guidelines regarding the frequency in which certain services are billed. Subsequent services within the noted time frames will be denied.

- Frequency of Routine Foot Care – Routine foot care is allowed one time within a two-month period.
- Only one hospital discharge day management service is payable per patient, per hospital stay, regardless of the order in which the discharge management service codes are received.
- Corneal pachymetry performed for a diagnosis of glaucoma or ocular hypertension or glaucomatous optic atrophy should only be billed once in a patient's life.
- Only one definitive drug testing code may be reported per day. The HCPCS code selected should be G0480, G0481, G0482, G0483, or G0659.
- Only one initial observation care code will be allowed throughout a hospital stay. Claims will be denied if codes for the first day of treatment are used for care given on subsequent days.

Medical technologies and policies

Availability of utilization management criteria upon request

In addition to publishing utilization management criteria in the EmblemHealth Provider Manual and in Clinical Corner, EmblemHealth makes the criteria available upon request through the following methods:

- In person at EmblemHealth at 55 Water Street, New York, NY 10041.
- By telephone at **866-447-9717**.
- Through the Message Center on our secure provider portal.

Our medical technologies database and our medical policies are routinely reviewed to ensure they are current. Medical policy changes are announced in our monthly provider newsletter. Both are available at **emblemhealth.com/providers**.

Below, find the new and revised medical policies published since last year's October 2017 Annual Mailing:

New Policies

- Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (SPAD)
- Yescarta® (axicabtagene ciloleucel)
- Acupuncture — Medicare Dual Eligible Members
- Hyperthermia Treatment for Cancer
- Kymriah™ (tisagenlecleucel) for Acute Lymphoblastic Leukemia — Medicaid
- Pasteurized Donor Human Breast Milk (PDHM) — Medicaid
- Luxturna™ (Voretigene neparvovec) — Medicaid
- Fasenra™ (benralizumab)
- Lutathera® (lutetium Lu 177 dotatate)

Revised Policies

- Hydroxyprogesterone Caproate (Makena®) for the Prevention of Preterm Labor
- Nucala® (mepolizumab)
- Alpha-1-Proteinase Inhibitors Infusion Therapy
- Xofigo® for Castration-Resistant Prostate Cancer
- Stereotactic Radiosurgery and Proton Beam Therapy
- BRCA 1 and 2 Genetic Testing
- Gene Expression Profiling and Biomarker Testing for Breast Cancer
- Genetic Testing for Cystic Fibrosis
- Chelation Therapy
- Cognitive Rehabilitation
- Glaucoma Surgery
- Imfinzi® (durvalumab)
- Sacroiliac Joint Fusion
- Varicose Vein Treatment
- Carrier Screening for Parents or Prospective Parents
- Assisted Reproductive Technologies
- Gene Expression Profiling
- Gender Reassignment Surgery
- Pasteurized Donor Human Breast Milk (PDHM)
- Membrane Transplantation for Ocular Reconstruction
- Insulin Delivery Devices and Continuous Glucose Monitoring Systems
- Capsule Endoscopy (Camera Pill)
- Radiofrequency Ablation of Tumors
- Gene Expression Profiling
- Kymriah® (tisagenlecleucel)
- Gene Expression Profiling of Melanomas
- Clotting Disorder Therapy
- Lyme Disease Diagnosis and Treatment
- Vitamin D Deficiency Testing
- Gender Affirming/Reassignment
- Prostatic Urethral Lift (PUL)

Pharmacy

Update your taxonomy codes

Express Scripts, Inc. (ESI), our primary pharmacy network, is following New York State prescriptive authority logic. This compares the drugs being prescribed with a prescriber's taxonomy in the National Plan and Provider Enumeration System (NPPES).

If your taxonomy code is invalid or your taxonomy indicates you do not have the right to prescribe certain drugs, pharmacies using ESI will not fill your patients' prescriptions, even if it is a refill of a previous prescription.

Don't let your patients get turned away at the pharmacy. To avoid getting calls from upset patients or pharmacies, update your taxonomy codes.

National drug code requirements for physician-administered drugs

Starting Oct. 27, 2017, EmblemHealth began denying claims submitted with missing or incorrect National Drug Codes (NDCs). As a reminder, the Deficit Reduction Act (DRA) of 2005 requires physicians, nurse practitioners, licensed midwives, and other health care professionals who administer drugs in ambulatory care settings to report the NDCs on their Medicaid claims. Visit our website **emblemhealth.com/Providers/Claims-Corner/Coding/NDC-Requirements-for-Physician-Administered-Drugs** for more information and requirements.

Accredo: new specialty pharmacy

Starting Jan. 1, 2019, Accredo, an ESI subsidiary, will replace Magellan as EmblemHealth's preferred specialty pharmacy vendor for all of our members. Prescriptions will be transferred to Accredo so your patients will not miss any remaining refills. You will be able to contact Accredo at **855-216-2166**, Monday to Friday, 8 a.m. to 11 p.m., and Saturday, 8 a.m. to 5 p.m. To initiate a prescription, use **accredo.com**.

EmblemHealth injectable drug utilization management program updates

EmblemHealth will be taking the management of the injectable drug utilization management program back in-house. Starting Jan. 1, 2019, please call **888-447-0295** or fax **877-243-4812** to request prior approval. The list of injectable drugs requiring prior approval was last updated on Jan. 12, 2018 and is available in the EmblemHealth Injectable Drug Utilization Management Program chapter of the Provider Manual.

Finding pharmacy updates

EmblemHealth communicates its pharmaceutical updates and pharmaceutical management procedures to members and prescribers through eblasts, in the Provider Manual, and on our website **emblemhealth.com/Providers/Provider-Resources/Clinical-Corner/Formulary-Updates**.

These include the following information:

- Covered pharmaceuticals.
- Copayment information, including tiers.
- Pharmaceuticals that require prior authorization.
- Limits on refills, doses, or prescriptions.
- Use of generic substitution, therapeutic interchange, or step-therapy protocols.
- How formulary updates are communicated, and how often, if the organization has scheduled formulary updates.

Formulary updates

Our current Pharmacy Formulary Updates are available at **emblemhealth.com/Providers/Provider-Resources/Clinical-Corner/Formulary-Updates**.

New pharmacy guidelines

- Aliqopa™ (copanlisib)
- Besponsa® (inotuzumab ozogamicin)
- Cyramza®
- Marqibo®
- Trogarzo™
- Unituxin™
- Vyxeos™ (daunorubicin and cytarabine)
- Akynzeo® (fosnetupitant/ palonosetron)
- Baxdela™ (delafloxacin)
- Colony Stimulating Factors: Fulphila™ (pegfilgrastim-jmdb)
- Colony Stimulating Factors: Nivestym™ (filgrastim-aafi)
- Lartruvo™ (olaratumab)
- Mylotarg™ (gemtuzumab ozogamicin)
- Relizorb™ (immobilized lipase) cartridge
- Varubi® (rolapitant)
- Zilretta® (triamcinolone acetonide extended release injection)

Utilization management

Utilization management decisions

As a managed care organization, EmblemHealth is dedicated to providing quality care and service to all our members. We do not make any payment, directly or indirectly, to a physician, physician group, other provider, or practitioner as an inducement to reduce or limit medically necessary services furnished to any particular member. When conducting utilization review, EmblemHealth bases all decisions solely on the appropriateness of care and services, existence of coverage, benefit design, appropriate place of service, medical necessity, and applicable state and federal law. In addition, staff making utilization management (UM) decisions do not receive financial incentives or rewards for issuing denials of coverage and are not encouraged to make improper denials.

Affirmative statement regarding incentives

EmblemHealth distributes a statement to all members, practitioners, providers, and employees who make UM decisions, affirming the following:

- UM decision making is based only on appropriateness of care and service, and existence of coverage.
- EmblemHealth does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

The statement can also be found in the Provider Manual.

EmblemHealth hospital readmission policy

In June 2018, we changed our hospital readmission policy to align with CMS' guidance. A second admission to the same hospital or hospitals within the same health system within 30 calendar days of a member's discharge for the same or similar diagnosis will be subject to a clinical review.

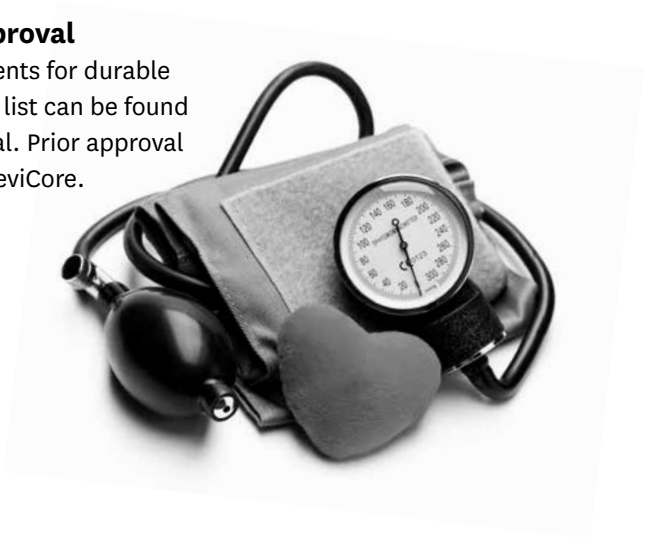
How to request prior approval

For information on how to request prior approval, refer to the Provider Manual.

For general inquiries regarding UM, contact our Provider Call Center at **866-447-9717**. Our hours are 8 a.m. to 6 p.m., Monday to Friday. You may also use our Message Center at **emblemhelath.com**. Select "General Information" from the drop-down menu on the "Ask a Question" page.

Durable medical equipment codes requiring prior approval

In Jan. 2018, EmblemHealth updated its prior approval requirements for durable medical equipment (DME). The most current prior approval code list can be found in the appendix section of the DME chapter of the Provider Manual. Prior approval rules apply to all members, even those who are not managed by eviCore.



eviCore utilization management

eviCore manages the following services for Health Insurance Plan of Greater New York (HIP) members:

- Durable medical equipment (DME)
- Skilled nursing facility care (SNF)
- Inpatient rehabilitation facility care (IRF)
- Long-term acute facility care (LTAC)
- Home health care (HHC)*
- Radiology services provided by radiologists
- Radiation therapy and cardiology imaging services

Prior approval requests for these services for HIP members not managed by Montefiore or HealthCare Partners are no longer processed on **emblemhealth.com**. All requests for prior approval must be submitted directly to eviCore at **evicore.com** or by calling **866-417-2345**.

eviCore does not manage UM for the following members:

- GHI members
- Members whose Managing Entity is:
  - Montefiore
  - HealthCare Partners

eviCore is responsible for UM, provider customer service issues, and grievances and appeals for all affected members except Medicare members. EmblemHealth continues to provide customer service to all members, and continues to address grievances and appeals for Medicare members. eviCore credentials those organizations that contract directly with them.

*Except personal care assistants (PCAs) and Consumer Directed Personal Assistance Programs (CDPAPs).

St. Barnabas and Union Community Health Center members included in special utilization management programs

For members assigned to a St. Barnabas or Union Community Health Center primary care provider, the requirements of these special utilization management programs now apply:

- The EmblemHealth Spine Surgery and Pain Management Therapies Program. To obtain prior approval, complete an OrthoNet EmblemHealth Pain Management Fax Request form and fax it to OrthoNet at **844-296-4440**. A link to the forms is located at the end of the Spine Surgery and Pain Management Therapies Program chapter of the EmblemHealth Provider Manual. Contact OrthoNet at **844-730-8503**, Monday through Friday, 8:30 a.m. to 5:30 p.m. with any program questions.
- Lab Services listed on the EmblemHealth Provider Office Lab list.
- Radiology, Cardiology Imaging, Durable Medical Equipment, Home Care Services, and Post-acute Care Services that include Home Health, Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), and Long-Term Acute Care Facilities (LTACs).

For information on how to request prior approval, refer to the Provider Manual.

Laboratory services

Use Quest Diagnostics for lab services. Quest is our preferred free-standing, independent, commercial lab for all clinical laboratory services. Quest helps our members receive maximum plan benefits, and ensures clinical outcome data is shared with us.

For specimens drawn outside your office, please give our members the requisition form and direct them to the nearest Quest Laboratory Patient Service Center. For network hospitals that have a lab as well as associated pathologists contracted with EmblemHealth, you may use that lab, if applicable. EmblemHealth will not pay for specimens drawn by or sent to any non-participating laboratory. To establish an account with Quest, call **800-631-1390**, or visit **questdiagnostics.com**.

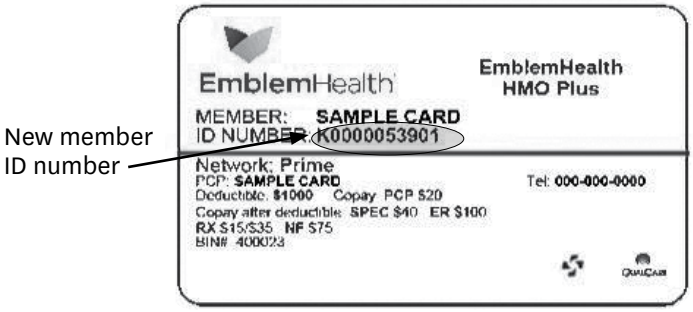
Section 2: Simplifying your administrative tasks

The information below will help you find what you need quickly so you can focus on what matters most—giving care.

Members receive new member ID numbers upon plan renewal

We're upgrading our technology. As members renew their plans, they will be given new member ID cards. These will have new member ID numbers that start with the letter "K" for our commercial plan members.

Always ask your patients for their member ID cards. Use the new member ID number when you submit your claims; otherwise, our system will not recognize your patient as a current member and the claim will be denied.



Use our provider website—it was made for you

Our provider landing page is available at **emblemhealth.com/providers**. It's your hub for the latest information from EmblemHealth. Use "Take a Tour" for a video tutorial that demonstrates how to use our website. It highlights the tools and resources available to you. The link to Take a Tour is located inside the box marked "Sign In to My Account."

After your tour, look around at everything our site offers, including:

Provider Manual

Our online Provider Manual is an extension of your contract with us. It has information about your administrative responsibilities, contractual and regulatory obligations, and best practices for helping members navigate our delivery systems. Revisions are made as policies are renewed, new programs are introduced, and contractual and regulatory obligations change.

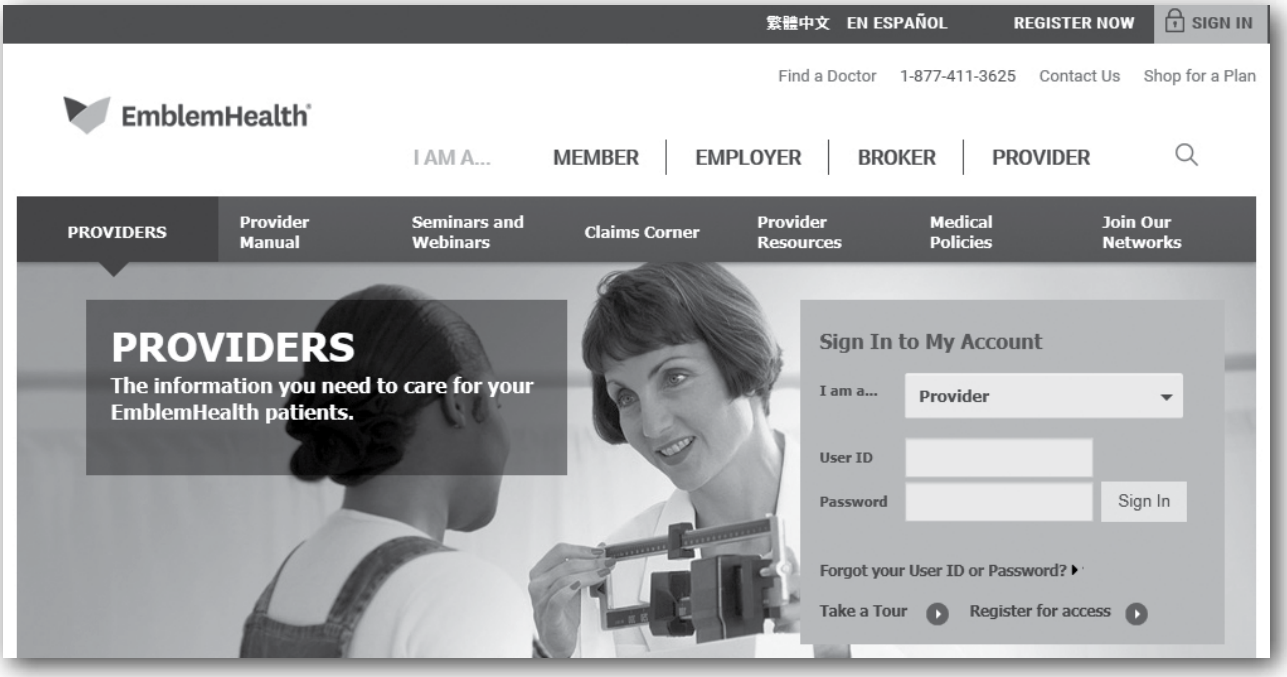
To receive alerts about updates, subscribe to the Provider Manual by chapter or section. Go to **emblemhealth.com/Providers/Provider-Manual** and select the entire manual, a chapter, or a section, and click the Subscribe button at the top right of the chapter. You'll also find a copy of the Provider Manual chapter list with a description of each chapter's content.

Claims Corner

We know accurate and timely claims payment is a priority. Our Claims Corner section lists the latest updates to processes and policies, and includes answers to common coding and billing questions.

Provider Resources

- Policy Updates Newsletters (eNews) – Our Policy Updates, Medical Policy Updates, and Critical Reminders are emailed to your office approximately once a month. To receive these and other communications, please make sure we have a valid email on file for you. You can update your email from the home page of our secure website.
- Clinical Corner – In this section, we offer guidance for the treatment of acute, chronic, and behavioral health issues as well as the medical appropriateness of specific interventions.
- Provider Toolkit – Our toolkit houses a large list of resources and quick guides, including our Access and Availability standards. Please review this information.



Access our secure website

To access our secure website, go to **emblemhealth.com/providers**. In the box labeled "Sign In to My Account," click "Register" and fill in the required fields. To note:

- HIP providers have a provider number for each of their locations and must register each provider number separately.
- GHI providers have only one provider number per tax identification number (TIN) and must register for each of their TINs separately.
- If you are both a HIP and GHI provider, please follow the instructions in the first two bullets.

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

For registration help, call **866-447-9717**. We also host monthly webinars for our providers on the second Wednesday of each month. Registration is available through our website.

Our secure provider website also includes tools we hope you find useful:

- Provider Carousel – a news carousel with our recently published articles and important reminders.
- Create a Valuable Experience – a guide, "How You and Your Staff Can Improve the Patient Experience."
- Consider referring members to population health/case management programs – call **877-411-3625**.

Keep your directory information current
In order for our members to find you, please review the information we have on file for you in our online directory and make any necessary changes.

- If you work for an organization that has been delegated for credentialing, please inform your practice administrator and ask them to include the correction on the next dataset submission.
- If your application was credentialed directly by EmblemHealth's staff, review and make changes to your profile by signing in to your account at **emblemhealth.com/providers**. Follow the process outlined in the Access to Care and Delivery System chapter of the Provider Manual.
- If you don't have access to a computer, please fax any changes to our Provider Modifications team at **877-889-9061**.
- You can mail changes to EmblemHealth, Provider Modifications, 55 Water St., New York, NY 10041.

Adding new providers to participating groups

When adding providers to an existing group, you must submit a completed and current application. The credentialing process cannot begin until we receive a complete application. Practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision.

Help patients find you: Confirm your practice information using New York State's new tool

The NYSDOH and the New York State of Health (NYSOH) have launched a new tool called NYS Provider & Health Plan Look-Up.

It's an online tool that allows consumers to quickly locate information about their doctors and the health insurance plans in which their doctors participate.

To make sure plan members can find you, please go to **health.ny.gov/health_care/pnds/** to review your practice information.

To report an error in the listing, go to the NYS Provider & Health Plan Look-Up home page and select the Contact/ Report an Error button. Then, select the health plan and the reason you are contacting them. The issue will be routed electronically to the NYSDOH and to the selected health plan(s) for review and follow-up.

Enroll in our free electronic funds program

Go electronic. PNC Bank is EmblemHealth's trading partner for electronic funds transfer and electronic remittance advice (ERA or 835). Our PNC Remittance Advantage Program offers paperless claim payments and electronic remittances for free. Electronic transactions are fast, convenient, and lower the risk of lost or stolen payments. PNC Remittance Advantage combines direct electronic funds transfer payments with 835 electronic remittance advice. Go to **rad.pnc.com** to enroll. If you need help, call **877-597-5489**. You will need your provider ID number to enroll. You can find it on your paper remittance.

TriZetto is our preferred electronic data interchange source

EmblemHealth and Cognizant Healthcare Services, LLC have partnered, enabling our trading partners to submit electronic claims through Cognizant's TriZetto Provider Solutions (TPS). EmblemHealth's preferred electronic data interchange (EDI) connection is TPS. If you would like to connect directly to TPS for free, please complete the form at **trizettoprovider.com/EmblemHealth/New-User-Request**. If you already use a clearinghouse, such as Ability, SSI, Availity, or ClaimLogic, your claims will be sent to EmblemHealth. There will be no changes and you do not need to complete the form.

Make sure you have your correct NPI on file

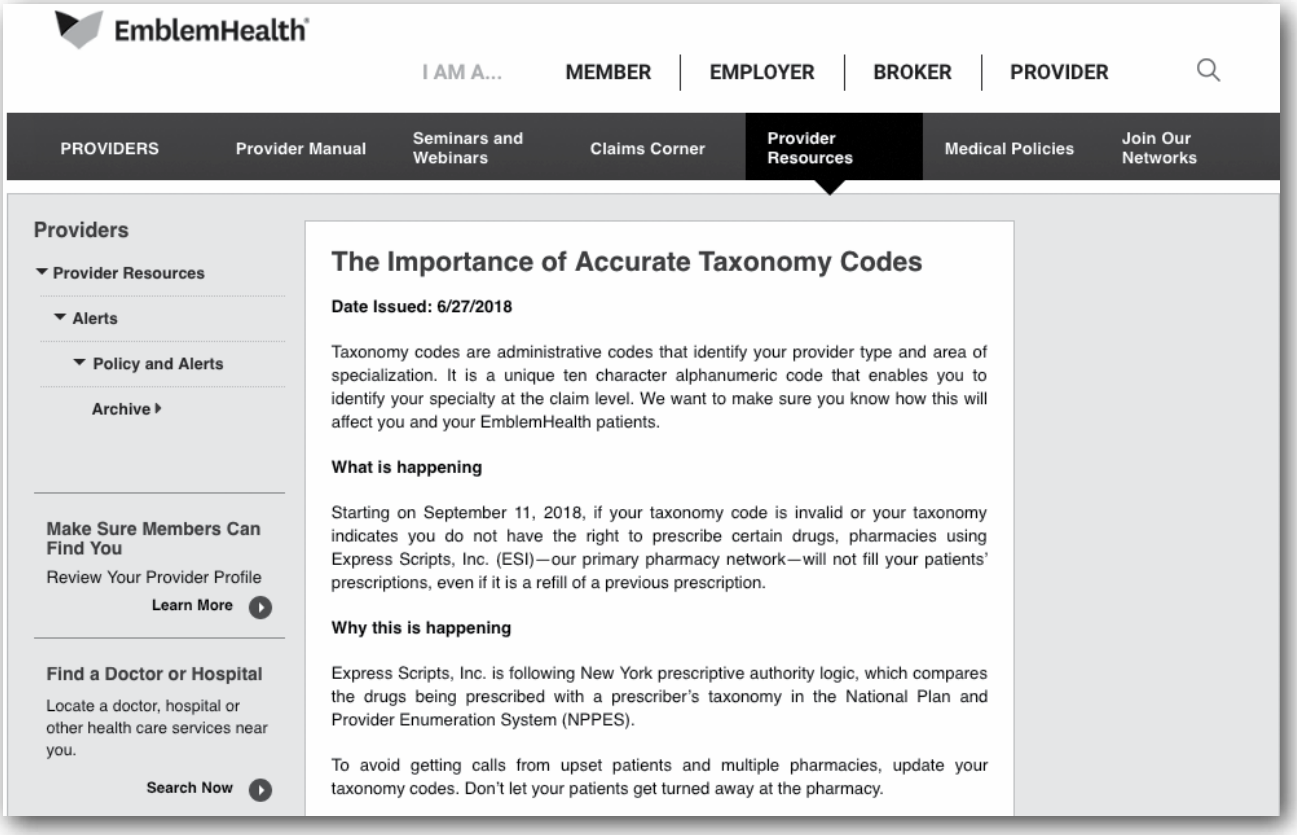
Sign in to your provider profile on **emblemhealth.com** to make sure you have the right National Provider Identifier (NPI) on file. Using an incorrect NPI can result in denied claims. Federal law mandates that health care practitioners use their unique, 10-digit NPI when submitting standard electronic health care transactions, such as claims.

Taxonomy codes are important

Remember to provide taxonomy codes on all EmblemHealth claims. The absence of these codes may result in incorrect payments or the inability of your patients to fill their prescription.

Taxonomy codes are administrative codes that identify health care professionals at both the individual practitioner and organizational level. These codes include information on the practitioner's specialty.

- You must register all taxonomy codes – Taxonomy codes are self-reported by registering with the National Plan and Provider Enumeration System (NPPES) and by claims submission. Taxonomy codes may be obtained by visiting the National Provider Identifier Registry website. It is critical to register all applicable taxonomy codes with the NPPES and to use the correct taxonomy code to assist EmblemHealth in processing claims more timely and accurately.
- How to submit taxonomy codes on your claims – Taxonomy codes on electronic claim submissions with the ASC X12N 837P and 837I format are placed in segment PRV03 and loop 2000A for the billing level, and segment PRV03 and loop 2420A for the rendering level. For paper CMS-1500 professional claims, the taxonomy code should be identified with the qualifier "ZZ" in the shaded portion of box 24i. The taxonomy code should be placed in the shaded portion of box 24j for the rendering level, and in box 33b preceded with the "ZZ" qualifier for the billing level.



Section 3: Improving the patient experience

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)* survey is an annual survey that measures patients' experience with their doctor and doctor's office. It reviews the areas of getting appointments quickly, ease of getting needed care, ease of communicating with staff and doctors, getting help in coordinating care, flu vaccination, and the overall experience of getting care. Positive experiences result in better survey ratings. The sections below include tips for improving the patient experience that you can apply in your practice.

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Improve access to care

- Keep a few appointments open for patients that need same-day care. This open access scheduling has been shown to decrease the patient's no-show rate.
- Consider having your patients arrange their next appointment at the end of their current visit.
- Make a specialist appointment while the patient is in the office. This helps ensure the patient is adhering to the mutually agreed-upon treatment plan and coordination of care.
- Direct patients to find physicians and hospitals at **emblemhealth.com/Find-a-Doctor**.

Focus on communication

Effective communication can have a positive impact on patient experience, resulting in greater patient compliance, increased patient safety, and better clinical outcomes. Improve your relationship with your patients with the following tips:

- Use plain language.
- Listen carefully.
- Understand and address your patients' cultural and language needs.
- Show respect for what is said.
- Spend some time with them sharing decisions about care.
- Coordinate care between yourself and other medical and behavioral health practitioners and settings.
- Share information in order to optimize population health management.

Enhance patient engagement among frontline staff

- Greet patients with a warm and friendly smile.
- Minimize wait times by analyzing bottlenecks in your office workflow.
- Ask patients if they need help with their care, such as scheduling an appointment with a specialist.
- At the end of the visit, make sure patients can recall in their own words what they were told, including any written instructions, and make sure they understand follow-up actions.

EmblemHealth has developed a guide that you may find useful when you provide care. It's called "How You and Your Staff Can Enhance the Patient Experience." Find it by clicking on "Improving the Patient Experience" from our Provider Toolkit.

Create a positive first impression

The patient experience begins before they ever walk into your office. To enhance their experiences before meeting you, try these simple steps that can create a positive first impression:

- Keep your directory listing current. If someone has left your practice, please let us know.
- Know which of our networks you participate in and be able to quickly tell a caller if you are in their network.
- Make sure EmblemHealth has your email address so we can keep you informed.
- Follow the enclosed "Appointment Availability Standards During Office Hours & After Office Hours Access Standards" when setting appointments.
- See patients within 15 minutes of their scheduled appointment time.

Member responsibility for self-care

Member rights and responsibilities include their responsibility to self-care. For a complete description of what members can expect of EmblemHealth and what responsibilities our members have to EmblemHealth, visit the member rights and responsibilities page of our online Provider Manual.

Dispute resolution

All members have the right to dispute a determination that results in a denial of payment and/or covered services. The process, terminology, filing instructions, applicable time frames, and additional rights (including external review rights) vary based on the type of plan in which the member is enrolled. Our Provider Manual includes separate chapters on the dispute resolutions for:

- Commercial & Child Health Plus plans.
- Medicare plans.
- Medicaid/HARP plans.

We will not attempt to terminate a practitioner agreement or disenroll a member who disputes a determination.

Access and Availability

Are You Accessible to Your Patients?

Patients need access to care at all hours, so it's important to establish methods for them to reach you after office hours. We conduct audits and so does the Department of Health to see if you're accessible to your patients. To make sure you are always prepared, become familiar with the enclosed "Appointment Availability Standards During Office Hours & After Office Hours Access Standards." It is also in the Provider Toolkit under Provider Resources at **emblemhealth.com/Providers/Provider-Resources/Provider-Toolkit**. Please post it for your appointment schedulers. Making yourself available is a contractual requirement. Failure to comply with these standards may result in termination from our network. The standards also include a list of avoidable mistakes that count as audit failures. Please take the time to review these common errors.

New Appointment Availability Standard Added

Effective Sept. 1, 2018, the specialty of oncology will be audited for appointment availability based on the following standard:

Initial oncology visit:

- For medical care when the patient has a positive test result and is requesting an initial visit.
- Requires an appointment within three business days of member request.

EmblemHealth will audit a random sample of participating oncologists on an annual basis to assess compliance with this standard.

Quality improvement

EmblemHealth's Quality Improvement Program includes protocols in medical, pharmaceutical, dental, and behavioral health care, and in services given to EmblemHealth's complex, culturally and linguistically diverse membership. Our Provider Toolkit contains a link to the Quality Improvement Program Overview. Use it when you address patient needs and safety. Go to **emblemhealth.com/Providers/Provider-Resources/Provider-Toolkit**.

PATH programs

The Provider Toolkit provides information about the Care Management PATH programs. These are focused on keeping members healthy, managing members with emerging risk, assessing social determinants of health, patient safety, and supporting members with multiple complex health conditions. The programs support your care plans by using evidence-based clinical practice guidelines to emphasize how members can prevent complications and flare-ups of chronic conditions.

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

- Care Management PATH programs – **800-447-0768**.
- Healthy Beginnings PATH Pregnancy – **888-447-0337**.
- Kidney Care PATH (for end-stage renal disease or chronic renal failure, we partner with OptumHealth Kidney Resource Services) – **866-561-7518**.
- New York State Smoker's Quitline (tobacco cessation) – **866-697-8487**.

Collaborative activities

EmblemHealth annually conducts activities to improve behavioral health and general medical care, including collaboration with behavioral health practitioners. These include:

Practitioners' opportunities for collaboration, continuity, and coordination of care:

- Improve the process for members to authorize sharing of behavioral health information.
- Implement primary care guidelines for assessing, treating, and referring common behavioral problems.
- Increase non-behavioral health care practitioner satisfaction with feedback from behavioral health care practitioners.
- Improve procedures for treating hospitalized members with coexisting medical and behavioral health conditions.
- Improve management of elderly members with indications of depression and multiple behavioral health care medications.
- Educate primary care practitioners about appropriate indications for referring patients with hyperactivity disorder or depression to behavioral health care specialists.
- Facilitate communication between a medical practitioner and the behavioral health care practitioner who is treating the medical practitioner's patient.
- Implement a prevention program for behavioral disorders commonly managed in the primary care setting.

EmblemHealth promotes:

- Exchange of information between behavioral health care and medical practitioners.
- Appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.
- Appropriate use of psychotropic medications.
- Oversight of access to treatment and proactive follow-up for members with coexisting medical and behavioral disorders.
- Preventive behavioral health care program implementation in both primary and secondary settings.
- Accommodations to be made for the special needs of our members with severe and persistent mental illness.

Performance management

Performance related to patient care is continuously being assessed by regulatory agencies. Their goal is to make sure patients get the most appropriate care for the best possible result. These include:

- Healthcare Effectiveness Data and Information Set (HEDIS®)* – a tool that measures care and service provided to patients.
- Quality Assurance Reporting Requirements (QARR) – captures the quality of that care.
- Health Outcomes Survey (HOS) – allows Medicare patients to report on their own current health status.

These show areas where there is room for improvement. Use the results to guide your patient care efforts.

Here are some non-clinical tips to boost your measurement scores:

- When billing, use the correct codes that relate to ALL services given during the visit.
- Be sure to include the codes with the most specific definition of the diagnosis, procedure, and/or associated result. This may reduce chart collection.
- Remember to:
  - Bill with appropriate Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases (ICD) codes.
  - Give the health plan access to the member's medical record or encounter data.
  - Closely follow Clinical Practice Guidelines.
  - Use codes associated with HEDIS®/QARR value sets.

Health care professionals have the greatest impact on clinical outcomes. Those who follow established guidelines and best practices are successfully increasing quality measure scores and patient satisfaction.

*HEDIS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Improve outcomes: Encourage members to complete Health Risk Assessments

Special Needs Plan (SNP) Model of Care members receive health risk assessments (HRAs) after they enroll in their health plans and each year after that. HRAs help identify medical needs, allowing you to give more patient-specific care. SNP members may complete the HRA online by signing in to **emblemhealth.com** and going to the "Manage Your Health" section. They can also call us at **888-246-2934**. A representative will be happy to help.

Panel reports help close gaps in preventive care

When EmblemHealth identifies gaps in care, we notify members, educate them about the importance of the needed service, and encourage them to discuss the topic with their doctors. To make sure you know about the same issues, we send you panel reports that identify the patient and his/her issue so you can address any needed care.

Keep accurate medical records and comply with submission requests

CMS requires you to keep accurate, complete, and legible patient records. EmblemHealth performs annual medical record data collections for HEDIS® and New York State Department of Health QARR. You may be asked to send us records as part of this requirement. As a reminder, if you use a service to store and retrieve requested records, you may not bill EmblemHealth for this service.

Section 4: Credentialing process requirements

Obstetrics specialty review

Our directories will be updated to change the obstetrics/gynecology (OB/GYN) specialty designation to GYN for those clinicians who have not submitted a claim for obstetric services in the prior 24 months. If you stopped practicing obstetrics less than two years ago, please let us know and we will update our records.

Provider data validation during the credentialing process

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

Through the initial credentialing and periodic recredentialing processes, EmblemHealth validates the accuracy of a provider's service location data for its groups and providers not delegated for credentialing. This is done by reviewing against the provider's data in CAQH ProView™ and performing telephone outreach.

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

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

Free provider training: EmblemHealth offers several instructor-led webinar opportunities to help you learn how to work with us and our vendor partners, and offers other useful topics. Visit our Webinars and Seminars page at **emblemhealth.com/Providers/Forums-and-Webinars** to register and access our current offerings. These include:

- Free Pulse8 Webinars for Patient Management and ICD-10 Coding.
- eviCore Orientation Webinar Sessions.

Use our video tutorials to find the information you need: Our step-by-step tutorials available through our Learn Online page will guide you on how to use our online tools. Please review the following tutorials:

- How Do I Know Which Networks I Participate In?
- How Do I Know Which Members Are In My Network?
- How Do I Update My Directory Information?

We'll post new videos throughout the year, so remember to come back to the site for the latest videos.

Cultural competency training: Cultural competency continuing education and resources are available to you to improve awareness and skills in addressing the health care needs of diverse patient populations. Find these by signing in to the secure provider website at **emblemhealth.com**. Training will help you recognize communication barriers and show you how to be sensitive to various beliefs and traditions.

Required training: Special Needs Plan Model of Care: Each year, CMS requires you to complete Special Needs Plan (SNP) Model of Care (MOC) training for each of the dual eligible SNPs in which you participate. Medicare providers in the VIP Prime Network must complete the EmblemHealth SNP MOC provider training, and providers in the Medicare Choice PPO Network must complete training offered by GuildNet and ArchCare. Find all required training modules on our website. Access the hyperlink from the Learn Online section of our Provider Resources webpage.

Section 5: Regulatory requirements and notices

Required annual compliance certification on Office of the Medicaid Inspector General's website
If you are a Medicaid provider, you are likely required to attest each December that you have developed and implemented a compliance program to detect and prevent fraud, waste, and abuse in the Medicaid program. Depending on the type of provider you are, or the extent to which you treat Medicaid members, you may be required to complete one or both Office of the Medicaid Inspector General (OMIG) Annual Compliance Certifications. The certifications may only be done by completing the certification form available on OMIG's website (**omig.ny.gov/compliance#ComplianceHome3**) and clicking on the appropriate certification button ("SSL Certification" or "DRA Certification").

One attestation is needed for each Federal Employer Identification Number (FEIN) or Social Security number (SSN) used to receive Medicaid payments. You do not need to submit a copy of the compliance plan or self-assessment of your plan.

With regard to the Social Services Law (SSL) certification, New York State's (NYS's) mandatory compliance program law applies to Medicaid providers subject to Public Health Law (PHL) Articles 28 or 36, or Mental Hygiene Law (MHL) Articles 16 or 31, regardless of the amount that they bill, order, or receive from NYS's Medicaid program. Plans will need to monitor network provider compliance with the SSL certification requirement.

Required annual compliance certification on Office of the Medicaid Inspector General's website (continued)

In addition, a compliance program is required for other persons, providers, or affiliates who provide care, services, or supplies under the Medicaid program, or who submit claims for care, services, or supplies for or on behalf of another person for which Medicaid is, or should be reasonably expected by the provider to be, a substantial portion of their business operations as follows:

1. A person, provider, or affiliate that claims, orders, has claimed or ordered, or should be reasonably expected to claim or order at least $500,000 in any consecutive 12-month period from Medicaid;
2. A person, provider, or affiliate that receives, has received, or should be reasonably expected to receive at least $500,000 in any consecutive 12-month period directly or indirectly from Medicaid or a Medicaid Managed Care Plan; or
3. A person, provider, or affiliate that submits or has submitted claims for care, services, or supplies to the Medicaid program on behalf of another person or persons in the aggregate of at least $500,000 in any consecutive 12-month period.

The law and regulations contain a set of eight minimum core elements that are applicable to all providers, regardless of size. However, the law also recognizes that compliance programs should reflect the provider's size, complexity, resources, and culture as long as the compliance program meets the requirements.

The second annual compliance attestation, referred to as the Deficit Reduction Act (DRA) certification, must be completed by health care entities that receive or make $5 million or more in Medicaid payments. Providers required to meet both provisions usually include the DRA requirements in their (typically more comprehensive) mandatory compliance programs.

OMIG suggests that Medicaid providers review OMIG's published Compliance Guidance, Medicaid Updates, and Compliance Alerts, among other OMIG publications and outreach methods, for information on how to meet NYS's mandatory compliance program requirements. There is a Compliance Library on OMIG's website that guides providers in developing and implementing an effective compliance program. Medicaid providers are encouraged to subscribe to OMIG's listserv. The listserv provides an email notification of any changes to OMIG's website, including changes to published compliance program-related materials.

To see more detail on the compliance program requirements, see: **omig.ny.gov/images/stories/provider_compliance/ssl_faqs.pdf#page=1** and **omig.ny.gov/images/stories/provider_compliance/dra_faqs.pdf#page=2**.

Confidentiality for domestic violence or endangered victims

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

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

Mandatory reporting

To ensure public safety and track conditions that affect public health, New York State and New York City agencies have enacted laws that health care professionals must follow. Our network practitioners are required to participate in government reporting procedures and adhere to all rules, regulations, and codes. For a list of government agencies that require reporting, access the Regulatory Mandatory Reporting chapter of our online Provider Manual.

Communicable disease reporting

New York State and New York City health laws require practitioners to report suspected or confirmed cases of communicable diseases to the patient's local health department. View the New York State reporting guidelines at **health.ny.gov**. EmblemHealth conducts a monthly Communicable Disease Record Audit to ensure that practitioners comply with regulations. Practitioners are chosen at random based on a review of reportable diagnoses identified by the New York State Department of Health.

Citywide registry reporting

Health care professionals that give care to Medicaid and Child Health Plus members are also required to report vaccines they give to their patients to the Citywide Immunization Registry and Lead Poisoning Prevention Program.

New York City's Health Code Article 11 requires that certain diseases and conditions be reported to the Department of Health and Mental Hygiene immediately and others within 24 hours. Visit the New York City Department of Health and Mental Hygiene website at **nyc.gov/health**. For immediate consultation on public health issues, call the Provider Access Line at **866-692-3641**.

Nondiscrimination rule

Practitioners shall comply with all applicable laws prohibiting discrimination against any member and in accordance with the same standards and priority as the provider treats his/her/its other patients regardless of any of the following factors:

- Age
- Amount of payment
- Claims experience
- Color
- Creed
- Disability
- Ethnicity
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Gender
- Genetic information
- Health literacy
- Health needs
- Health status
- HIV status
- Language
- Marital status
- Medical history
- Mental or physical disability or medical condition
- National origin
- Need for health services
- Place of residence
- Plan membership
- Race
- Religion
- Sex
- Sexual orientation
- Source of payment
- Type of illness or condition
- Veteran status

In addition, providers are to comply with:

- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Title VI of the Civil Rights Act of 1964
- Terms of the plan's contracts with NYSDOH and/or CMS
- Health Insurance Portability and Accountability Act
- HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law
- Section 1557 of the Affordable Care Act (ACA) of 2010
- Other laws applicable to recipients of federal funds, and all other applicable laws and rules, as required by applicable laws or regulations

Required language in your Provider Agreement

Your Provider Agreement includes mandatory contract language required by the State of New York and CMS. Below is a list of the required contract language documents, copies of which can be found in the Required Provisions to Network Provider Agreements chapter of our online Provider Manual, which is incorporated into all provider agreements.

- Managed Care Law of 2009
- Medicare Advantage/Medicare-Medicaid Required Provisions
- New York State Standard Clauses – April 2017
- Special Provisions Related to Medicaid & HARP Members

Compliance: Home Care Worker Wage Parity Law

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

We will contact you via fax several times each year to ask you to fax us your wage parity certifications. Please comply with this regulation and send the information when requested.

Medicaid provider disclosure of ownership and control

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

- Section 42 CRF455.104 – Requires Managed Care Organizations, like EmblemHealth, to collect the disclosure of complete ownership, control, and relationship information from certain entities identified in the statute. These include:
  - all participating hospitals
  - skilled nursing facilities
  - home health agencies
  - independent clinical laboratories
  - renal disease facilities; and
  - any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges for health-related services for which it provides claims payment under any plan or program established under Title V or Title XX of the Social Security Act

- Section 42 CRF455.106 – Requires Managed Care Organizations, like EmblemHealth, to collect and report health care-related criminal conviction disclosure information (initially and upon renewal of their contracts) of any managing employee who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or a Title XX program.

Disclosure forms must be completed and submitted as part of the credentialing and recredentialing processes. This applies to both directly contracted providers and delegated entities. Disclosure forms must also be submitted when a reportable event occurs and upon request of the New York State Department of Health and EmblemHealth.

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Contact us – We're here to help you.

- **Emblemhealth.com/providers** – the easiest and fastest way to get answers to your questions on claim status, member coverage, and benefits.
- Use our Message Center. Sign in to **emblemhealth.com** and select "General Information" on the "Ask a Question" page.
- If you don't have web access and need to speak with a representative, call us at **866-447-9717**. It's best to call before 10 a.m. or after 2 p.m.

Note: This document provides website names as a convenience, as well as an educational and informational service to our providers. They are not intended to provide medical or professional advice. All medical information, whether from these websites or another source, must be reviewed carefully by the practitioner. The opinions and information expressed herein are not necessarily those of EmblemHealth. EmblemHealth does not guarantee or warrant that the websites referenced in this document, or any information contained therein, are complete, accurate, or up to date since the date of this document's publication in December 2018.

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2019 Network and Benefit Plan Updates

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Introduction and Summary Table

Company	Provider Network	Member Benefit Plan	
GHI	**Commercial:** CBP Network (Member ID cards may show: CBP, EPO, EPO1, EPO2, PPO, PPO1, or PPO4)	**New York City Plans** • GHI CBP plan • DC37 Med-Team	
	Commercial: National Network Tristate Network	EmblemHealth EPO/PPO	
	Commercial: Network Access Network	Network Access Plan	
	Medicare: Medicare Choice PPO Network	EmblemHealth Group Access Rx (PPO) EmblemHealth Group Access Rx National (PPO) ArchCare Advantage HMO SNP **Until December 31, 2018** • GuildNet Gold HMO SNP	
HIP/HIPIC	**Commercial:** Metro NY Network (Until December 31, 2017 for new sales)	**As of August 1, 2018, members moved to Prime Network:** • EmblemHealth CompreHealth EPO	
	Commercial: Premium & Vytra Premium Networks (Until December 31, 2017 for new sales)	Access I/II Prime HMO/POS/PPO/EPO Select PPO/EPO Vytra ASO	
	Commercial: Select Care Network	**Until December 31, 2018** **Individual On/Off Exchange:** • EmblemHealth Silver Value/Silver Value D • EmblemHealth Bronze Value/Bronze Value D	**As of January 1, 2019** **Individual On/Off Exchange:** • EmblemHealth Platinum/EmblemHealth Platinum D • EmblemHealth Gold/EmblemHealth Gold D • EmblemHealth Silver/EmblemHealth Silver D • EmblemHealth Bronze/EmblemHealth Bronze D • EmblemHealth Basic/EmblemHealth Basic D • EmblemHealth Gold Value/EmblemHealth Gold Value D • EmblemHealth Silver Value/ EmblemHealth Silver Value D **Small Group:** • EmblemHealth Platinum Choice • EmblemHealth Gold Choice • EmblemHealth Gold Value S • EmblemHealth Silver Choice • EmblemHealth Silver Value S • EmblemHealth Bronze Value S

Company	Provider Network	Member Benefit Plan	
HIP/HIPIC (Continued)	**Commercial:** Prime Network	**Until December 31, 2018** **Prime Network – NYC, LI & Westchester** • Child Health Plus **Large Group – Prime Network with Tristate Access:** • Prime HMO • HIP HMO Preferred (City of NY) • EmblemHealth HMO Plus • EmblemHealth HMO Preferred Plus • Prime POS • Access I • Access II • EmblemHealth EPO Value • GHI HMO • Vytra HMO **Large Group – Prime Network:** • Prime PPO • HIP Select PPO **Individual On/Off Exchange - Prime Network – NY Only:** • EmblemHealth Platinum/EmblemHealth Platinum D • EmblemHealth Gold/EmblemHealth Gold D • EmblemHealth Silver/EmblemHealth Silver D • EmblemHealth Bronze/EmblemHealth Bronze D • EmblemHealth Basic/EmblemHealth Basic D **Small Group - Prime Network with Tristate Access:** • EmblemHealth Platinum 15/35 • EmblemHealth Gold 40/60 • EmblemHealth Healthy NY Gold • EmblemHealth Silver Value S • EmblemHealth Bronze Value S • EmblemHealth Gold Open Access • EmblemHealth Bronze H.S.A.	**As of January 1, 2019** **Prime Network – NYC, LI & Westchester** • Child Health Plus **Large Group – Prime Network with Tristate Access:** • Prime HMO • HIP HMO Preferred (City of NY) • EmblemHealth HMO Plus • EmblemHealth HMO Preferred Plus • Prime POS • Access I • Access II • EmblemHealth EPO Value • GHI HMO • Vytra HMO **Large Group – Prime Network:** • Prime PPO • HIP Select PPO **Small Group - Prime Network with Tristate Access:** • EmblemHealth Platinum Premier • EmblemHealth Gold Premier • EmblemHealth Gold Premier 1 • EmblemHealth Gold Plus • EmblemHealth Gold Plus 1 • EmblemHealth Healthy NY Gold • EmblemHealth Silver Premier • EmblemHealth Silver Premier 1 • EmblemHealth Silver Plus • EmblemHealth Silver Plus 1 • EmblemHealth Bronze Plus H.S.A.
	Medicaid/Commercial: Enhanced Care Prime Network	EmblemHealth Enhanced Care (Medicaid) EmblemHealth Enhanced Care Plus (HARP) Essential Plan (BHP)	
	Medicare: Medicare Essential Network (Until December 31, 2018)	**Until December 31, 2018, members moved to VIP Prime Network:** • EmblemHealth VIP Essential (HMO) • EmblemHealth VIP Value (HMO)	
	Medicare: VIP Prime Network	**Until December 31, 2018** • EmblemHealth VIP Dual (HMO SNP) • EmblemHealth VIP Gold (HMO) • EmblemHealth VIP Gold Plus (HMO) • EmblemHealth VIP Premier (HMO) • EmblemHealth VIP Rx Carve-Out (HMO) • EmblemHealth VIP Dual Group (HMO SNP) • Medicare Cost Plan	**As of January 1, 2019** • EmblemHealth VIP Dual (HMO SNP) • EmblemHealth VIP Gold (HMO) • EmblemHealth VIP Gold Plus (HMO) • EmblemHealth VIP Premier (HMO) • EmblemHealth VIP Rx Carve-Out (HMO) • EmblemHealth VIP Dual Group (HMO SNP) • EmblemHealth VIP Rx Saver (HMO) • EmblemHealth VIP Part B Saver (HMO) • EmblemHealth VIP Go (HMO-POS) • EmblemHealth VIP Essential (HMO) • EmblemHealth VIP Value (HMO) • EmblemHealth Affinity Medicare Passport Essentials (HMO) • EmblemHealth Affinity Medicare Passport Essentials NYC (HMO) • EmblemHealth Affinity Medicare Ultimate (HMO SNP) • EmblemHealth Affinity Medicare Solutions (HMO SNP)

Company	Provider Network	Member Benefit Plan	
HIP/HIPIC (Continued)	**FIDA:** Associated Dual Assurance Network (Until December 31, 2018)	**Until December 31, 2018** GuildNet Gold Plus FIDA Plan	
ConnectiCare, Inc.	**Commercial:** Choice Network (includes full Prime Network) Passage Network (includes Prime Network except PCPs)	 Choice HMO Choice POS Passage HMO Passage POS	
ConnectiCare Insurance Company, Inc.	**Commercial:** Choice Network (includes full Prime Network) Flex Network (includes full Prime Network) Passage Network (includes Prime Network except PCPs)	 Choice EPO Choice POS FlexPOS Passage EPO Passage POS	
	Medicare: Passage Network	**Until December 31, 2018** n/a	**As of January 1, 2019** • Medicare Advantage • HMO SNP Plans
ConnectiCare of Massachusetts, Inc.	**Commercial:** Choice Network (includes full Prime Network)	 Choice HMO Choice POS	

2019 Network and Benefit Plan Updates

Section 1: Medicare Products

Network Area Expansion

Effective January 1, 2019, EmblemHealth's Medicare VIP Prime Network will include the following counties for all new and existing plans: Dutchess, Sullivan, Ulster, and Putnam counties. Additionally, it will include the boroughs of New York City, and Westchester, Nassau, Suffolk, Rockland, and Orange counties. Medicare product offerings may depend on the county.

Retiring Medicare Essential Network

The Essential Network is being retired at the end of 2018, and Medicare members will have access to the VIP Prime Network providers.

Key things to know about our 2019 Medicare plans

VIP Gold (HMO)

- Some changes in premium and cost-sharing. Primary care doctor (PCP) and specialist copays remain at 2018 levels.

VIP Essential (HMO)

- $0 PCP copays – NEW for 2019!
- 15 acupuncture visits per year added as a benefit
- Remains as $0 premium plan in NYC's 4 counties
- Some premium and cost-sharing changes
- Expanded network

VIP Value (HMO)

- Remains as $0 premium plan
- Reduced PCP copays to $15
- Optional dental and fitness benefit riders are available
- Some cost-sharing changes
- Expanded network

VIP Dual (HMO)

- Over-the-counter (OTC) amounts going up to $125 per month for NYC's 4 counties, and changing in other counties
- New Centers for Medicare & Medicaid Services (CMS) regulation allows dual members with Medicare and Medicaid to change plans only once per calendar quarter. They cannot change plans every month starting calendar year 2019.

VIP Gold Plus (HMO)

- We will continue to offer this plan with premium and cost-sharing changes.

New Medicare products for 2019

VIP Rx Saver (HMO)

- Low premium plan available in Bronx and Westchester counties
- $5 PCP copays and other great benefits
- Comprehensive dental and fitness benefits with no maximums

VIP Part B Saver (HMO)

- $0 premium plan that gives Part B premium money ($500 per year) back to members
- No deductible on primary care and specialist visits
- Deductible of $1,000 applies to some services
- Optional dental and fitness benefit riders are available at a low cost

VIP GO (POS)

- No referral requirements
- A PCP of record is optional
- Out-of-network coverage allowed on many benefits
- Inpatient hospital, primary care, specialty, outpatient hospital/surgery, ambulatory surgery, skilled nursing, and rehabilitation therapies are accessible in- and out-of-network
- Deductible of $500 applies to some services
- Beneficiary cost-sharing to be shared once finalized and approved

Section 2: Large Group Products

As of January 1, 2018, the CompreHealth EPO plan has been fully discontinued.
In the fourth quarter of 2018, we will increase the number of EmblemHealth EPO Value plans currently being marketed. Please be sure to verify your patients' copays as there will be additional cost-sharing options available.

As of January 1, 2018, the CompreHealth EPO plan has been fully discontinued.

Section 3: Small Group Products

In 2018, we moved most of our small group plans to the Prime Network to give our members access to more providers. We expanded our small group's Prime Network access to include New Jersey via QualCare and Connecticut via ConnectiCare.

Here are the changes to our suite of small group plans in 2019:

Plan	Change
EmblemHealth Platinum 15/35 (Platinum Premier)	No PCP required New Jersey & Connecticut added 7/1/18
EmblemHealth Gold Open Access (Gold Premier)	New Jersey & Connecticut added 7/1/18
EmblemHealth Gold 40/60 (Gold Plus)	New Jersey & Connecticut added 7/1/18
Silver Value	Moving back to Select Care Network in 2019
Bronze Value	Moving back to Select Care Network in 2019
Platinum Choice	New plan
Gold Premier 1	New plan
Gold Plus 1	New plan
Gold Choice	New plan
Gold Value	New plan
Silver Premier	New plan
Silver Premier 1	New plan
Silver Plus	New plan
Silver Plus 1	New plan
Silver Choice	New plan

In 2018, we moved most of our small group plans to the Prime Network to give our members access to more providers.

Section 4: New Individual Plan Being Offered in 2019

EmblemHealth Gold Value (with adult dental and vision)

This HMO plan offers specialist visits, urgent care visits, 3 free sick visits and primary care visits, lab services, $25 generic drugs, free telemedicine, free preventive care, free acupuncture, and dental and vision coverage for adults and kids — all before meeting the deductible.

Section 5: Children's Medicaid Redesign

EmblemHealth currently serves 56,000 Medicaid children. We are committed to taking care of New York's children. We have applied to provide expanded care under New York State's Medicaid Redesign program. This means that, if approved, we will enhance our Behavioral Health Services program to include more behavioral health services. We will also be able to offer home and community-based services (HCBS) to qualifying children, and better serve children in foster care. Below is a high-level summary of the new services that may be offered. The dates shared are based on the best information available from New York State at the time this brochure was printed. All dates are subject to change. More information will be provided as part of the new benefit implementations.

Children Under Waivers

Today, the state has a number of "waivers," or exceptions, in place that carve-out certain children from Medicaid Managed Care. The exceptions were generally for people who would otherwise be in an institution, nursing home, or hospital, but who were instead provided with a special package of benefits so they could continue to live at home with their families.

Each waiver describes a different population of children who are slated to move to managed care. They are referred to based on the name of the regulation or the governmental agency that made the services available. The objective is to sunset these separate programs and have health plans like ours administer these benefits instead. For example, under a 1915(c) HCBS Waiver Program, HCBS meet the needs of people who prefer to get long-term care services and support in their home or community, rather than in an institutional setting. Here are the key waiver programs in scope for the transition:

1915(C) HCBS Waiver Programs Care at Home Waivers (CAH): Provides medical and related services to families with physically and developmentally disabled children.

- DOH CAH Waiver (CAH I/II): for physically disabled children
- OPWDD CAH Waiver (CAH III, IV, V): for developmentally disabled children

Office of Children and Families (OCFS), Bridges to Health (B2H), Developmental Disability (DD), and Medically Fragile Waivers

- Provides children in foster care who have significant mental health or developmental disabilities, or health care needs, with services to help them live in a home or community-based setting.

OMH Waiver for Children and Adolescents with Serious Emotional Disturbance (SED)

- Provides services and support to children and adolescents with serious emotional disturbances and their families to enable them to remain at home and in the community.

Medically Fragile Children

In addition to children who have been receiving services via one of the waiver programs, New York State would like managed care plans to provide enhanced services to medically fragile children who meet the following criteria:

- Chronic debilitating conditions that **may** include:
  - Bronchopulmonary dysplasia
  - Cerebral palsy
  - Congenital heart disease
  - Microcephaly
  - Muscular dystrophy
- They may also meet one or more of the following:
  - Technologically dependent for life or health-sustaining functions
  - Require complex medication regimen or medical interventions
  - In need of ongoing assessment or intervention to prevent serious deterioration

Foster Care Transition

Exclusion from mandatory managed care enrollment for children in the care of Voluntary Foster Care Agencies will be removed.

- Children in the care of Voluntary Foster Care Agencies will be required to enroll in a Medicaid Managed Care plan.
- Children in foster care who receive aligned HCBS will be required to enroll in a Managed Plan.

Reminder: Children in foster care in the care of the local district began enrolling in plans in 2013.

- Plans who currently serve these children will continue to maintain responsibility for their care.
- Their aligned children's HCBS will continue to be paid through the fee-for-service delivery system until July 1, 2019.

Children's Home and Community-Based Services (HCBS)

The following are the HCBS that will be available to qualifying children:

- Health Home Care Management
- Accessibility Modifications
- Adaptive and Assistive Equipment
- Caregiver/Family Supports and Services
- Community Self-Advocacy Training and Support
- Habilitation
- Non-Medical Transportation
- Palliative Care
- Prevocational Services
- Respite
- Supported Employment
- Financial Management Services for the Customized Goods and Services (phased in as a pilot)
- Customized Goods and Services (phased in as a pilot)

Eligibility: 1) target criteria; 2) risk factors; and 3) functional criteria as well as Medicaid eligibility; limited to children that would otherwise qualify for institutional placement level of care (LOC) criteria.

Community First Choice Option (CFCO)

CFCO State Plan Services for children meeting aligned children's HCBS eligibility criteria. CFCO services include:

- Assistive Technology
- Community Transitional Services
- Congregate and Home Delivered Meals
- Environmental Modification
- Home and Community Support Services
- Moving Assistance
- Transportation

Eligibility: Available to children who are eligible for Medicaid solely because of receipt of HCBS.

Section 6: Medicaid Children's Behavioral Health Carve-in

New York State created HARP (Home Affordable Refinance Program) to cover Medicaid adults with behavioral health issues. The program started in NYC and then expanded to additional counties. Similarly, the state is now looking to move the responsibility for behavioral health for Medicaid children to a managed care plan like ours. These are the new services that will be available:

Behavioral Health Services

- New York State Office of Alcoholism and Substance Abuses Services (OASAS) opioid treatment program (OTP) services (hospital-based programs)
- OASAS outpatient rehabilitation programs (hospital-based programs)
- OASAS outpatient services (hospital-based programs)
- Partial hospitalization
- Personalized recovery-oriented services (minimum age is 18 for this adult-oriented service)
- Continuing day treatment (minimum age is 18 for this adult-oriented service)
- Comprehensive psychiatric emergency program (CPEP) including extended observation bed
- Assertive community treatment (minimum age is 18 for this adult-oriented service)
- Residential supports and services (new early and periodic screening, diagnostic and treatment [EPSDT] prevention, formerly known as foster care Medicaid per diem)

Eligibility: Available to any Medicaid enrollee under 21 years of age who meets Medical Necessity Criteria (MNC).

State Plan EPSDT Services:

- EPSDT: Early and Periodic Screening, Diagnostic and Treatment
- Other Licensed Practitioner (OLP)
- Children's Crisis Intervention (CCI)
- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation Services (PSR)
- Family Peer Support Services (FPSS)
- Youth Peer Support and Training (YPST)

Eligibility: Available to any Medicaid enrollee under 21 years of age who meets Medical Necessity Criteria (MNC).

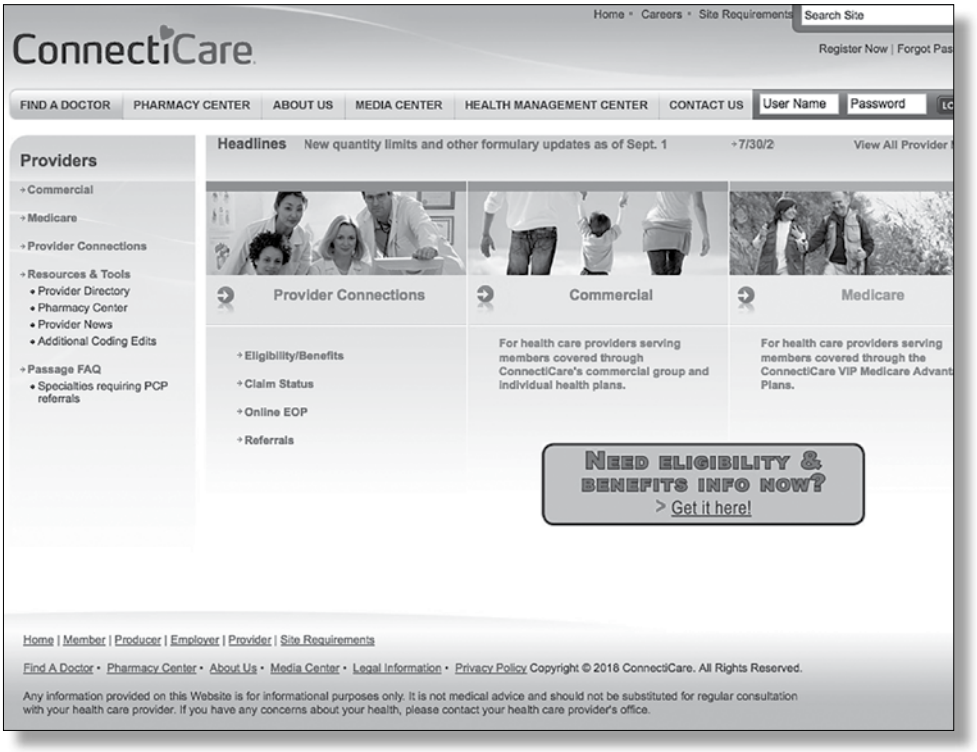
Subject to the availability of Global Cap Resources in Excess of Budget Restoration; Subject to timely CMS and other state approvals	
• All 1915(c) children's waivers transition to Health Home	October 2018
• Implement three **new** state plan services (OLR, PSR, CPST) in Managed Care Benefit • Children from OMH SED, DOH CAH, and OPWDD CAH 1915(c) waivers transition to Managed Care • Implement **new** array of 12 HCBS in Managed Care Benefit	January 2019
• Implement **new** FPSS • Implement three-year phase-in of LOC eligibility for HCBS Begins (within limits of Global Spending Cap) • Foster care population, including B2H Waiver Program children, transition to Managed Care • Existing behavioral health benefits transition to Managed Care for children	July 2019
• Implement **new** YPST and CCI services	January 2020

Support Medicaid recertification

Remind Medicaid members to recertify two months prior to their Eligibility End Date to avoid losing eligibility. Anticipated end dates may be found on the Eligibility Detail screen in the provider portal and on the PCP Roster. If your Medicaid patients have questions about the renewal process or want help in completing the renewal application, they can call us at **888-432-8026**.

Section 7: ConnectiCare Products

EmblemHealth Prime Network providers in New York State are also in-network providers for commercial group members of ConnectiCare. ConnectiCare, based in Connecticut, is a subsidiary of EmblemHealth. Payment for services to ConnectiCare members follows your contract with EmblemHealth for commercial members in the Prime Network. Register on **connecticare.com/providers** to look up ConnectiCare medical and pharmacy policies and check members' eligibility and benefits. The EmblemHealth logo will be displayed on the front or back of the members' ConnectiCare ID card.



Section 8: ASO Client's Plans

GuildNet Gold Plus-Fully Integrated Dual Advantage Plan (FIDA) and GuildNet Gold-Medicare Advantage Plan end on December 31, 2018

Beginning January 1, 2019, EmblemHealth will no longer supply the provider networks (Associated Dual Assurance Plan Network underwritten by Health Insurance Plan of Greater New York and Medicare Choice PPO Network underwritten by Group Health Incorporated) and management services to GuildNet. Clinicians that currently serve special needs plan (SNP) members still need to take GuildNet's 2018 SNP MOC (model of care) training.

Notes

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Access, Availability & After Hours Coverage Standards

The access to care standards in the following tables are monitored using random audits. We want you to pass if you are selected for one! Below are avoidable mistakes that count as audit failures. Please take the time to periodically review these common mistakes and the standards that follow with your appointment schedulers.

TIP: Successful practices conduct their own secret shopper audits!

Don't Fail! Avoid These Mistakes

	Routine and Non-Urgent "Sick" Appointments	**After Hours Access**
Failure reasons if no "live voice" reached:	• No answer • On hold for >10 minutes • Answering machine/voicemail • Answering service • Wrong telephone number • Telephone number is not in service • Constant busy signal	• No answer • No answer at the after-hours number • Wrong telephone number • Telephone number is not in service • Constant busy signal • Answering machine/voicemail with no instruction on how to access non-emergency after-hours care (Messages that instruct patients to go directly to the hospital are counted as failures.) • Answering machine/voicemail with instruction to leave message for provider but the call-back time was unspecified
Failure reasons if a "live voice" is reached, but an appointment cannot be made:	• Staff inaccurately states that the health care professional is: – Not accepting new patients – Not a plan participant – Restricted to specialty care or changed specialty • Staff not scheduling appointments at this time • Staff requires previous medical records before appointment can be made • Health care professional requires a referral • Health care professional not at site and no alternative provider available • Health care professional will not see patient because the pregnancy is too far along • Health care professional must see Social Worker/Case Manager before a medical appointment can be made • Caller told they must complete a health questionnaire/registration form before medical appointment can be made • Caller instructed to go to Emergency Room	• Health care professional does not participate with caller's health plan • Health care professional no longer at site • Health care professional is not covered by an answering service • On hold for >10 minutes • Caller told to call back the next day for an appointment • Hospital/facility staff could not identify the requested health care professional

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

Standards	Definition	Scheduled Appointment Time Frame
Emergency Care (Emergent)[1]	Emergency care is medical care given for a condition that, without immediate treatment, could result in placing the member's life or general health in severe jeopardy, or cause severe impairment in one or more bodily function(s), or cause severe dysfunction of one or more body organ(s) or parts. Examples of emergency conditions include seizure, stab/ gunshot wounds, diabetic coma, cardiac arrest, meningitis, and obvious fracture (bone showing through skin).	Requires **immediate** face-to-face medical attention. If a practitioner or covering practitioner is not immediately available, the member or representative should call **911**.
Urgent Care	Urgent care is medical care given for a condition that, without timely treatment, could be expected to deteriorate into an emergency or cause prolonged, temporary impairment in one or more bodily function(s), or development of a chronic illness or need for a more complex treatment. Examples of urgent conditions include abdominal pain of unknown cause, unremitting new symptoms of dizziness (cause unknown), and suspected fracture.	Requires timely face-to-face medical attention within **24 hours** of member notification of the existence of an urgent condition.
Non-Urgent Sick Visit	Medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non- urgent sick visits include cold symptoms, sore throat, and nasal congestion.	Requires face-to-face medical attention within **48 to 72 hours** of member notification of a non-urgent condition, as clinically indicated.
Routine Primary Care	Routine primary care services include the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/ reduce risk of development of chronic illness or the need for more complex treatment. Examples include psoriasis, and chronic low back pain.	Requires a face-to-face visit within **4 weeks** of member request.
Preventive Care/Routine Physical Exam	Preventive care or services are rendered to avert disease/ illness and/or its consequences. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred.	Requires a face-to-face visit within **4 weeks** of member request.
Routine Specialty Care	Specialty care is medical care given by a specialist. Examples include podiatry and neurology.	Requires a face-to-face visit within **4 weeks** of member request.
Oncology Specialist Visit	Initial oncology visit for medical care when the patient has a positive test result and is requesting an initial visit.	Requires appointment within **3 business days** of member request.
Assessment Regarding Ability to Perform/Return to Work	An appointment for assessment of the member's mental health/ medical status needs as related to recommendation regarding member's capability to perform or return to work.	Requires appointment within **2 business days** of member request.
Initial Family Planning/ Reproductive Health Visits	Family planning/reproductive health services include screening and treatment services to prevent, diagnose, alleviate, or ameliorate sexually transmitted diseases, anemia, cervical cancer, glycosuria, proteinuria, hypertension, and breast disease. Also includes routine gynecological examinations, pregnancy testing, and HIV counseling and testing.	Requires a face-to-face visit within **2 weeks/14 days** of member request.

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

Standards	Definition	Scheduled Appointment Time Frame
Initial Prenatal Visit	Initial prenatal visit is medical care given for a condition in which the patient has tested positive for pregnancy and is requesting an initial visit.	Requires appointment scheduled within **3 weeks** for first trimester, **2 weeks** for second trimester, and **1 week** for third trimester. A schedule of follow-up appointments is given to the patient based on American College of Obstetricians and Gynecologists guidelines and practitioner risk assessment.
Postpartum Visit	During the postpartum visit, an assessment of the mother's blood pressure, weight, breasts, abdomen, and a pelvic exam is conducted to determine the mother's physical health status and general well-being following childbirth.	Requires a face to face visit within 2**1 – 56 days** following delivery.
Routine GYN Visit	Routine GYN care is a situation in which a short delay in treatment would not result in deterioration to a more severe level or cause need for more complex treatment. Examples include routine pap smear, and refill of oral contraceptives.	Requires a face-to-face visit within **4 weeks** of member request.
Pediatrician Conference	A prenatal visit (during 3rd trimester) is recommended for parents who are at high risk, for first-time parents, and for those who request a conference.	Requires appointment scheduled within **10 days** of member request or as clinically indicated.
Follow-Up Visit for Breast- Fed Infants	Follow-up visit for a breast-fed infant is medical care given for a condition in which delay of treatment could result in failure to thrive, dehydration, and/or malnutrition.	Requires face-to-face medical attention within **48 to 72 hours** of discharge.
Initial Newborn PCP Visit	An appointment for assessment of a newborn's physical status to ascertain the general well- being of the child and to promote early detection of immediate medical needs and promote early educational opportunities.	Requires appointment within **2 weeks** of hospital discharge.
Routine Well-Child Visits	Well-child services are those provided to members under 21 years of age that are essential to: a) prevent, diagnose, prevent the worsening of, alleviate, or ameliorate the effects of an illness, injury, disability, disorder, or condition; b) assess the overall physical, cognitive, and mental growth and developmental needs of the child; and c) assist the child to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.	Requires well-child services within **4 weeks** of member request.
Any Other Condition		Up to medical judgment of the practitioner.

Standards	Definition and Benchmark
Geographic (GEO) Access Standards for All Physicians	Members must be offered a choice of at least three (3) PCPs, three (3) OB/GYNs, and three (3) high-volume specialists within program distance/travel time standard. Normal condition/primary road – 30 miles/30 minutes. Rural areas – 60 miles/60 minutes.
Office Waiting Time Standard	Members with appointments should be seen within 15 minutes, but no later than 30 minutes, of their scheduled appointment time or arrival time, whichever is later. If a delay is unavoidable, the member should be informed and alternatives offered to the patient.
24-Hour Accessibility	All network practitioners must be available, either directly or through coverage arrangements, 24 hours a day, 7 days a week, 365 days a year. Availability must be by live voice direct to the practitioner or covering practitioner, or via an answering service that can reach the practitioner or covering practitioner. If an answering machine is used, it must provide an option for the member to directly contact the practitioner or covering practitioner in case of emergencies. An answering machine cannot simply refer the member to an emergency room unless it is a life-threatening issue.

Behavioral Health Standards

Standards	Definition	Scheduled Appointment Time Frame
Emergency Care (Emergent)	An emergency appointment for life- threatening mental health or substance abuse conditions (suicidal intent) or for non-life-threatening mental health or substance abuse conditions that nevertheless necessitate immediate intervention, i.e., psychosis.	Requires **immediate** face-to-face medical care. The member or representative should call **911**.
Urgent Care	An urgent appointment for an acute mental health or substance abuse condition, or a condition that may become an emergency if not treated, i.e., acute major depression and acute panic disorder.	Requires appointment scheduled within **24 hours**.
Follow-Up for Emergency/ Hospital Discharge	An appointment for a follow-up visit related to an emergency room or hospital discharge for evaluation of acute mental health condition.	Requires appointment scheduled within **5 days** of member request or as clinically indicated, but no later than **7 days** post discharge.
Routine Care	An appointment for specific mental health or substance abuse concerns that are not of an urgent nature, i.e., marital problems, tensions at work, and general anxiety disorder.	Requires appointment within **10 business days** of member request.
Average Speed to Answer	The amount of time it takes for a live voice to answer the telephone in the Mental Health Department.	Telephone call answered by a live voice within **30 seconds**.
Call Abandonment	The number of calls that went unanswered by a "live voice" and ultimately voluntarily disconnected in the Mental Health Department.	Less than **5 percent**.

Appointment Availability Standards for Medicaid Behavioral Health Providers

Service Type	Emergency	Urgent	Non-Urgent MH/ SUD	BH Specialist	Pursuant to Emergency or Hospital Discharge	Pursuant to Incarceration Release
MH or SUD Outpatient Clinic/ PROS Clinic		Within 24 hrs	Within 1 wk of request		Within 5 days of request	Within 5 days of request
ACT		Within 24 hrs for AOT		N/A	Within 5 days of request	
PROS		Within 24 hrs	Within 2 wks of request	Within 2 wks of request	Within 5 days of request	Time frame to be determined
Continuing Day Treatment				2-4 wks		Time frame to be determined
IPRT				2-4 wks		
Partial Hospitalization					Within 5 days of request	
Inpatient Psychiatric Services	Upon presentation					
CPEP	Upon presentation					
OASAS Outpatient Clinic		Within 24 hrs	Within 1 wk of request		Within 5 days of request	Time frame to be determined
Detoxification	Upon presentation					
SUD Inpatient Rehab	Upon presentation	Within 24 hrs				
Stabilization Treatment Services in OASASCertified Residential Settings		Within 24 hrs				
Opioid Treatment Program		Within 24 hrs			Within 5 days of request	
Rehabilitation Services for Residential SUD Treatment Supports				2-4 wks	Within 5 days of request	
Home and Community-Based 1915(I)-Like Services						
Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, and Family Support and Training	N/A	N/A	Within 2 wks of request		Within 5 days of request	Within 5 days of request
Short-Term and Intensive Crisis Intervention/Respite	Immediately	Within 24 hrs	N/A		Immediate	
Educational and Employment Support Services, including Pre-Vocational Services	N/A		Within 2 wks of request		N/A	
Peer Supports	N/A	Within 24 hrs for symptom management	Within 1 wk of request		Within 5 days of request	

KEY
MH - Mental Health
PROS - Personalized Recovery Oriented Services
ACT - Assertive Community Treatment
AOT - Assisted Outpatient Treatment
BH - Behavioral Health
IPRT - Intensive Psychiatric Rehabilitation Treatment Programs
CPEP - Comprehensive Psychiatric Emergency Program
OASAS – Office of Alcoholism and Substance Abuse Services
SUD - Substance Use Disorder

Standards	Definition and Benchmark
Appointment Waiting Time	Providers must have policies and procedures addressing members who present for unscheduled, non-urgent care with the aim of promoting access to appropriate care.
Travel Time Standards for Primary Care	Travel time/distance to primary care sites shall not exceed 30 minutes from the member's residence in metropolitan areas or 30 minutes/30 miles from the member's residence in non-metropolitan areas. Transport time and distance in rural areas to primary care sites may be greater than 30 minutes/30 miles from the member's residence if based on the community standard for accessing care, or if by member's choice. The member may, at their discretion, select a participating primary care physician (PCP) located farther from their home as long as they are able to arrange and pay for transportation to the PCP themselves. In the case of a Restricted Enrollee, the member can select a Restricted Recipient Program (RRP) PCP further from their home as long as they are able to arrange and pay for transportation to the RRP PCP themselves.
Travel Time Standards for Other Providers	Travel time/distance to specialty care, hospitals, mental health, lab, and x-ray providers shall not exceed 30 minutes/30 miles from the member's residence. Transport time and distance in rural areas to specialty care hospitals, mental health, lab, and x-ray providers may be greater than 30 minutes/30 miles from the member's residence if based on the community standard for accessing care, or if by member's choice.

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EmblemHealth®

2019 EmblemHealth Contact Information

	Prime Network Select Care Network VIP Prime Network Enhanced Care Prime Network	CBP Network (City of New York) Tristate Network/National Network Medicare Choice PPO (GHI Retirees)
Provider Customer Service	Use the Message Center link at emblemhealth.com; **866-447-9717** Montefiore (CMO)-managed members: **888-666-8326** HealthCare Partners (HCP)-managed members: **800-877-7587** **Note:** To identify managing entity, refer to member's ID card or sign in to emblemhealth.com and use Benefits/Eligibility link.	Use the Message Center link at emblemhealth.com; GHI PPO City of New York members: **800-624-2414** Non City of New York members: **866-447-9717** GHI retirees: **866-557-7300**
Member Customer Service	Commercial non-HIX: **800-447-8255 (TTY: 711)** Health care exchange: **888-447-7703 (TTY: 711)** Medicare: **877-344-7364 (TTY: 711)** Medicaid/HARP and Child Health Plus: **855-283-2146 (TTY: 711)**	GHI PPO City of New York members: **212-501-4444 (TTY: 711)** Non City of New York members: **877-842-3625 (TTY: 711)** GHI retirees: **866-557-7300 (TTY: 711)**
Pre-Certifications/Prior Approvals	HIP-managed members: emblemhealth.com; **866-447-9717/866-215-2928** CMO-managed members: **888-666-8326** HCP-managed members: **800-877-7587/888-746-6433**	GHI PPO City of New York members, contact Empire BCBS: **800-521-9574/800-241-5308** Non City of New York members and GHI retirees: **800-223-9870/212-563-8391**
Referrals	HIP-managed members: emblemhealth.com; **866-447-9717** CMO-managed members: **888-666-8326** HCP-managed members: **800-877-7587/888-746-6433** **Note:** Referrals not required for Access I, Access II, and EPO/PPO plans.	These plans do not require referrals.
Independent/Free-Standing Laboratory Services	questdiagnostics.com Quest Diagnostics customer service: **866-697-8378;** Quest Diagnostics patient service center locator: **800-377-7220** **Note:** For a full list of contracted labs, go to emblemhealth.com/labservices.	
Behavioral Health **Note:** Behavioral health is not a covered benefit for Healthy NY members.	Prior approvals: beaconhealthoptions.com Beacon Health Options: **888-447-2526** CMO-managed members: **800-401-4822**	Pre-Certifications: beaconhealthoptions.com Beacon Health Options: **800-692-2489**
Pharmacy Services	Prior approvals: **877-444-3657** **Note:** Medicaid/HARP members use the Walgreens Advantage Pharmacy. Use express-scripts.com/emblemmedicaid or call **855-283-2146** to find an in-network pharmacy. Mail order: Express Scripts: **800-305-5287** Preferred Specialty Pharmacy: Accredo: accredo.com **855-216-2166/888-302-1028**	
Injectable Drug Utilization Management (UM) Program	Prior approvals for HIP-managed members: **888-447-0295/877-243-4812** CMO-managed members: **888-666-8326** HCP-managed members: **800-877-7587/888-746-6433**	GHI PPO City of New York members, call Empire BCBS: **800-521-9574** Prior approvals for FEHB members and GHI retirees, use: **888-447-0295/877-243-4812**

For a comprehensive listing of all EmblemHealth Networks and corresponding benefit plans, see the Provider Networks and Member Benefit Plans chapter of the EmblemHealth Provider Manual at emblemhealth.com. EmblemHealth also supports ASO clients with provider networks and administrative services. Information specific to GuildNet is provided in separate guides. A referral or approval is not a guarantee of payment. Payment is subject to the participation agreement, member's eligibility and benefits on the date of service, compliance with utilization management policies, and application of EmblemHealth's medical and claims policies.

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2019 EmblemHealth Contact Information (Continued)

	Prime Network Select Care Network VIP Prime Network Enhanced Care Prime Network	CBP Network (City of New York) Tristate Network/National Network Medicare Choice PPO (GHI Retirees)
Home Infusion Therapy	Prior approvals: homeinfusion@emblemhealth.com; **800-367-8103**/ **212-510-5978**	Pre-Certifications: emblemhealth.com; **800-223-9870**/ **212-563-8391**
Radiology Services	eviCore Scheduling Program for HMO/POS members: **866-699-8131** Prior approvals for HMO/POS members: evicore.com; **866-417-2345**/ **800-540-2406** Prior approvals for EPO/PPO members: emblemhealth.com; **866-447-9717**/ **866-215-2928** CMO-managed members: **888-666-8326** HCP-managed members: **800-877-7587**/ **888-746-6433**	Pre-Certifications: **evicore.com**; **800-835-7064**
Cardiology Imaging Services	eviCore Scheduling Program for HMO/POS members: **866-699-8131** Prior approvals for HMO/POS members: **evicore.com**; **866-417-2345**/ **888-622-7369** Prior approvals for: EPO/PPO members: emblemhealth.com; **866-447-9717**/ **866-215-2928** CMO-managed members: **888-666-8326** HCP-managed members: **800-877-7587**/ **888-746-6433**	Pre-Certifications: emblemhealth.com; **800-223-9870**/ **212-563-8391**
Durable Medical Equipment (DME); Skilled Nursing Facility; Inpatient Rehabilitation Facility; Long-Term Care Facility; Home Health Care	Prior approvals: evicore.com; **866-417-2345**/ **888-622-7369** Not all medical/surgical supplies are covered for state-sponsored HMO members. See the DME chapter of the Provider Manual at emblemhealth.com/Providers/Provider-Manual. Personal Care Assistants & Consumer Directed Personal Assistance Program Prior Approvals: emblemhealth.com; **866-447-9717** CMO-managed members: **888-666-8326** HCP-managed members: **800-877-7587**/ **888-746-6433**	GHI PPO City of New York members, contact Empire BCBS: **800-521-9574**/ **800-241-5308** Commercial Benefits Plan Durable Medical Equipment over $2,000, call NYC Health Line: **800-521-9574**
Diabetic Testing Supplies	Orders: abbottdiabetescare.com; **888-522-5226**	Pre-Certifications (only for insulin pumps and related supplies), contact Health Solutions: **800-881-4008**/ **800-860-4326** Orders: CCS Medical: **800-248-9505** CCS Medical, 3601 Thirlane Rd. NW, Suite 4, Roanoke, VA 24019 Orders for GHI retirees: abbottdiabetescare.com; **888-522-5226**
Hearing Aids	HearUSA: hearusa.com/; **877-664-9353** Bronx, Kings, Monroe, Nassau, New York, Queens, Rensselaer, Richmond, Rockland, Suffolk, Ulster, and Westchester CPS Hearing: cpshearing.com; **212-675-5745** Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Upstate New York	
Outpatient Physical and Occupational Therapy **Note:** For Healthy NY members, physical therapy is only covered as part of home health care or following surgery or a hospital stay.	Initial referrals and prior approvals for Healthy NY High Deductible Health Plan (HDHP): emblemhealth.com; **866-447-9717** Prior approvals for HMO/POS members: palladianhealth.com; **877-774-7693**/ **716-809-8324** CMO-managed members: **888-666-8326** HCP-managed members: **800-877-7587** **888-746-6433**	GHI PPO City of New York members, contact Empire BCBS: **800-521-9574**/ **800-241-5308** Commercial Benefits Plan (CBP): • Physical therapy precertification required after 16th visit. Call NYC Health Line: **800-521-9574** • Occupational therapy only covered in conjunction with home health care. Pre-Certification required. All other members: no prior approval required.

2019 EmblemHealth Contact Information (Continued)

	Prime Network **Select Care Network** **VIP Prime Network** **Enhanced Care Prime Network**	**CBP Network (City of New York)** **Tristate Network/National Network** **Medicare Choice PPO (GHI Retirees)**
Chiropractic Services **Note:** Chiropractic services are not a covered benefit for Medicaid, Child Health Plus, or Healthy NY members.	Prior approvals for HMO/POS members: palladianhealth.com; **877-774-7693/716-712-2802** Prior approvals for: EPO/PPO, Access I, Access II members: emblemhealth.com; **866-447-9717/866-215-2928** CMO-managed members: **888-666-8326** HCP-managed members: **800-877-7587/888-746-6433**	Pre-certifications required after the first eight visits in a calendar year: palladianhealth.com; **877-774-7693/716-712-2817**
Vision Services	EyeMed: eyemed.com; **888-581-3648** Medicaid/HARP and Child Health Plus members: **877-324-2791**	
Dental Services	DentaQuest: dentaquest.com; **844-822-8108** Medicaid/HARP and Child Health Plus members: **844-776-8748**	**800-624-2414**
Pain Management & Spinal Surgery	Prior approvals for HIP-managed members: OrthoNet: **844-296-4440** For forms: orthonet-online.com; **844-730-8503** Prior approvals for: CMO-managed members : **888-666-8326** HCP-managed members: **800-877-7587/888-746-6433**	For pre-certification status: Medical Management: **844-730-8503** GHI PPO City of New York members, contact Empire BCBS: **800-521-9574/800-241-5308**
MTM Transportation Service	**888-857-1509**	**n/a**

EmblemHealth®

Network Laboratory Services For All Plan Members

Fall 2018

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

LABORATORY NAME	PLANS COVERED	PHONE NUMBER	WEBSITE
ROUTINE CLINICAL LABORATORY SERVICES			
Quest Diagnostics, Inc.	All Plans*	**1-866-697-8378**	**questdiagnostics.com**
ACM Medical Laboratory	EmblemHealth EPO/PPO, GHI PPO	**1-800-525-5227**	**acmlab.com**
Lab Alliance of Central New York, LLC	EmblemHealth EPO/PPO, GHI PPO	**1-315-461-3008**	**laboratoryalliance.com**
CARDIOVASCULAR DISEASE			
Quest Diagnostics, Inc.	All Plans*	**1-866-697-8378**	**questdiagnostics.com**
DERMATOPATHOLOGY			
Quest Diagnostics, Inc.	All Plans*	**1-866-697-8378**	**questdiagnostics.com**
AmeriPath New York, LLC (aka Dermpath Diagnostics and Ackerman Academy of Dermatopathology)	All Plans*	**1-800-942-3376** (Dermpath) and **1-800-553-6621** (Ackerman)	**ameripath.com**
InterScience Diagnostics	GHI Underwritten Networks and Plans ONLY	**1-718-698-5461**	**intersciencelabs.net**
Inform Diagnostics, Inc.	EmblemHealth EPO/PPO, GHI PPO	**800-979-8292**	**www.informdx.com**
DIALYSIS TESTING			
DaVita Labs	All Plans*	**1-800-604-5227**	**davita.com**
Spectra Laboratories	All Plans*	**1-800-522-4662 or 1-800-433-3773**	**spectra-labs.com**
ENDOCRINOLOGY			
Quest Diagnostics, Inc.	All Plans*	**1-866-697-8378**	**questdiagnostics.com**
GASTROENTEROLOGY/PATHOLOGY			
Quest Diagnostics, Inc.	All Plans*	**1-866-697-8378**	**questdiagnostics.com**
AmeriPath New York	All Plans*	**1-866-393-7434**	**ameripath.com**
Lakewood Pathology Associates (dba Miraca Life Sciences)	EmblemHealth EPO/PPO, GHI PPO	**1-800-440-7284**	**plusdx.net**
GENE-BASED TESTING			
Quest Diagnostics, Inc.	All Plans*	**1-866-697-8378**	**questdiagnostics.com**
AmeriPath New York, LLC (aka AmeriPath Northeast)	All Plans*	**1-866-436-9631**	**ameripath.com**

(Continued)

Network Laboratory Services for All Plan Members

(Continued)

LABORATORY NAME	PLANS COVERED	PHONE NUMBER	WEBSITE
Genomic Health	All Plans*	**1-866-662-6897**	**genomichealth.com**
Mount Sinai Genetic Testing Laboratory	All Plans*	**1-212-241-7518**	**mssm.edu**
HEMATOLOGY/ONCOLOGY/PATHOLOGY			
Quest Diagnostics, Inc.	All Plans*	**1-866-697-8378**	**questdiagnostics.com**
AmeriPath New York, LLC (aka AmeriPath Northeast)	All Plans*	**1-866-436-9631**	**ameripath.com**
Lakewood Pathology Associates (dba Miraca Life Sciences)	EmblemHealth EPO/PPO, GHI PPO	**1-800-440-7284**	**plusdx.net**
Interscience Diagnostic Laboratories, Inc.	GHI – Underwritten Networks and Plans ONLY	**1-718-698-5461**	**interscience labs.com**
NEUROLOGY/PATHOLOGY			
Quest Diagnostics, Inc.	All Plans*	**1-866-697-8378**	**questdiagnostics.com**
Interscience Diagnostic Laboratories, Inc.	GHI – Underwritten Networks and Plans ONLY	**1-718-698-5461**	**interscience labs.net**
PAIN MANAGEMENT			
Quest Diagnostics, Inc.	All Plans*	**1-866-697-8378**	**questdiagnostics.com**
American Forensic Toxicology Services	All Plans*	**1-855-895-8090**	**aftslabs.com**
UROLOGY/PATHOLOGY			
Quest Diagnostics, Inc.	All Plans*	**1-866-697-8378**	**questdiagnostics.com**
AmeriPath New York	All Plans*	**1-866-393-7434**	**ameripath.com**
Lakewood Pathology Associates (dba PLUS Diagnostics)	EmblemHealth EPO/PPO, GHI PPO	**1-800-440-7284**	**plusdx.net**
Interscience Diagnostic Laboratories, Inc.	GHI – Underwritten Networks and Plans ONLY	**1-718-698-5461**	**interscience labs.com**

* All Plans: EmblemHealth Select Care, , EmblemHealth EPO/PPO, EmblemHealth Medicare HMO/PPO, GHI HMO, HIP and Vytra HMO/ASO

Note: In addition, for network hospitals that have their own lab and pathology group(s) contracted with EmblemHealth, physicians may use their lab and pathology services.

EmblemHealth®

EmblemHealth Provider Manual Chapter List

Our online provider manual is separated into chapters, so it's easy for you to find what you need, including information about all our plans.

Plus, you can also get automatic email updates when we make changes. Just follow these steps:

- Go to **emblemhealth.com/providers/provider-manual**.
- Click on the "Select Chapter" drop-down menu and select from the list.
- Click on the "Chapter Sections" drop-down menu and select from the list.
- Click "Go."
- Click "Subscribe" at the top-right of the section you want to subscribe to.
- Answer the questions.
- Click "Submit."

Note: The manual has information about all our networks and plans, but your contract(s) explains the networks and plans that apply to you. Our **Learn Online** webpage includes video tutorials to help you.

Provider Manual Chapters

CHAPTER TITLE	WHAT'S THERE
Directory	Information about how to reach key contacts.
Credentialing	Requirements for credentialing or re-credentialing, including: • The managed care law requiring provisional credentialing. • How to appeal if your participation changes.
Member ID cards	Samples of our member ID cards.
Member policies and rights	Member rights and responsibilities, including privacy rights.
Provider networks and member benefit plans	Our networks and member benefit plans.
Fully Integrated Dual Advantage (FIDA) (until 12/31/18)	GuildNet's Dual Assurance FIDA plan (Medicare-Medicaid Plan), including: • Covered services. • Rights and responsibilities. • Criteria for culturally-, linguistically-, and disability-competent care. • Accessibility requirements.
Access to care and delivery system	Policies about access standards, including: • Participation requirements. • Roles of primary care and specialty care providers. • How to update your practice records. • Provider termination procedures. • Direct access services. • Access and availability standards.
Health promotion and disease management	Programs that can help members with special health needs.
Pharmacy services	Drug coverage, including: • Pharmacy benefits. • Medication Therapy Management program. • Home delivery.
Injectables and specialty pharmacy program	Information about our Injectables and Specialty Pharmacy program, including prior approval requirements.

(Continued)

EmblemHealth Provider Manual Chapter List

(Continued)

Chapter title	What's there
Spine surgery and pain management therapies program	Information about our Spine Surgery and Pain Management Therapies program
Durable medical equipment	Instructions about how to get prior approval for durable medical equipment.
Home health care	Prior approval process for services to HIP members, including transitional care.
SNF IRF LTAC	The prior approval process for post-acute care and direct admissions to the facilities below for HIP members. • Skilled Nursing Facilities (SNF) • Inpatient Rehabilitation Facilities (IRF) • Long Term Acute Care (LTAC)
Medical transportation procedures	Information about transportation for Medicaid and Medicare Advantage members.
Care management	Care coordination policies, including: • Referrals, prior approvals/pre-certifications, and notices. • Utilization review guidelines. • Concurrent review policy. • Case management programs.
Clinical practice guidelines	Evidence-based recommendations for giving care to members.
Radiology program	Information about prior approval and scheduling procedures for our Diagnostic Imaging Management program.
Radiology privileging	Lists of procedures and associated CPT-4 Codes that network physicians other than radiologists can perform for specific benefit plans based on their specialty and network participation.
HIP outpatient diagnostic imaging referral payment policy	Learn which imaging procedures may be paid for if done in an office setting.
Cardiology imaging program	Information about prior approvals and how to schedule outpatient imaging services for certain cardiology patients.
Radiation therapy program	Learn about Cancer Clinical Pathways, including: • Place of service for select outpatient radiation therapy services. • Prior approval requirements. • Urgent requests/non-urgent requests. • Formal dispute resolution.
Chiropractic program	Learn about the network and utilization management program for chiropractic services for certain members.
Physical and occupational therapy program	Referral and prior approval requirements for certain members.
Behavioral health services	Learn about our policies for mental health and substance abuse services, including: • Prior approval requirements. • Case Management Program. • Behavioral Health Screening tools. • Mental health parity and addiction equity act of 2002 (MHPAEA).
Vision services	Information about routine eye care.
Quality improvement	Quality improvement programs improve medical and mental health outcomes. This chapter includes information about: • The annual Quality Improvement Program. • Healthcare Effectiveness Data and Information Set (HEDIS). • Quality Assurance Reporting Requirements (QARR).
Medical record guidelines	How to keep good medical records using set standards.
Claims	Instructions about how to send claims to the right place.
Podiatry	Special payment program for certain podiatrists.
Dispute resolution for commercial and CHP plans	Find out how to dispute a determination that denies a payment or covered service. • Commercial/CHPlus • Provider and member clinical appeal processes • Clinical appeal expedited process • Clinical appeal standard process

EmblemHealth Provider Manual Chapter List

(Continued)

Chapter title	What's there
Dispute resolution for Medicaid Managed Care plans	Find out how to dispute a determination that denies a payment or covered service. • Initial adverse determinations • Notification methods and time frames • Action appeals • Notifying final adverse determinations • Expedited action appeals • Final adverse determinations • Member complaint process • New York State external appeals • New York State fair hearings
Dispute resolution for Medicare plans	Find out how to dispute a determination that denies a payment or covered service.
Regulatory mandatory reporting	Find out the mandatory reporting requirements for New York State and New York City.
Fraud and abuse	How to spot and report claims fraud and how to prevent it in the future.
Required provisions to network provider agreements	Contract language required by the State of New York and the Centers for Medicare & Medicaid Services, including: • New York State Department of Health Standard Clauses. • Special provisions for Medicaid & HARP members. • Medicare Advantage addendum. • Fully Integrated Dual Advantage (FIDA) standard clauses.
Glossary	Find out what our terms mean.
Forms, brochures & more	Link to our Provider Toolkit webpage where you will find quick reference materials including a section dedicated to materials you can give to your members.

ConnectiCare members may use providers in the EmblemHealth Prime Network

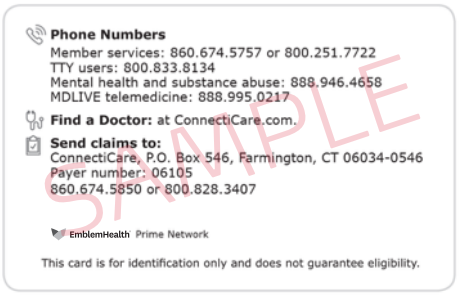
As a provider in the EmblemHealth Prime Network, you are also an in-network provider for commercial group members of ConnectiCare. ConnectiCare, based in Connecticut, is a subsidiary of EmblemHealth. Payment for services to ConnectiCare members follows your contract with EmblemHealth.*

For information and help

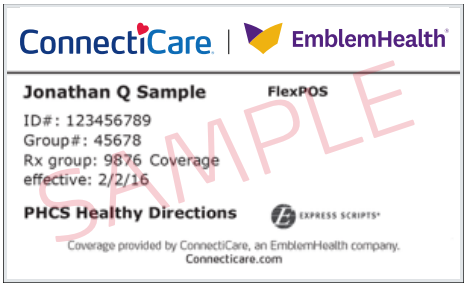
- Register on **connecticare.com/providers**. Use the website to look up ConnectiCare medical and pharmacy policies and check members' eligibility and benefits. The enclosed flyer has more information on what the provider website offers.
- You may also call ConnectiCare provider services at **1-800-828-3407**.

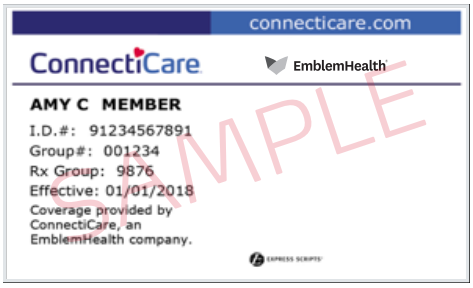
How to check eligibility

- Log in to **connecticare.com/providers**.
- Check the member's ID card. The EmblemHealth logo will be displayed on the front or the back of the ID card, like the samples below.



Other cards you may see:





Where to send claims

Submit claims to ConnectiCare electronically, or mail them to:

ConnectiCare
P.O. Box 546
Farmington, CT 06034-0546

The payer ID for electronic claim filing is **06105**.

Some important ConnectiCare numbers

Provider services 1-800-828-3407

Utilization/preauthorization management 1-800-562-6833

Health management programs 1-800-390-3522

Pharmacy services 1-800-828-3407

Behavioral health program 1-800-349-5365 (through Optum)

Radiology preauthorization program 1-877-607-2363 (through RadMD)

*EmblemHealth Prime Network in New York State

ConnectiCare | EmblemHealth®

Better relationships start with better information

Easier administration tools for you. Faster answers for patients. ConnectiCare's provider website helps you build relationships in so many different ways.

Administrative efficiency

- Verify member eligibility and benefits
- Check claims status
- Preauthorization requirements
- Explanation of Payment (EOP) Statements
- Electronic funds transfer

24/7 knowledge

- Physician & Provider Manual
- Billing and claims payment policies
- Preauthorization requirements
- Medical and health management programs
- Preventive health guidelines
- In-office laboratory and radiology
- Credentialing and re-credentialing

Late-breaking news

- Office Visit email newsletter
- Provider headlines
- Industry updates

Register today for your Provider Resources at **connecticare.com/register**

ConnectiCare®