FULLY INTEGRATED DUAL ADVANTAGE (FIDA) - CLOSED EFFECTIVE 12/31/18

TABLE OF CONTENTS

FULLY INTEGRATED DUAL ADVANTAGE (FIDA) - CLOSED

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

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

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

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

[1]GuildNet Gold Plus FIDA Plan POS members are not required to have a PCP. However, EmblemHealth is required to populate PCP information on the member's ID card to comply with NYSDOH requirements. The provider listed on the member's ID card may be a participating or non-participating provider in accordance with GuildNet's policy and procedures. For more information, please contact the member's case manager.
[2] No in-network or out-of-network cost-sharing.

OVERVIEW AND CONTACTS

Model of Care

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

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

FULLY INTEGRATED DUAL ADVANTAGE (FIDA) - CLOSED

EmblemHealth's goals include:

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

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

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

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

Contact Information

PROVIDER CUSTOMER CARE ADVOCATES
1-866-447-9717, Seven days a week (excluding major holidays), 8:00 a.m. to 8:00 p.m. Free multi-language interpreter service is available. To access an interpreter, call a Provider Customer Care Advocate for assistance.

CLAIMS CONTACTS					
Benefit Plan	**Type of Claim**	**Payor ID**	**Clearing House**	**Submission Address**	**Contact for Inquiries**
GuildNet Gold Plus FIDA Plan (Medicare-related services only)	Professional/ Hospital	55247	Vendor or direct submission	EmblemHealth PO Box 2845 New York, NY 10116-2845	**www.emblemhealth.com** or 1-866-447-9717
	Behavioral Health			EmblemHealth PO Box 803 Latham, NY 12110	
GuildNet Gold Plus FIDA Plan (Medicaid-related services only)	Professional/ Hospital	55247	Vendor/ Relay Health	GuildNet c/o Relay Health 1564 Northeast Expy	1-866-775-8860

				MS HQ-2361 Atlanta, GA 30329	

CLINICAL PHARMACY SERVICES (PRACTITIONERS)	
1-877-362-5670, Monday through Friday, 8 am to 6 pm	
RETAIL PHARMACY SERVICES (PHARMACIES)	
GuildNet Gold Plus FIDA Plan (Medicare-related services only)	**1-877-793-6253**, 24 hours a day, 7 days a week
BEHAVIORAL HEALTH SERVICES	
1-888-447-2526, Monday through Friday, 9 am to 5 pm and 24 hours, 7 days a week for emergencies	
HOW TO OBTAIN A PRIOR APPROVAL	
The IDT makes service and authorization decisions. Authorizations between IDT meetings and before the PCSP is developed must be made through EmblemHealth's Utilization Management process for Medicare-only GuildNet members. Submit requests via the EmblemHealth website: **www.emblemhealth.com** or call **1-866-447-9717**.	

ACTION APPEAL - STANDARD PARTICIPANT, PARTICIPANT DESIGNEE OR PRACTITIONER FILING ON PARTICIPANT'S BEHALF				
Benefit Plan	**What/How /Where to File: Instructions**	**Time Frames**		
		Initial Participant Filing	EmblemHealth Acknowledges Receipt	EmblemHealth Determination Notification
GuildNet Gold Plus FIDA Plan (Medicare-related services only)	**For Medicare Services:** Write to: EmblemHealth PO Box 2807, New York, NY 10116-2807 Telephone (for participants): **1-855-283-2148** TTY/TDD: **711** ***For Medicaid Services:*** Write to: GuildNet 15 W 66 St, 6th Floor New York, NY 10023 Telephone (for participants): **1-800-932-4732**	Within 60 calendar days from receipt of written adverse determination	Within 15 calendar days from receipt of request	Within 30 calendar days from receipt of request. May be extended for up to 14 days for reasons similar to those noted in the EmblemHealth Provider Manual Dispute Resolution chapters.
Additional Rights: If applicable, will be included in the determination letter				

FULLY INTEGRATED DUAL ADVANTAGE (FIDA) - CLOSED

EXPEDITED ACTION APPEAL PARTICIPANT, PARTICIPANT DESIGNEE OR PRACTITIONER FILING ON PARTICIPANT'S BEHALF			
Benefit Plan	**What/How /Where to File: Instructions**	**Time Frames**	
		Initial Participant Filing	**EmblemHealth Determination Notification**
GuildNet Gold Plus FIDA Plan (Medicare-related services only)	Sign in to: **www.emblemhealth.com** Write to: EmblemHealth PO Box 2807 New York, NY 10116-2807 Telephone (for participants): **1-855-283-2148** TTY/TDD: **711**	Within 60 calendar days from receipt of written adverse determination	Paper review unless a participant requests in-person review. As fast as the participant's condition requires, but no later than within 72 hours of the receipt of the request.
Additional Rights: If applicable, will be included in the determination letter			

PRACTITIONER COMPLAINT PROCEDURES PRACTITIONER FILING ON HIS/HER OWN BEHALF				
Benefit Plan	**What/How /Where to File: Instructions**	**Time Frames**		
		Initial Participant Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**
GuildNet Gold Plus FIDA Plan (Medicare-related services only)	Sign in to: **www.emblemhealth.com** Write to: EmblemHealth PO Box 2807 New York, NY 10116-2807	Within 45 calendar days from event	Within 15 calendar days from receipt of request	**Complaint:** Within 30 calendar days from receipt of request **Grievance:** Within 45 calendar days from receipt of request
Additional Rights: Decision is final				

COMPLAINT - PARTICIPANT, PARTICIPANT DESIGNEE OR PRACTITIONER PROCEDURES FILING ON PARTICIPANT'S BEHALF				
Benefit Plan	**What/ How/ Where to File: Instructions**	**Time Frames**		
		Initial Participant Filing	**EmblemHealth Acknowledges Receipt**	**EmblemHealth Determination Notification**

GuildNet Gold Plus FIDA Plan POS (Medicare-related services only)	Sign in to: **www.emblemhealth.com** Write to: EmblemHealth PO Box 2807, New York, NY 10116-2807 Telephone (for participants): **1-855-283-2148** TTY/TDD: **711**	Within 60 calendar days from from event	Within 15 calendar days from receipt of request	**Expedited:** Decision and notification within 24 hours in certain circumstances. For all other circumstances decision and notification within 48 hours from receipt of all necessary information and no more than 7 calendar days from the receipt. **Standard:** Within 30 calendar days from receipt of request.
Additional Rights: None				

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

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

- Following the main menu, if you do not enter the ID and date of birth of the participant you

are calling about, you will hear a list of member plan types, press #7 when you hear "Are you inquiring about a FIDA Member? Press 7."
- Following the main menu, if you selected eligibility and benefits; check claim status; verify a referral; pre-certification/prior approval, behavioral health and substance abuse information and other services, you will have the option to hold and be transferred to a customer service advocate.

Participant Information - Target Population

FIDA-eligible participants must meet the following three criteria:

- Age 21 or older
- Entitled to benefits under Part A and enrolled under Parts B and D, and receiving full Medicaid benefits
- Reside in a FIDA Demonstration county

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

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

COVERED ITEMS AND SERVICES

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

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

PARTICIPANT RIGHTS AND RESPONSIBILITIES

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

FIDA Plan participants have the right to:

- To receive medically necessary items and services as needed to meet the participant's needs,

in a manner that is sensitive to the participant's language and culture and that is provided in an appropriate care setting, including the home and community.

- To receive timely access to care and services.
- To request and receive written and oral information about the FIDA Plan, its participating providers, its benefits and services and the participants' rights and responsibilities in a manner the participant understands.
- To receive materials and/or assistance in a foreign language and in alternative formats, if necessary.
- To be provided qualified interpreters free of charge if a participant needs interpreters during appointments with providers and when talking to the FIDA Plan.
- To be treated with consideration, respect and full recognition of his or her dignity, privacy, and individuality.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Not to be neglected, intimidated, physically or verbally abused, mistreated or exploited.
- To not be discriminated against on the basis of and to get care without regard to sex, race, health status, disability, color, age, national origin, sexual orientation, marital status or religion.
- To be told where, when and how to get the services the participant needs, including how to get covered benefits from out-of-network providers if they are not available in the FIDA Plan network.
- To complain to NYSDOH or the Local Department of Social Services, and the right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- To be advised in writing of the availability of the NYSDOH toll-free hotline, the telephone number, the hours of its operation and that the purpose of the hotline is to receive complaints or answer questions about home care agencies.
- To appoint someone to speak for him/her about the care he/she needs.
- To be informed of all rights, and the right to exercise such rights, in writing prior to the effective date of enrollment.
- To participate in his/her care planning and participate in any discussions around changes to the person-centered service plan, if/when they are warranted.
- To recommend changes in policies and services to agency personnel, NYSDOH or any outside representative of the participant's choice.
- To have telephone access to a nursing hotline and on-call participating providers 24/7 in order to obtain any needed emergency or urgent care or assistance.
- To access care without facing physical barriers. This includes the right to be able to get in and out of a provider's office, including barrier-free access for participants with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act.
- To receive reasonable accommodations in accessing care, in interacting with the FIDA Plan and providers, and in receiving information about one's care and coverage.
- To see a specialist and request to have a specialist serve as primary care provider.
- To talk with and receive information from providers on all conditions and all available treatment options and alternatives, regardless of cost, and to have these presented in a manner the participant understands. This includes the right to be told about any risks

involved in treatment options and about whether any proposed medical care or treatment is part of a research experiment.

- To choose whether to accept or refuse care and treatment, after being fully informed of the options and the risks involved. This includes the right to say yes or no to the care recommended by providers, the right to leave a hospital or other medical facility, even if against medical advice, and to stop taking a prescribed medication.
- To receive a written explanation if covered items or services were denied, without having to request a written explanation.
- To have privacy in care, conversations with providers, and medical records such that:
  - Medical and other records and discussions with providers will be kept private and confidential.
  - Participant gets to approve or refuse to allow the release of identifiable medical or personal information, except when the release is required by law.
  - Participant may request that any communication that contains protected health information from the FIDA Plan be sent by alternative means or to an alternative address.
  - Participant is provided a copy of the FIDA Plan's Privacy Practices, without having to request the same.
  - Participant may request and receive a copy of his or her medical records and request that they be amended or corrected, if the privacy rule applies.
  - Participant may request information on how his/her health and other personal information has been released by the FIDA Plan.
- To seek and receive information and assistance from the independent, conflict-free Participant Ombudsman.
- To make decisions about providers and coverage, which includes the right to choose and change providers within the FIDA Plan's network and to choose and change coverage (including how one receives his/her Medicare and/or Medicaid coverage – whether by changing to another FIDA Plan or making other changes in coverage).
- To be informed at the time of enrollment and at PCSP update or revision meetings of the explanation of what is an advance directive and the right to make an advance directive – giving instructions about what is to be done if the participant is not able to make medical decisions for him/herself - and to have the FIDA Plan and its participating providers honor it
- To access information about the FIDA Plan, its network of providers, and covered items and services.

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

FIDA Plan participants have the responsibility to:

- To try to understand covered items and services and the rules around getting covered items

and services.

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

CULTURAL, LINGUISTIC AND DISABILITY COMPETENCY

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

EmblemHealth policies ensure culturally, linguistically, and disability-competent and service delivery. Available resources, such as the multi-language interpreter service, give providers the capacity to communicate with participants in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing, blind or visually impaired.

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

ACCESSIBILITY REQUIREMENTS

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

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

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

UTILIZATION MANAGEMENT

Utilization Management Process and Role of the Interdisciplinary Team

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

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

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

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

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

Utilization Management - Clinical Practice Guidelines

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

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

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

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

Utilization Management - Prior Approval and Referral Procedures

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

- Emergency or urgently needed care
- Out-of-network dialysis when the participant is out of the service area
- Primary care doctor visits
- Physician specialty services, excluding psychiatric services

- Family planning and women's health specialists services
- Indian health care providers for any participant that is Indian eligible
- Public health agency facilities for tuberculosis screening, diagnosis and treatment
- Immunizations
- Palliative care
- Other preventive services
- Vision services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services
- Dental services through Article 28 clinics operated by academic dental centers
- Cardiac rehabilitation, first course of treatment (physician or RN approval for subsequent treatment)
- Supplemental education, wellness and health management services
- Prescription drugs:
  - which are on the formulary
  - which are not on the formulary, but where a refill request is made for an existing prescription within the 90-day transitional period
- Mental Health Specialty Services – Non-Physician
  - Authorization required after initial visit for visits 2-5
  - Additional authorization required thereafter
- Psychiatric services
  - Authorization required after initial visit for visits 2-5
  - Additional authorization required thereafter
- Outpatient diagnostic procedures, Tests and Lab Services
  - Genetic testing subject to prior authorization rules
- Outpatient Diagnostic and Therapeutic Radiological Services
  - Authorization required for MRI, MRA, CT, PET scans and nuclear imaging
- Outpatient Substance Abuse Services
  - Authorization required after initial visit for visits 2-5
  - Additional authorization required thereafter

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

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

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

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

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

Utilization Management - Continuity of Care

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

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

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

GRIEVANCE AND APPEAL

Grievance

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

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

initial requests for coverage, or appeals, and has processes to ensure that such requests are processed through the appropriate avenues in a timely manner.

Appeal

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

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

a. Participants are entitled to file appeals directly with EmblemHealth. The appeal must be requested within 60 days of postmark date of notice of action if there is no request to continue benefits while the appeal decision is pending. If there is a request to continue benefits while the appeal decision is pending and the appeal involves the termination or modification of a previously authorized service, the appeal must be requested within 10 days of the notice's postmark date or by the intended effective date of the action, whichever is later.
b. Upon receipt of an appeal, EmblemHealth sends written acknowledgement of appeal to the participant and their providers or representatives (if the participant did not file the appeal) within 15 calendar days of receipt. If a decision is reached before written acknowledgement is sent, EmblemHealth will not send the written acknowledgement.
c. EmblemHealth decides and notifies the participant (and provider, as appropriate) of its decision as fast as the participant's condition requires but:
   i. **Expedited:** Paper review unless a participant requests in-person review - as fast as the participant's condition requires, but no later than within 72 hours of the receipt of the appeal.
   ii. **Standard:** Paper review unless a participant requests in-person review - as fast as the participant's condition requires, but no later than 7 calendar days from the date of the receipt of the appeal on Medicaid prescription drug appeals and no later than 30 calendar days from the date of the receipt of the appeal.
   iii. **Extension:** An extension may be requested by a participant or provider on a participant's behalf (written or oral). EmblemHealth may also initiate an extension if it can justify need for additional information and if the extension is in the participant's interest. In all cases, the extension reason must be well-documented, and when EmblemHealth requests the extension it notifies the participant in writing of the reasons for delay and informs the participant of the right to file an expedited grievance if he or she disagrees with EmblemHealth's decision to grant an extension.
d. EmblemHealth makes a reasonable effort to provide prompt oral notice to the participant for expedited appeals and document those efforts. EmblemHealth sends written notice within 2 calendar days of providing oral notice of its decision for appeals.

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

CLAIMS

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

BILLING

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

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

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

IDT MEETINGS	
CPT CODE	**PROCEDURE DESCRIPTION**
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99487	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month
99488	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month
99489	Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Required Use of Codes in Screening for Clinical Depression

Effective January 2015, the Associated Dual Assurance Network primary care and behavioral health providers must include the G codes noted below in claims and encounter submissions as

applicable to Screening for Clinical Depression and Follow-up Plan. CMS and DOH have developed data reporting requirements for all FIDA plans to measure the percentage of patients screened for clinical depression using an age appropriate standardized tool with appropriate follow-up plan documented in the medical record. Please see page 31 of the **Medicaid Adult Core Set** for a list of acceptable depression screening tools.

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

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

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

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

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

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

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

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

REPORTING

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

TRAINING

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

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

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

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

EMBLEMHEALTH ADA ATTESTATION

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

EmblemHealth®

AMERICANS WITH DISABILITIES ACT (ADA) ATTESTATION

FROM: Practice Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Instructions: Please answer each question and subquestion by filling in the appropriate circle. Then, based on your practice location, mail the completed attestation and any related documentation to:

New York City, Nassau, Suffolk:
EmblemHealth
55 Water Street
New York, NY 10041
Attn: Physician Contracting, 7th Floor

All Other Counties in New York:
EmblemHealth
5015 Campuswood Drive
East Syracuse, NY 13057
Attn: Physician Contracting

If you are completing this form on behalf of a practice, please attach a listing of practitioners at your office. If your practice has more than one location, please complete a form for each location and attach a listing of practitioners for each location. Once submitted, please notify EmblemHealth within 10 business days of any change to your answers below. Additional forms can be downloaded from the "Join Our Networks" page at **www.emblemhealth.com**.

Note: If you do not see patients at the address above (e.g., you're an inpatient provider only or administrative only), please answer N/A here, sign the form and mail it back. ◯ N/A

1. Does the office have at least one wheelchair-accessible path from an entrance to an exam room?	◯ Yes	◯ No	◯ N/A
2. Are examination tables and all equipment accessible to people with disabilities?	◯ Yes	◯ No	◯ N/A
3. If parking is provided, are there spaces reserved for people with disabilities and pedestrian ramps at sidewalks and drop-offs?	◯ Yes	◯ No	◯ N/A
4. If parking is provided, are there an adequate number (see below) of accessible parking spaces (8 feet wide for a car and 5-foot access aisle)? **Total spaces** / **Accessible spaces** 1-25 / 1 26-50 / 2 51-75 / 3 76-100 / 4	◯ Yes	◯ No	◯ N/A
5. a. For a provider with a disability-accessible parking space, is there a path of travel from the disability-accessible parking space to the facility entrance that does not require the use of stairs?	◯ Yes	◯ No	◯ N/A
b. Is the path of travel stable, firm and slip resistant?	◯ Yes	◯ No	◯ N/A
c. Except for curb cuts, is the path at least 36 inches wide?	◯ Yes	◯ No	◯ N/A
6. a. Is there a method for persons using wheelchairs or requiring other mobility assistance to enter as freely as everyone else?	◯ Yes	◯ No	◯ N/A
b. Is that route of travel safe and accessible for everyone, including people with disabilities?	◯ Yes	◯ No	◯ N/A
7. Does the main exterior entrance door used by persons with mobility disabilities to access public spaces meet the following:			
a. 32 inches clear opening.	◯ Yes	◯ No	◯ N/A
b. 18 inches of clear wall space on the pull side of the door, next to the handle.	◯ Yes	◯ No	◯ N/A
c. The threshold edge is no greater than ¼-inch high; if beveled, no greater than ¾-inches high.	◯ Yes	◯ No	◯ N/A
d. The door handle is no higher than 48-inches high and can be operated with a closed fist.	◯ Yes	◯ No	◯ N/A

(Continued)

EMB_PR_FRM_18881_ADA_Attestation 10/14

8. a. Are there ramps to permit access? If **yes**, complete the following four questions:	◯ Yes	◯ No	◯ N/A
b. Are the slopes of the ramp accessible for wheelchair access?	◯ Yes	◯ No	◯ N/A
c. Are the railings sturdy and high enough for wheelchair access?	◯ Yes	◯ No	◯ N/A
d. Is the width between railings wide enough to accommodate a wheelchair?	◯ Yes	◯ No	◯ N/A
e. Are the ramps nonslip and free from any obstruction (cracks)?	◯ Yes	◯ No	◯ N/A
9. If there are stairs at the main entrance, is there also a ramp or lift or is there an alternative accessible entrance?	◯ Yes	◯ No	◯ N/A
10. Do any inaccessible entrances have signs indicating the location of the nearest accessible entrance?	◯ Yes	◯ No	◯ N/A
11. Can the accessible entrance be used independently and without assistance?	◯ Yes	◯ No	◯ N/A
12. Are doormats ½-inch high or less with beveled or secured edges?	◯ Yes	◯ No	◯ N/A
13. Are waiting rooms and exam rooms accessible to people with disabilities?	◯ Yes	◯ No	◯ N/A
14. Does the layout of the interior of the building allow people with disabilities to obtain materials and services without assistance?	◯ Yes	◯ No	◯ N/A
15. Do the interior doors comply with the criteria set forth for exterior doors (see question 7)?	◯ Yes	◯ No	◯ N/A
16. Are the accessible routes to all public spaces in the facility 31-inches wide?	◯ Yes	◯ No	◯ N/A
17. Is there a 5-foot circle or a T-shaped space for a disabled person using a wheelchair to reverse direction in public areas where services are rendered?	◯ Yes	◯ No	◯ N/A
18. Are all buttons or other controls in the hallway no higher than 42 inches?	◯ Yes	◯ No	◯ N/A
19. Do elevators in the facility meet the following standards:			
a. There are raised and Braille signs on both door jambs on every floor.	◯ Yes	◯ No	◯ N/A
b. The controls inside the cab have raised and Braille lettering.	◯ Yes	◯ No	◯ N/A
c. The call buttons in the hallway are not higher than 42 inches.	◯ Yes	◯ No	◯ N/A
20. Are sign language interpreters and other auxiliary aids and services provided in appropriate circumstances?	◯ Yes	◯ No	◯ N/A
21. Is the public lavatory wheelchair-accessible?	◯ Yes	◯ No	◯ N/A
22. With respect to the public restroom, do the accessible route, the exterior door and the interior stall doors comply with standards set forth for exterior doors (see question 7)?	◯ Yes	◯ No	◯ N/A
23. Is there at least one wheelchair-accessible stall in the public restroom that has an area of at least 5 feet by 5 feet clear of the door swing or is there at least one stall that is less accessible but provides greater access than a typical stall (either 36 by 69 inches or 48 by 69 inches)?	◯ Yes	◯ No	◯ N/A
24. In the accessible stall of the public restroom, are there grab bars behind and on the side wall nearest the toilet?	◯ Yes	◯ No	◯ N/A
25. Is there one lavatory in the public restroom that meets the following standards:			
a. 30-inches wide by 48 inches; deep bar space in front.	◯ Yes	◯ No	◯ N/A
b. A maximum of 19 inches of the required depth may be under the lavatory.	◯ Yes	◯ No	◯ N/A
c. The lavatory rim is no higher than 34 inches.	◯ Yes	◯ No	◯ N/A
d. There are at least 29 inches from the floor to the bottom of the lavatory apron.	◯ Yes	◯ No	◯ N/A
e. The faucet can be operated with a closed fist.	◯ Yes	◯ No	◯ N/A
f. The soap dispenser and hand dryers are within reach and usable with one closed fist.	◯ Yes	◯ No	◯ N/A
g. The mirror is mounted with the bottom edge of the reflecting surface 40 inches from the floor or lower.	◯ Yes	◯ No	◯ N/A

I hereby attest that I am a provider that occupies a physical site at which participants might possibly be physically present and that the answers provided are accurate. Or, I do hereby attest that I hold the authority to make these attestations.

Name:	Date:
Signature:	