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Introduction

VNSNY CHOICE is pleased to welcome you to our provider network. You have joined a network of physicians and community providers that partner with us to advance the VNSNY Mission of promoting health and well-being through the provision of high quality, cost effective health care in the home and community.

Since our first member enrolled in 1998, VNSNY CHOICE has focused on the successful delivery of comprehensive care for our members. Our guiding principles include:

- Offering plan benefits that improve access to appropriate care, including assistance navigating an increasingly complex health care system.
- Shifting the focus of care from the institution to the home and community
- Targeting and customizing interventions based on the need of the enrollee
- Making care management the cornerstone of all managed care plan options by assigning a Care Manager to all members

We currently offer the following plan options to eligible individuals.

Long Term Care Options

1. **VNSNY CHOICE Medicaid Managed Long Term Care (MLTC):** MLTC serves as an alternative to long-term institutional care and offers fourteen home and community based services, including care management, nursing home, adult day care, home delivered meals and dental care to nursing home eligible individuals age 18 and older. Upon enrollment, each member is assigned a Care Manager who coordinates the receipt of all covered and non-covered services.

   Managed Long Term Care members are not required to select a PCP, however their physician must be willing to work with the plan as a condition of enrollment. This program does not pay for physician or hospital services. These services are available through a member’s Medicare or Medicaid coverage. Members are not required to get a referral from their physician to see a specialist.

2. **VNSNY CHOICE Total, an Integrated Medicare Advantage Special Needs Plan and Medicaid Managed Long Term Care Plan:** This program is a comprehensive health plan that combines the services offered in a Medicaid Managed Long Term Care plan and a Medicare Advantage Special Needs Plan.

   The plan includes many of the features specifically designed for individuals who have special health care needs and require supportive services in order to remain at home. This plan combines Medicare and Medicaid together for people who require assistance with day-to-day tasks due to their long term care needs.

   Members must choose a PCP upon enrollment. Members are not required to get a referral from their physician to see a specialist.

Medicare Advantage/Prescription Drug Plans

VNSNY CHOICE offers multiple MA-PD plans for enrollees.
Introduction

1. VNSNY CHOICE Medicare Advantage Special Needs Plans (SNPs) for individuals who have Medicare and Medicaid.

2. VNSNY CHOICE Medicare Advantage plans that provide all of the services covered by Original Medicare in addition to Medicare prescription drug coverage.

These plans provide all of the services covered by Medicare Parts A, B and D including hospitals, doctors, laboratories and prescription drugs. Depending on the plan, supplemental benefits may include dental, hearing, vision and transportation benefits.

Members in these plans must choose a PCP upon enrollment. Members are not required to get a referral from their physician to see a specialist.

VNSNY CHOICE Medicare Advantage plan names currently include:
- Preferred (an HMO Special Needs Plan for members who have both Medicare and Medicaid)
- Total (an HMO Special Needs Plan for members who have both Medicare and Medicaid and which integrates the Medicaid long term care services)
- Enhanced (an HMO for members with Medicare)
- Maximum (a Medicare/Medicaid Advantage HMO for members which integrates Medicare and Medicaid services)

SelectHealth Medicaid Special Needs Plan

VNSNY CHOICE SelectHealth is a Medicaid HIV Special Needs Plan that provides accessible, comprehensive, high quality services to individuals with HIV/AIDS and their children. Our network of hospitals and community-based professionals provide care to Medicaid recipients infected with HIV and their children (regardless of HIV status).

Individuals with both Medicare and Medicaid (dually eligible) or Medicaid spenddown are not eligible for enrollment.

Members must choose a PCP upon enrollment. Although members do not need a referral to seek care from an in-network specialist, they should have a prescription from their primary care provider.

At VNSNY CHOICE, we understand the importance of the provider-member relationship and the administrative requirements of managing your patient’s healthcare needs. This manual was designed to assist you and your office staff in understanding the requirements that govern the management of VNSNY CHOICE members while serving as a resource for any questions you have about our programs. If VNSNY CHOICE updates any of the information in this manual, we will provide bulletins, as necessary, and post the changes on our website – www.vnsnychoice.org. You can also find a copy of this manual on our website.

We are proud of the relationship we have with our participating providers and are committed to working with you to provide the support and assistance necessary to meet the needs of your patients.
## Dedicated Staff to Assist Our Participating Providers

### Provider Relations
The VNSNY CHOICE Provider Relations Department is the primary connection between you and our plan. They are responsible for recruiting providers and managing the plan’s provider relationships that make up the health care delivery system, including individual practitioners, groups, hospitals, skilled nursing facilities, medical equipment suppliers and other providers.

The main focus of the Provider Relations Department is to assist you with all aspects of your plan participation.

Your Provider Relations Account Manager will assist you by:

- Serving as a point of contact with the plan
- Orienting you and your staff on the VNSNY CHOICE policies and procedures
- Providing ongoing education concerning changes in operational procedures
- Responding in a timely manner to any of your questions or concerns
- Establishing provider connection to the VNSNY CHOICE systems
- Administering the credentialing process

### Claims
The Claims Department is responsible for paying claims as defined in the terms of your contract with VNSNY CHOICE.

### Quality Management
The Quality Management Department oversees the following aspects of our members’ healthcare and service provision:

- Quality of care for our members
- Member satisfaction, including the evaluation of grievances and appeals
- Access and availability standards

### Member Services
The Member Services staff is responsible for:

- Providing telephone access through the member call center
- Providing members with information about their health benefits
- Assisting members to select or change a PCP or help them find a network provider
- Fielding and responding to member questions and complaints
- Clarifying information in the member handbook
- Responding to communications received from members and providers

The Member Services Department provides member feedback to VNSNY CHOICE through the inclusion of a member representative on our Quality Improvement Committee or by designating a subcommittee of any advisory body consisting of member volunteers.

### Medical Management
The Medical Management Department is responsible for assuring appropriate utilization of services including the following functions:

- Prospective, concurrent and retrospective clinical reviews
Section 1: Key Contacts and Resources

- Care management of clinical procedures and services, diagnostic testing and interventions/treatments
- Ongoing care management for complex members

Specific activities performed include: (a) assisting providers in determining and coordinating the most appropriate setting for care; (b) assisting in the provision of timely access to health care services based on member need, available resources and community standards of care; (c) assisting in the assurance of continuity of patient care that provides early intervention and prompt initiation of discharge planning; (d) assisting in the implementation of related policies and procedures, (e) educating members on prevention and obtaining disease specific intervention, (f) coordinating Medicare and Medicaid services for the member and (e) ensuring psychosocial case management is provided by contracted and credentialed behavioral health vendors, community-based organizations, Designated AIDS Centers (DACS) and hospitals within the plan’s network.

Additional Information about VNSNY CHOICE Managed Long Term Care

VNSNY CHOICE MLTC coordinates all of our member’s home and community-based services as well as their medical care. Upon enrollment, our members work closely with a Care Manager whose responsibility is to understand all of their health care needs and coordinate the necessary services.

Our members help to develop their plan of care and, of course, agree to it. As their health care needs change, a member and his/her Care Manager, along with their doctor, may decide to change the plan of care. The Care Manager works with the providers to make sure that the overall plan of care meets the health care needs of our members. And if a member needs to receive care in a hospital or nursing home, our Care Managers work with the staff of the facility to be sure that our member's needs are met.

The healthcare needs for members of VNSNY CHOICE MLTC are managed by a regional team.

The VNSNY CHOICE Regional Program Director is responsible for all aspects of regional VNSNY CHOICE service operations including clinical and support staff supervision. The Regional Clinical Manager, reporting directly to the Regional Program Director, serves as a resource and advisor to the Team Managers on a day-to-day basis concerning clinical issues, problem resolution, complaint resolution, and other clinical or service-related issues.

Each Service Team is led by a Team Manager and is comprised of Nurse Consultants working collaboratively with Member Service Representative(s) and Social Worker(s). In addition, Nurse Practitioners, Rehabilitation Therapists, and paraprofessionals provide home care services as needed. The roles of each are outlined below.

- Nurse Consultants are the primary Care Manager for each member, and are responsible for coordinating all health care. His/her role includes: assessing member needs, completing enrollment, case management and coordination of care, authorizing services, evaluating effectiveness of care, and collaborating with all service providers. S/he also provides home care services, including supervision of paraprofessional workers. The Nurse Consultant
Section 1: Key Contacts and Resources

- may see a member in the home, in day care sites, in other community settings, in the hospital, or in a nursing home.

- **Member Service Representatives** (MSR) are stationed in VNSNY CHOICE offices to provide ongoing support to the team and its members. The MSR works closely with Nurse Consultants to implement service plans. Responsibilities include service ordering and tracking, follow-up with members and other providers, responding to member and family requests and resolving problems.

- **Social Workers** provide initial assessments of all new members, in coordination with Nurse Consultants. A Certified Social Worker will also provide psychosocial counseling and concrete social services related to entitlements and other issues. Social Workers may also serve as the primary care manager for members who reside in nursing homes or for whom it is determined that a nurse’s supervision is not required.

- **Nurse Practitioners** provide skilled nursing and consultation in the care and management of medically complex members. S/he may function as a Nurse Care Manager for the most medically needy members. When appropriate, the Nurse Practitioner may provide primary care services in the home, under the direction of a collaborating physician.

- **Rehabilitation Therapists** provide consultation and ongoing rehabilitation therapy to members with extensive focus on enhancing functional capacity and independence. The program works with designated Physical Therapists, Occupational Therapists, and Speech Therapists in each region.

- **Paraprofessional staff** (home health aides and personal care workers) provides personal care to members in their home. The program works with a number of licensed agencies through contractual relationships throughout the VNSNY CHOICE service area. Services are delivered based on tasks (not hours) and clustering is used, when feasible, to improve efficiency.

Each region’s staff also includes a **Membership Coordinator**, who is responsible for coordination of the membership enrollment process including tracking of referrals through the enrollment process, follow-up internally and externally to move an individual from referral to enrollment, analysis of referrals, and internal and external marketing activities.
### Section 1: Key Contacts and Resources

#### Directory of Important Phone Numbers and Addresses

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<td>Behavioral Health, Mental Health, and Substance</td>
<td>866-317-7773 (ValueOptions)</td>
<td>866-783-0222</td>
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<td>Abuse – Prior Authorization</td>
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<td>Claims/Billing Inquiries</td>
<td>866-783-0222</td>
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<td>Compliance Hotline</td>
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<td>888-634-1558 Fax 646-459-7730</td>
<td>888-634-1558 Fax 646-459-7730</td>
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<td>Dental Benefits, Dental Network</td>
<td>800-468-0608 (Healthplex)</td>
<td>800-468-0608 (Healthplex)</td>
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<td>General Information for Prospective Members</td>
<td>866-867-0047</td>
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<td>Grievances and Appeals (including Appeals</td>
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<td>866-791-2212 Fax 866-791-2213</td>
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<td>Medical Management</td>
<td>866-783-0222 Fax 866-791-2214</td>
<td>866-783-0222 Fax 646-459-7731</td>
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<td>Member Services</td>
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<td>866-469-7774</td>
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<tr>
<td>Prior Authorizations</td>
<td>866-783-0222 Fax 866-791-2214</td>
<td>866-783-0222 Fax 646-459-7731</td>
<td>Regional offices or 888-867-6555</td>
</tr>
<tr>
<td>Provider Disputes</td>
<td>Fax 866-791-2213</td>
<td>Fax 866-791-2213</td>
<td>Fax 866-791-2213</td>
</tr>
<tr>
<td>Provider Services</td>
<td>866-783-0222</td>
<td>Tel 866-783-0222</td>
<td>212-609-5600 or 888-867-6555</td>
</tr>
<tr>
<td>Referral Coordinator for SelectHealth</td>
<td>n/a</td>
<td>866-783-0222</td>
<td>n/a</td>
</tr>
<tr>
<td>Transportation Arrangements (except Metrocard</td>
<td>866-783-1444</td>
<td>866-469-7774</td>
<td>Regional offices or 888-867-6555</td>
</tr>
<tr>
<td>requests)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VNSNY CHOICE Main Office</td>
<td>888-867-6555 or 212-609-5600</td>
<td>888-867-6555 or 212-609-5600</td>
<td>888-867-6555 or 212-609-5600</td>
</tr>
</tbody>
</table>
Section 1: Key Contacts and Resources

VNSNY CHOICE Addresses

<table>
<thead>
<tr>
<th>Providers can send claims to:</th>
<th>For Behavioral Health and Substance Abuse Services send claims to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>VNSNY CHOICE Claims Department</td>
<td>ValueOptions</td>
</tr>
<tr>
<td>PO Box 4498</td>
<td>PO Box 1380</td>
</tr>
<tr>
<td>Scranton, PA 18505</td>
<td>Latham, NY 12110</td>
</tr>
<tr>
<td>Electronic submissions of HIPAA covered services can be billed using our Payer ID number 77073.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For Covered Part D vaccines send claims to:</th>
<th>For Grievances and Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caremark Medicare Vaccine Processing</td>
<td>VNSNY CHOICE</td>
</tr>
<tr>
<td>P.O. Box 52193</td>
<td>Attn: Grievance and Appeals Department</td>
</tr>
<tr>
<td>Phoenix, AZ 85072-2193</td>
<td>1250 Broadway, 3rd Floor</td>
</tr>
<tr>
<td></td>
<td>New York, NY 10001</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For Claims and Utilization Review Appeals:</th>
<th>To Report a Compliance Violation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>VNSNY CHOICE</td>
<td>VNSNY CHOICE</td>
</tr>
<tr>
<td>Attn: Grievance and Appeals Department</td>
<td>Attn: Compliance Officer</td>
</tr>
<tr>
<td>1250 Broadway, 3rd Floor</td>
<td>1250 Broadway</td>
</tr>
<tr>
<td>New York, NY 10001</td>
<td>New York, NY 10021</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior Authorizations or Transitional Care Requests:</th>
<th>Provider Dispute Resolution:</th>
</tr>
</thead>
<tbody>
<tr>
<td>VNSNY CHOICE</td>
<td>VNSNY CHOICE</td>
</tr>
<tr>
<td>Attn: Medical Management Department</td>
<td>Attn: Grievance and Appeals Department</td>
</tr>
<tr>
<td>1250 Broadway</td>
<td>1250 Broadway, 3rd Floor</td>
</tr>
<tr>
<td>New York, NY 10001</td>
<td>New York, NY 10001</td>
</tr>
</tbody>
</table>

VNSNY CHOICE Web Site

Please take a look at our website – www.vnsnychoice.org. On our website you can find information about:

- Our Policies and Procedures
- Forms
- List of Services that Require Prior Authorization
- Provider Search
- Online Eligibility and Claims Access
- Formulary
- Overview of the VNSNY CHOICE Medicare Model of Care
Section 2: Verifying Member Eligibility and Covered Benefits

VNSNY CHOICE will reimburse providers only for services rendered to currently eligible members. It is the responsibility of the provider to verify eligibility prior to providing services.

Providers of All VNSNY CHOICE Medicare Advantage Plan Members

Verifying Member Eligibility

You may obtain information on VNSNY CHOICE member eligibility by calling the Member Eligibility contact phone number listed in Section 1 of this provider manual. Our hours are Monday through Friday from 8:00 AM to 8:00 PM Eastern Time.

You may also check claims and eligibility status via the Internet at: https://vnsproviderweb.tmghealth.com

Upon initial registration, you will be asked to complete a “Provider Portal Registration”. Upon proper completion, the registration is submitted and an assigned password will be sent to you within 2 business days.

All VNSNY CHOICE members in our Medicare Advantage plans are given an identification card (sample below). Members should present their ID cards when they request any type of covered healthcare service. This card is for identification only and does not guarantee eligibility for coverage.

Covered Services

VNSNY CHOICE Medicare Advantage Plans offer the same coverage as traditional Medicare as well as a limited set of supplemental benefits.

The full description of covered benefits for each plan is available in the Summary of Benefits which is available on the VNSNY CHOICE web site (www.vnsnychoice.org).

Covered benefits include:

<table>
<thead>
<tr>
<th>Doctor Office Visits</th>
<th>Inpatient Hospital Care</th>
<th>Podiatry Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services / Surgery</td>
<td>Home Health Care</td>
<td>Skilled Nursing Facility Services</td>
</tr>
</tbody>
</table>

Sample
Section 2: Verifying Member Eligibility and Covered Benefits

<table>
<thead>
<tr>
<th>Emergency Care</th>
<th>Ambulance Services</th>
<th>Outpatient Rehabilitation Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Services</td>
<td>Durable Medical Equipment</td>
<td>Prosthetic Devices</td>
</tr>
<tr>
<td>Diabetes Self-Monitoring, Training and Supplies</td>
<td>Physical Exams (“Welcome to Medicare” and annual physical exams)</td>
<td>Diagnostic Tests, X-Rays &amp; Lab Services</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Medicare Part B Prescription Drugs</td>
<td>Medicare Drugs Covered Under Part D</td>
</tr>
<tr>
<td>All Medicare covered preventive screenings and services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VNSNY CHOICE Medicare Advantage plans offer supplemental services that are in addition to the benefits covered by traditional Medicare. Please see www.vnsnychoice.org for the supplemental benefits that are available in each product.

**Medicaid Covered Benefits**

VNSNY CHOICE will ensure our members have access to all the services they are eligible to receive. In addition to the benefits covered by VNSNY CHOICE Medicare Advantage plans, members who are dually eligible (eligible for Medicare and Medicaid services), also have their Medicaid funded benefits coordinated by our staff. A significant number of members in VNSNY CHOICE’s Medicare Advantage plans are also enrolled in the VNSNY CHOICE Managed Long Term Care plan. For those members, VNSNY CHOICE coordinates all Medicare and Medicaid benefits, including in-home supportive services.

If you have questions regarding benefits for a VNSNY CHOICE Medicare Advantage plan member, please contact Provider Services at the telephone number listed in Section 1 of this provider manual or you can access a list of Medicaid funded services by visiting our website www.vnsnychoice.org.

Medicaid covers the cost sharing for the following types of services when they are covered by Medicare. Medicaid funded services may include:

<table>
<thead>
<tr>
<th>Smoking Cessation Agents</th>
<th>Treatment &amp; Preventive Health (Doctors)</th>
<th>Hospital Inpatient and Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory and X-Ray Services</td>
<td>Nursing Home Care</td>
<td>Care through Home Health Agencies and Personal Care</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Medicine, Supplies, Medical Equipment and Appliances (Wheelchairs, etc)</td>
<td>Clinic Services</td>
</tr>
<tr>
<td>Transportation to Medical Appointments, including public transportation and car mileage</td>
<td>Emergency Ambulance Transportation to a Hospital</td>
<td>Prenatal Care</td>
</tr>
</tbody>
</table>
Section 2: Verifying Member Eligibility and Covered Benefits

<table>
<thead>
<tr>
<th>Some Insurance and Medicare Premiums</th>
<th>Other Health Services</th>
<th>Dental Care (Dentists)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment in Psychiatric Hospitals (for persons under 21 or those 65 and older, mental health facilities and facilities for the mentally retarded or the developmentally disabled)</td>
<td>Early periodic screening, diagnosis and treatment for children under 21 years of age under the Child/Teen Health Program</td>
<td></td>
</tr>
</tbody>
</table>

### Member Coinsurance

VNSNY CHOICE Medicare Advantage Special Needs Plans are Medicare Advantage products, which DO NOT cover the Medicaid coinsurance for covered services. Providers must bill the New York State Medicaid program as appropriate for the Medicaid portion of covered services. Members enrolled in a VNSNY CHOICE Medicare Advantage plan may have coinsurance or copayment responsibilities.

In order to ensure reimbursement, providers should always ask members at the time of service about their medical coverage. In the event that the provider is unable to ascertain benefits or deductible status at the time of service, the provider may, as appropriate, contact Provider Services for clarification.

The VNSNY CHOICE Integrated Medicare Advantage and Medicaid Managed Long Term Care program incorporates the Medicaid reimbursement of covered services. Providers MUST NOT bill New York State Medicaid (except for certain services that are carved out) or the member for any portion of the Medicaid benefit.

If you have any questions about how to bill properly or how to determine the appropriate coinsurance or deductible, please contact Provider Services at the telephone number listed in Section 1 of this provider manual.

### Providers of VNSNY CHOICE SelectHealth

The primary care team plays a critical role in assisting VNSNY CHOICE to verify the HIV status of its members. Acceptable verification for HIV includes:

- Positive HIV antibody screen assay
- Positive viral identification assay (e.g. antigen assay, viral culture, DNA Polymerase chain reaction [PCR])
- CD4<200
- Attestation of the member’s HIV status by HIV PCP

### Verification of Eligibility

VNSNY CHOICE reimburses providers for services rendered to eligible members currently enrolled in the plan. Verification of eligibility for services may be accomplished by one of the following means:

**Identification Card:** VNSNY CHOICE generates an identification card to all actively enrolled members of the plan within 14 days of the member’s effective date of enrollment. Information on the card includes: member name, CIN number, primary care provider name and telephone
number, and the 24-hour VNSNY CHOICE toll-free number. At the time of the member’s visit, providers should ask the member for his/her member identification card. Most providers make a copy of both sides of the card for their files.

EMEVs (Electronic Medicaid Eligibility Verification System) or ePACES: Eligible members are verified by the code “VS” on the EMEVS/EPACES. You can find additional information on the web through the following link - http://www.emedny.org/HIPAA/SupportDocs/ePACES.html

Member Roster: Primary care providers receive a member roster from VNSNY CHOICE each month. The roster contains information regarding the members on the PCP’s panel, including name, CIN number, and enrollment effective date.

Referral: Although members do not need a referral to seek care from an in network specialist, they should have a prescription from the primary care provider.

Member Services: If you have questions with regard to member eligibility, call Provider Services at the telephone number listed in Section 1 of this provider manual.

Newborn Enrollment

All newborn children of VNSNY CHOICE SelectHealth members are enrolled in this program, effective from the first day of the child’s month of birth. The infant may be disenrolled at any time at the mother’s request.

 Covered Services

<table>
<thead>
<tr>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital care</td>
<td>Covered with no annual limit.</td>
</tr>
<tr>
<td>Inpatient hospital alternate level of care for medical and psychiatric hospitalizations</td>
<td>Covered with no annual limit.</td>
</tr>
</tbody>
</table>
### Section 2: Verifying Member Eligibility and Covered Benefits

<table>
<thead>
<tr>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital alternate level of care for medical and psychiatric hospitalizations</td>
<td>Covered with no annual limit.</td>
</tr>
<tr>
<td>Outpatient hospital services (professional ambulatory services)</td>
<td>Covered in full as medically needed.</td>
</tr>
<tr>
<td>Physician services</td>
<td>Covered in full as medically needed.</td>
</tr>
<tr>
<td>Home health services (short term, acute)</td>
<td>Covered in full as medically needed.</td>
</tr>
<tr>
<td>Emergency room services</td>
<td>Covered in full as medically needed.</td>
</tr>
<tr>
<td>Audiology hearing aid services and care</td>
<td>Covered in full as medically needed.</td>
</tr>
<tr>
<td>Foot care services</td>
<td>Covered when medically needed.</td>
</tr>
<tr>
<td>Eye care and low vision services</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>Dental care</td>
<td>Covered when members obtain services from a network provider. Members may also obtain covered services from a clinic that is operated by an academic dental center. Please call Provider Services for the telephone number for an academic dental clinic.</td>
</tr>
<tr>
<td>Laboratory services</td>
<td>Covered when medically necessary.</td>
</tr>
<tr>
<td>Radiology services</td>
<td>Covered when medically necessary.</td>
</tr>
<tr>
<td>Diagnostic services</td>
<td>Covered when medically necessary.</td>
</tr>
<tr>
<td>Early Periodic Screening Diagnosis and Treatment (EPSDT) Services through the Child Teen Health Program (C/THP) and Adolescent Preventive Services</td>
<td>Provide to all children and young adults up to age 21 years.</td>
</tr>
<tr>
<td>Family planning and reproductive health care services</td>
<td>Free access.</td>
</tr>
<tr>
<td>Renal dialysis</td>
<td>Covered when medically necessary.</td>
</tr>
<tr>
<td>Private duty nursing</td>
<td>Covered when medically necessary.</td>
</tr>
<tr>
<td>Durable medical equipment (DME)</td>
<td>Covered when medically necessary.</td>
</tr>
<tr>
<td>Court-ordered services</td>
<td>Plan will be responsible for providing court-ordered Medicaid covered services.</td>
</tr>
<tr>
<td>Experimental &amp; Investigational Treatment &amp; Clinical Trials &amp; Rare Disease Treatment Programs</td>
<td>Covered when approved by plan Medical Director.</td>
</tr>
<tr>
<td>Prosthetic/Orthotic services</td>
<td>Covered when medically necessary.</td>
</tr>
<tr>
<td>Mental health services</td>
<td>Coverage up to 20 outpatient visits and 30 inpatient days (inpatient days are covered in combination with alcohol and substance abuse inpatient days). Additional days are covered when medically necessary.</td>
</tr>
<tr>
<td>Alcohol and substance abuse services</td>
<td>30 inpatient days (inpatient days are covered in combination with mental health inpatient days).</td>
</tr>
</tbody>
</table>
Inpatient and outpatient detoxification services
Covered when medically necessary. Additional days are covered when medically necessary.

Personal Care Services and Personal Emergency Response Systems
Covered when medically necessary. Requests for services will only be considered when supported by documentation from the member’s physician.

Prescription Drugs
Covered for all members. The plan uses a formulary, which is provided to all members and is available on the website at www.vnsnychoice.org. Certain over-the-counter items are also covered, when prescribed by the physician.

Enhanced Services

In addition to the benefits listed above, the VNSNY CHOICE SelectHealth ensures access to the following services:

• **Comprehensive care coordination** including clinical coordination and medical/clinical care coordination in consultation with the PCP, service utilization monitoring, assessment and service plan development that addresses identified patient needs, case manager involvement in quality assurance and continuous quality improvement, and non-intensive psychosocial case management as defined by the New York State Department of Health AIDS Institute’s standards and guidelines.

• **Treatment adherence services** including policies and procedures to encourage adherence to prescribed treatment regimens for all members, promotion of access to treatment adherence and supportive services integrated into the continuum of HIV care services, and development of management and operation designs that promote coordination and unification of treatment adherence services. Treatment adherence services include development and regular assessment of an individual treatment adherence plan for each member consistent with guidelines as developed by the AIDS Institute.

• **HIV primary and secondary prevention and risk reduction services** include education and counseling, harm reduction education and services, education to members regarding STDs and services available for STD treatment and prevention, counseling and supportive services for partner/spousal notification and HIV community education, outreach and health promotion activities.

Copayments/Deductibles

VNSNY CHOICE SelectHealth members are not subject to copayment or deductibles, with the exception of prescription drugs.

Excluded Services

There are a number of services excluded from the VNSNY CHOICE SelectHealth benefit package that are covered by fee-for-service Medicaid. VNSNY CHOICE SelectHealth
members may obtain these services from any Medicaid provider using their Medicaid card. A referral from the PCP or any form of approval from VNSNY CHOICE is not necessary to access these services. The following services are not covered:

<table>
<thead>
<tr>
<th>1. Medical Non-Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Health Care Facilities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Non-Covered Behavioral Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Alcohol Abuse Services</td>
</tr>
<tr>
<td>Outpatient Alcoholism Rehabilitation Services</td>
</tr>
<tr>
<td>Day Treatment</td>
</tr>
<tr>
<td>Home and Community Based Services Waiver for Seriously Emotionally Disturbed Children</td>
</tr>
<tr>
<td>Services Provided through OMH Designated Clinics for Children with Serious Emotional Disturbances</td>
</tr>
</tbody>
</table>

3. Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs

4. Office of Mental Retardation and Developmental Disabilities (OMRRD) Services

5. Other Non-Covered Services

<table>
<thead>
<tr>
<th>The Early Intervention Program (EIP) – Children Birth to Two (2) Years</th>
<th>Preschool Supportive Health Services - Children Three (3) through Four (4) Years</th>
<th>School Supportive Health Services – Children Five (5) through 21 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Medicaid Case Management (CMMC)</td>
<td>Directly Observed Therapy for Tuberculosis Disease</td>
<td>AIDS Adult Day Health Care</td>
</tr>
<tr>
<td>HIV COBRA Case Management</td>
<td>Fertility Services</td>
<td>Adult Day Health Care (ADHC)</td>
</tr>
</tbody>
</table>
Section 2: Verifying Member Eligibility and Covered Benefits

Transportation - MetroCards

All VNSNY CHOICE SelectHealth members are entitled to MetroCard reimbursement for public transportation expenses incurred traveling to and from each medical visit. Transportation is covered for adults accompanying children enrolled in the Plan. The provider’s responsibilities concerning distribution of MetroCards are as follows:

- Contact VNSNY CHOICE at the telephone number listed in Section 1 of this provider manual for an initial supply of (round-trip fare) MetroCards to distribute to VNSNY CHOICE members and for a copy of the MetroCard Distribution Log.
- Distribution of MetroCards must be documented on the MetroCard Distribution Log. If the provider uses the Public Transportation Automated System (PTAR), VNSNY CHOICE will accept the system generated report in lieu of the Distribution Log.
- Because children ride public transportation for free, MetroCards should not be distributed to children under 44” (3 ft., 8”).
- MetroCards must be kept in a secure area with limited access (e.g. a locked cabinet, a cashier’s desk). Providers must identify one staff member to be accountable for safekeeping of the MetroCards. (This individual does not, however, have to be the sole distributor of the MetroCards.)
- If a member is referred to a specialist who practices in a private office, the PCP will distribute a MetroCard to the member.
- If a member is referred to a center or hospital-based specialist, the member is to be reimbursed at the specialist’s site.
- Contact VNSNY CHOICE at the telephone number listed in Section 1 of this provider manual to replenish your supply of MetroCards.

Ambulette/Ambulance/Livery

Authorization is required for non-emergency ambulette services and is provided for members with a disability or medical condition that prevents the member from utilizing public transportation. Authorization for non-emergency ambulette may be obtained by submitting a MAP 115 Transportation form and faxing it to VNSNY CHOICE at the MetroCard fax number listed in Section 1 of this provider manual. The VNSNY CHOICE SelectHealth covers the cost of ambulance in conjunction with emergency services.

Providers of VNSNY CHOICE MLTC Members

VNSNY CHOICE MLTC coordinates all of our member’s home and community-based services as well as their medical care. Upon enrollment, our members work closely with a Care Manager whose responsibility is to understand all of their health care needs and coordinate the necessary services.

Our members help to develop their plan of care and, of course, agree to it. As their health care needs change, a member and his/her Care Manager, along with their doctor, may decide to change the plan of care. The Care Manager works with the providers to make sure that the overall plan of care meets the health care needs of our members. And if a member needs to receive care in a hospital or nursing home, our Care Managers work with the staff of the facility to be sure that our member’s needs are met.
Section 2: Verifying Member Eligibility and Covered Benefits

Verifying Member Eligibility

While the member’s Care Manager orders most services, providers are encouraged to verify member eligibility before providing the service. Providers are prohibited from billing VNSNY CHOICE MLTC members for covered services. However, if a provider wishes to provide a non-covered service to a member, the provider must inform the member in writing prior to the initiation of the service, indicating the cost and the member’s responsibility for payment.

VNSNY CHOICE may determine which covered services are medically necessary for each member. Medical necessity is defined as necessary to prevent, diagnose, correct or cure conditions in the enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such enrollee’s capacity for normal activity, or threaten some significant handicap.

Covered Services

VNSNY CHOICE MLTC covers the following services:

<table>
<thead>
<tr>
<th>Audiology/Hearing Aids</th>
<th>Chore Services</th>
<th>Dentistry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Home Health Aide / Paraprofessional</td>
<td>Home Health Care (Nursing, Social Work, Rehabilitation Therapy)</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>Medical Day Care</td>
<td>Medical / Surgical Supplies</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>Respite</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Post Acute Care / Short Term Rehabilitation</td>
<td>Orthotics and Orthopedic Footwear</td>
<td>Personal Emergency Response System (PERS)</td>
</tr>
<tr>
<td>Residential Care / Long Term Stay</td>
<td>Prosthetics</td>
<td>Rehabilitation Therapies Outside the Home</td>
</tr>
<tr>
<td>Optometry</td>
<td>Social and Environmental Supports</td>
<td>Social Day Care</td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergent Transportation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To verify eligibility for all of the covered services listed above, with the exception of dental services, please call the appropriate VNSNY CHOICE Regional Office.

To verify eligibility for dental services, please contact Healthplex, Inc. at the telephone number listed in Section 1 of this provider manual.
Section 2: Verifying Member Eligibility and Covered Benefits

Transportation

Transportation is provided at the appropriate level of care for the member to obtain necessary medical services or day care, i.e. via ambulette, taxi, car service, etc. The Care Manager determines the appropriate mode of transportation.

VNSNY CHOICE will arrange and pay for non-emergent transportation to and from providers of health-related services, including but not limited to doctor’s offices, social day programs, and clinics. Members should call the VNSNY CHOICE Member Services Representative (MSR) at least 2 business days in advance, if possible, so that transportation can be scheduled with a contracted transportation provider. The MSR will arrange with the provider and advise the member as to what company will be utilized.

If the member is well enough to travel by public transportation and it is available, VNS NY CHOICE will reimburse the member for the cost. If a family member or other caregiver accompanies the member, VNSNY CHOICE will also reimburse that person for the cost.

For members who are residents in nursing homes, the nursing home staff may make arrangements with their regularly utilized providers for transportation from the facility to and from health-related appointments and discharges. Those transportation providers should be instructed to bill VNSNY CHOICE.

Emergency related transportation is not included in VNSNY CHOICE’s covered services and members and caregivers are instructed to call 911 in emergencies. Ambulance transportation is billable to Medicare and/or Medicaid.

Although VNSNY CHOICE does not pay for the following services, we will help arrange appointments, pay for transportation to/from these appointments, and pay for an escort as required. These non-covered services are provided through Medicare and/or fee-for-service Medicaid. Members present their Medicare and/or Medicaid identification cards to providers of these services.

Non-Covered Services

The following services are not covered by VNSNY CHOICE MLTC. Providers should bill Medicare or Medicaid directly, depending on the type of service being provided.

<table>
<thead>
<tr>
<th>Inpatient hospital care</th>
<th>Outpatient hospital care</th>
<th>Physician services (including services provided in an office setting, a clinic, facility or in the home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory tests</td>
<td>Radiology and radioisotope services</td>
<td>Prescription and non-prescription drugs</td>
</tr>
<tr>
<td>Emergency transportation</td>
<td>Rural health clinic services</td>
<td>Chronic renal dialysis</td>
</tr>
<tr>
<td>Mental health services</td>
<td>Alcohol and substance abuse services</td>
<td>Services for persons with mental retardation and developmental disabilities</td>
</tr>
<tr>
<td>Family planning services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2-10
Section 3: Member Rights and Responsibilities

The health and safety of all VNSNY CHOICE members is important to everyone who is involved in their care. VNSNY CHOICE members have the following rights and responsibilities.

Member Rights

- To receive medically necessary care and treatment
- To be treated with dignity and respect and to have the privacy of a member’s health information protected
- To exercise these rights regardless of the member’s race, physical or mental ability, ethnicity, gender, sexual orientation, marital status, economic status, veterans’ status, creed, age, religion or national origin, cultural or educational background, English proficiency, reading skills, health status, source of payment for care
- The choice of qualified physicians, specialists and facilities so members can get the health care they need
- Timely access to quality care and services, network physicians, referrals (if necessary) and recommendations to specialists when medically necessary
- To be told where, when and how to get the services they need from VNSNY CHOICE, in a language that they understand, including how they can get covered benefits from out-of-network providers if VNSNY CHOICE does not have network providers available
- To receive information as necessary to give informed consent prior to the start of any procedure or treatment
- A candid discussion of appropriate or medically necessary treatment options and alternatives for a member’s condition, presented in a manner and language that they understand, regardless of cost or benefit coverage and a treatment plan of care from their doctor. The member has the right to get oral translation services regarding this information free of charge.
- To receive emergency services where and when you need it when the member, as a prudent layperson, acting reasonably would believe that an emergency medical condition exists
- To actively participate in decisions regarding health and treatment options
- To get a second opinion about their care
- To receive urgently needed services when traveling outside the VNSNY CHOICE service area or in the VNSNY CHOICE service area when unusual or extenuating circumstances prevent the member from obtaining care from a participating provider
- To confidential treatment of all communications and records pertaining to the member’s care except as required by law, contract or with a member’s consent
- To get a copy of and/or request amendment to the member’s medical records consistent with the terms of HIPAA and discuss this information with their physician
- To appoint any person (relative, friend, lawyer, etc.) who may have legal responsibility to make decisions on the member’s behalf regarding the member’s medical care and treatment
- To refuse treatment or leave a medical facility, even against the advice of physicians, provided the member accepts the responsibility and consequences of the decision, and be told what they may risk if they do.
- Right to be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation
- To complete and give an Advance Directive, living will or other directive to the member’s medical providers. Please be sure that you understand all of your rights, in
Section 3: Member Rights and Responsibilities

- To work with their physician to guard and improve their health
- Find out how their healthcare system works
- Receive all of their covered benefits from the VNSNY CHOICE program in which they are enrolled
- Use the providers listed in the VNSNY CHOICE Provider Directory for covered services
- Listen to their physician’s advice and ask questions when they are in doubt
- Call or go back to their physician if they do not get better or ask for a second opinion
- Treat healthcare staff with respect
- Inform VNSNY CHOICE if they have problems with any healthcare staff by contacting Member Services
- Keep their appointments. If they must cancel, call as soon as they can.
- If a member has any emergency, to get care immediately
- Use the emergency room only for true emergencies
- Call their physician when they need medical care, even if it is after hours.
- Talk with their Care Manager about the services they need. In most cases, the services a member receives from VNSNY CHOICE require the approval of their physician or Nurse Consultant before a member can get care. (Applies to VNSNY CHOICE Managed Long Term Care members only)
- If a member travels out of town, to let their Care Manager know before they leave. The Nurse Consultant will temporarily cancel the services a member is receiving in their home and community. In addition, if a member needs assistance while he/she is away, the Nurse Consultant may be able to arrange for care while they travel. (Applies to VNSNY CHOICE Managed Long Term Care members only.)
- Make every effort to pay VNSNY CHOICE any surplus that is owed. Surplus is based on Medicaid eligibility rules and is determined by a member’s Local Department of Social Services (also known as HRA in New York City). A member may want to contact their local DSS or HRA to discuss Medicaid eligibility rules and how their surplus is determined. A member’s Nurse Consultant or Social Worker will be glad to help with this. (Applies to VNSNY CHOICE Managed Long Term Care members only.)
Section 3: Member Rights and Responsibilities

**Member Satisfaction**

VNSNY CHOICE periodically surveys members to measure overall customer satisfaction as well as satisfaction with the care received from participating providers. VNSNY CHOICE reviews satisfaction survey information and the results are shared with participating providers. VNSNY CHOICE also reviews grievance and appeal data to identify opportunities to improve member satisfaction.

**Member Advocacy**

VNSNY CHOICE is committed to ensuring that its members receive the optimal level of service for meeting their health and psychosocial care needs.

In keeping with that commitment, VNSNY CHOICE has entered into an agreement with the AIDS Service Center of Lower Manhattan to offer Community Member Advocate Services. Through the development of a personal relationship with VNSNY CHOICE SelectHealth members, the Community Member Advocate will be a resource for the member to access services and remain in care.

**Services Provided in a Culturally Competent Manner**

VNSNY CHOICE is obligated to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating providers must cooperate with VNSNY CHOICE in meeting this obligation.

**Non-Discrimination**

Participating providers will comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. Section 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Section 794) and the regulations there under, Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Section 1681 et. seq.), the Age Discrimination Act of 1975, as amended (42 U.S.C. Section 6101 et. seq.), Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (42 U.S.C. Section 9849), the Americans With Disabilities Act (P.L. 101-365) and all implementing regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

Each participating provider will provide all covered services to members in the same manner as such services are provided to other patients of participating providers, except as required by VNSNY CHOICE. Participating providers will not unlawfully discriminate against any member on the basis of source of payment, medical condition, or in any manner in regards to access to, and the provision of, covered services. Participating providers will not unlawfully discriminate against any member, employee or applicant for employment on the basis of race, religion, color, national origin, ancestry, physical handicap, marital status, age or sex.
Section 3: Member Rights and Responsibilities

Patient Self-Determination

VNSNY CHOICE requires that participating providers comply with the requirements of the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990). The Patient Self-Determination Act protects an adult patient’s right to participate in health care decisions to the maximum extent of his/her ability and to prevent discrimination based on whether the patient has executed an Advance Directive for health care. All members must be informed of their right to make choices about their medical treatment, including the right to accept or refuse medical or surgical treatment and the right to formulate an Advance Directive. An Advance Directive is a member’s written instructions, recognized under State law, relating to the provision of health care when the member is not competent to make health care decisions as determined under State law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

Providers must inform a member of his or her medical condition and all available treatment options, including treatments, which may not be a covered service under the member’s VNSNY CHOICE Evidence of Coverage or Member Handbook. In addition, members must be informed of the risks and benefits of each treatment option. The adult member’s medical record must have documentation indicating whether or not the patient has executed an Advance Directive. The Advance Directive document must be signed by the member and witnessed. Providers may not make treatment conditional or otherwise discriminate on the basis of whether an individual has executed an Advance Directive.

Medicare law gives members the right to file a complaint with the state survey and certification agency if the member is dissatisfied with the organization’s handling of Advance Directives and/or if a provider fails to comply with Advance Directive instructions. If so, the member may write the NY State Department of Health.
**Section 4: Provider Responsibilities**

Participating providers are solely responsible for the medical care and treatment of members and will maintain the physician-patient relationship with each member. Nothing contained in the participating provider’s agreement is intended to interfere with such physician-patient relationship, nor is the participating provider agreement intended to discourage or prohibit participating providers from discussing treatment options or providing other medical advice or treatment deemed appropriate by participating providers.

Participating providers agree to provide services to all members in the same manner, in accordance with the same standards and with the same priority as their other patients. Providers may not discriminate on the basis of color, race, creed, gender, sexual orientation, place of origin, disability, source of payment, type of illness or condition or any other prohibited basis. VNSNY CHOICE also requires that network providers assist its members with limited English speaking proficiency and physical disabilities.

The following describes some important responsibilities for our participating providers.

**The Role of the Primary Care Provider**

**Selecting a Provider**

All members of VNSNY CHOICE Medicare Advantage Plans, Medicare Advantage Special Needs Plans and VNSNY CHOICE SelectHealth must choose a participating Primary Care Provider (PCP). Upon enrollment, every member selects a PCP from the VNSNY CHOICE Provider Directory. For members of the VNSNY CHOICE SelectHealth, every participating primary care provider (PCP) that follows HIV-infected members must be an HIV-Specialist who has met the criteria of one of the following recognized bodies: (a) The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider, (b) HIV-Specialist status accorded by the American Academy of HIV Medicine or (c) Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB).

If a member does not choose a PCP within 30 days of notification of enrollment, Member Services will assign a PCP to the member.

Enrollees in the VNSNY CHOICE Managed Long Term Care Plan are not required to select a PCP, however, their physician or Nurse Practitioner must be willing to work with the plan.

Members may change their designated PCP at any time by contacting Member Services at the telephone number listed in Section 1 of this provider manual. Members will receive a new ID card with updated PCP information.

As a Primary Care Provider (PCP), you are the manager of your patients' total healthcare needs. PCPs provide routine and preventive medical services, authorize covered services for members, and coordinate all care that is given by VNSNY CHOICE specialists, VNSNY CHOICE participating facilities, or any other medical facility where your patients might seek care (e.g., Emergency Services). The coordination provided by PCPs may include direct provision of primary care, referrals for specialty care and referrals to other programs including Disease Management and educational programs, public health agencies and community resources.

PCPs are generally Physicians of Internal Medicine, Family Practice, General Practice, Pediatricians, Geriatrics, OB/GYNs, physicians that specialize in infectious disease, and Nurse
Section 4: Provider Responsibilities

Practitioners in Adult Medicine, Gerontology Family Medicine, Gynecology or who meet the HIV Specialist Criteria referenced below.

Participation Guidelines

One of the cornerstones of VNSNY CHOICE's healthcare philosophy is the availability of services. All PCPs must:

1. Arrange to have coverage available to provide medical services to their members, 24 hours a day, seven days a week;
2. Treat all patients equally;
3. Not discriminate because of race, sex, marital status, sexual orientation, religion, ancestry, national origin, place of residence, disability, source of payment, utilization of medical, mental health services or supplies, health status, or status as a Medicare or Medicaid recipient, or other unlawful basis; and,
4. Agree to observe, protect, and promote the rights of VNSNY CHOICE members as patients.

For your reference, we have included a copy of VNSNY CHOICE’s Member Rights and Responsibilities in Section 3 of this provider manual.

In becoming a VNSNY CHOICE PCP, you and your staff agree to follow and comply with VNSNY CHOICE's administrative, medical management, quality assurance, and reimbursement policies and procedures.

The following four sections apply to providers of VNSNY CHOICE SelectHealth members.

Specialist Services Provided by PCPs

1. HIV Specialist Criteria

One of the distinguishing characteristics of the VNSNY CHOICE SelectHealth network is that every participating primary care provider (PCP) that follows HIV-infected members must be an HIV-Specialist who has met the criteria of one of the following recognized bodies: (a) The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider, (b) HIV-Specialist status accorded by the American Academy of HIV Medicine or (c) Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB). Eligibility requirements include:

- Current and valid MD, DO, PA or NP state license year,
- Provision of direct, ongoing care to at least 20 HIV patients over the 24 months preceding the date of application, and
- Completing a minimum of 30 credits of HIV-related Category 1 CME/CEU/CE within the 24 months preceding the date of application.

2. PCP Teams

Teams of physicians/nurse practitioners may serve as PCPs for members of the VNSNY CHOICE SelectHealth. Such teams may include no more than four (4) physicians/nurse practitioners and, when a member chooses or is assigned to a team,
Section 4: Provider Responsibilities

One of the practitioners must be designated as “lead provider” for that member. All such team practitioners must meet HIV Specialist PCP criteria. In the case of teams comprised of medical residents under the supervision of an attending physician, the attending physician must be designated as the lead physician and must meet HIV Specialist PCP criteria.

- **Member to Provider Ratios**

PCPs agree to adhere to the member-to-PCP ratios referenced in the Provider Agreement that governs their relationship with VNSNY CHOICE (Individual Provider or Hospital). These ratios are for Medicaid enrollees only, are VNSNY CHOICE-specific, and assume that the PCP is a full-time equivalent (FTE) defined as a provider practicing 40 hours per week for the VNSNY CHOICE SelectHealth. These ratios will be prorated for PCPs that represent less than an FTE to VNSNY CHOICE.

- **Minimum Office Hours**

A VNSNY CHOICE SelectHealth PCP must practice a minimum of 16 hours a week at each primary care site.* Providers must promptly notify VNSNY CHOICE of changes in office hours and location as soon as this information becomes available, but no later than three business days after the change takes effect.

*The minimum office hour requirement may be reduced under certain circumstances. Please contact the VNSNY CHOICE Provider Relations Department at the telephone number listed in Section 1 of this provider manual for further information.

Responsibility to Your Patients

The PCP coordinates all aspects of a member’s care covered under the plan. As a VNSNY CHOICE PCP, you agree to provide the following, where applicable:

1. All the services of a PCP or other health professional typically received in a PCP’s office. These include but are not limited to:
   a. Treatment of routine illness
   b. Health consultations and advice
   c. Injections
   d. Conducting baseline and periodic physical exams, including any tests and any ancillary services required to make your appraisal. (Members of a VNSNY CHOICE SelectHealth are to be assessed by the PCP within 4 weeks of the effective date of enrollment.)
   e. Diagnosing and treating conditions not requiring the services of a specialist.
   f. Initiating referrals from non-primary care service as required by the specific plan in which the member is enrolled
   g. Arranging inpatient care
   h. Consulting with specialists, laboratory and radiological services when medically necessary
   i. Coordinating the findings of consultations and laboratories
   j. Interpreting such findings for the member and his/her family, subject to
Section 4: Provider Responsibilities

regulatory requirements regarding confidentiality
k. Coordinating dental care as part of the overall health care management of VNSNY CHOICE SelectHealth members
l. Assessing the member’s need for mental health and/or alcohol/substance abuse services during initial, subsequent and annual visits. (For further assistance, see the paragraph entitled “Behavioral Health Assessment” on page 4-7 of this manual.)
m. Providing documentation of member HIV and AIDS status to VNSNY CHOICE. (For further information, see Section 2 Verifying Eligibility for Covered Services.)
n. Assisting the plan in securing laboratory results (CD4 measurements/viral loads) and prescription information
o. Maintains a current medical record for the member

2. Appropriate coverage for your patients who may be in a hospital or skilled nursing facility

3. Educational services including:
   a. Information to assist members in using healthcare services appropriately
   b. Information on personal health behavior and lifestyle
   c. Information on achieving and maintaining physical and mental health

4. Maintenance of certain standards for your office, service, and medical records. (See the paragraphs below, Section 5 and Section 7 for specific requirements.)

Referring to a Participating VNSNY CHOICE Specialist

1. Refer members only to VNSNY CHOICE network physicians, ancillary facilities, and providers. If a required specialty is not represented in VNSNY CHOICE’s Provider Directory and Directory Addenda, call VNSNY CHOICE’s Provider Services Department at the telephone number listed in Section 1 of this provider manual.

2. Members of the VNSNY CHOICE Medicare Advantage plans, VNSNY CHOICE Integrated Medicare Advantage Special Needs Plan and Medicaid Managed Long Term Care plan and VNSNY CHOICE MLTC plan do not require a referral to see a specialist. Although VNSNY CHOICE SelectHealth members do not need a referral to seek care from an in network specialist, they should have a prescription from the primary care provider.

Access Requirements – Appointment Availability Standards

All Primary Care and Specialist services provided by participating providers are to be provided by duly licensed, certified or otherwise authorized professional personnel in a culturally competent manner and at physical facilities in accordance with:
- The generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment;
- The provisions of VNSNY CHOICE’s Quality Improvement Program and Medical Management Program;
- The requirements of State and Federal Law; and
- The standards of accreditation organizations such as NCQA and Joint Commission.
Section 4: Provider Responsibilities

Each participating provider is required to provide advance written notice to VNSNY CHOICE in the event of any change in the capacity of the participating provider to continue services under the terms of the participating provider’s agreement with VNSNY CHOICE.

VNSNY CHOICE Medicare Advantage Plan Providers

Providers must agree to comply with the following appointment availability standards:

a. **Telephone Coverage After Hours**
   All providers must have either an answering service or a telephone recording that directs a member to call another telephone number or 911 in the event of an urgent or emergent situation. (Please be sure that if the on-call number is a beeper number, members understand how to punch in the telephone number.)

b. **Telephone Access During Normal Business Hours**
   Providers are expected to provide an immediate response to all emergent conditions. Providers should respond to urgent conditions within 4 hours and non-urgent/routine calls within 1-2 business days.

c. **Covering Provider**
   All Primary Care Providers on extended leave (vacation, illness, etc.) must arrange with another participating VNSNY CHOICE provider, or a non-VNSNY CHOICE provider who agrees to accept the contracted rate, to provide 24-hour coverage for your patients. The covering provider must also have 24-hour telephone coverage. Telephone coverage should not routinely direct a member to call 911, except in the event of an emergency or urgent situation.

d. **Appointments**
   Primary Care Providers must make every effort to see a member within the following timeframes:
   - Emergent – Member should be directed to call 911 in the event of an emergency or go to the Emergency Room for treatment. PCPs are required to have arrangements for coverage 24 hours a day, 7 days per week.
   - Urgent – Within 24 hours
   - Routine/Symptomatic – Within 7 days
   - Wellness/Non-Symptomatic – Within 30 days
     - Routine conditions are usually conditions that are chronic in duration. Preventive health care services are associated with keeping the member healthy. Preventive health services include, but are not limited to: physicals, mammography, digital rectal exams and colon screenings.

e. **Office Waiting Times**
   Office waiting time for visits should not exceed 30 minutes from the time of the scheduled appointment.

f. **Minimum Office Hours**
   A VNSNY CHOICE Medicare Advantage Plan provider must practice a minimum of 16 hours a week.* Providers must promptly notify VNSNY CHOICE of changes in
Section 4: Provider Responsibilities

office hours and locations as soon as this information becomes available, but no later than three business days after the change takes effect.

* The minimum office hour requirement may be reduced under certain circumstances. Please contact VNSNY CHOICE Provider Relations Department at the telephone number listed in Section 1 of this provider manual for further information.

VNSNY CHOICE SelectHealth Providers

Providers must agree to comply with the following appointment availability standards:

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Appointment Availability Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>Immediately upon presentation at a service delivery site.</td>
</tr>
<tr>
<td>Urgent medical or behavioral problem</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Non-urgent “sick” visit</td>
<td>Within 48 – 72 hours of request, as clinically indicated.</td>
</tr>
<tr>
<td>Routine non-urgent, preventive appointment</td>
<td>Within four (4) weeks of request.</td>
</tr>
<tr>
<td>Specialist referral (non-urgent)</td>
<td>Within four (4) to six (6) weeks of request.</td>
</tr>
<tr>
<td>Initial prenatal visit</td>
<td>Within three (3) weeks during first trimester, within two (2) weeks during second trimester, within one (1) week during third trimester, within four (4) to six (6) weeks of request.</td>
</tr>
<tr>
<td>Adult baseline and routine physical</td>
<td>Within four (4) weeks of enrollment (Adults &gt;21).</td>
</tr>
<tr>
<td>Initial visit for members with ongoing treatment needs</td>
<td>Within seven (7) days of enrollment if medically necessary</td>
</tr>
<tr>
<td>Well child care</td>
<td>Within four (4) weeks of request.</td>
</tr>
<tr>
<td>Initial family planning visit</td>
<td>Within two (2) weeks of request.</td>
</tr>
<tr>
<td>In-plan mental health follow-up visit (pursuant to an emergency or hospital discharge)</td>
<td>Within five (5) days of request, or as clinically indicated</td>
</tr>
<tr>
<td>In-plan, non-urgent mental health visits</td>
<td>Within two (2) weeks of request.</td>
</tr>
<tr>
<td>Initial PCP office visit for newborn</td>
<td>Within 48 hours of hospital discharge.</td>
</tr>
<tr>
<td>Provider visit to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding member’s ability to perform work when requested by Local Department of Social Services</td>
<td>Within ten (10) days of request.</td>
</tr>
</tbody>
</table>
Section 4: Provider Responsibilities

Note: These are general standards and are not intended to supersede sound clinical judgment as to the necessity for care and services on a more expedient basis.

a. Twenty-Four (24) Hour Access
   Primary Care Providers and qualified providers of obstetrical care must provide VNSNY CHOICE SelectHealth members with access to a 24 hour a day, seven (7) day a week live voice telephone triage system capable of appropriately instructing members with respect to the appropriate level of care they may need.

b. Telephone Response Time
   Primary Care Providers and qualified providers of obstetrical care must demonstrate the ability to return telephone calls of an urgent or emergent nature within 30 minutes.

c. Unscheduled, Non-Urgent Care (Walk-ins)
   VNSNY CHOICE requires that network providers have policies and procedures that guarantee access for members, particularly adolescents and substance abusers, who present for unscheduled, non-urgent care.

d. Appointment Waiting Times
   Members with appointments shall not routinely be made to wait longer than one (1) hour.

Additional Information for VNSNY CHOICE SelectHealth Providers:

Behavioral Health Assessment

Participating PCPs, as part of comprehensive primary care plan, must follow guidelines established by NYSDOH AIDS Institute with regard to the periodic screening for Behavioral Health morbidity. At a minimum this requires that each VNSNY CHOICE SelectHealth member should receive a comprehensive evaluation for mental health and chemical dependency issues on an annual basis or more frequently if clinically indicated. Screening should be adequately reflected in the medical record.

PCPs may refer members for mental health/substance abuse services directly (network providers are listed in the VNSNY CHOICE Provider Directory) or by contacting the Referral Coordination Service at the telephone number listed in Section 1 of this provider manual.

HIV Prevention and Risk Reduction Services

Participating providers are expected to provide the following HIV primary and secondary prevention and risk reduction education services:

- Education and counseling regarding reduction of perinatal transmission.
- HIV prevention and risk reduction education and counseling.
- Education for members regarding STDs and services for STD treatment and prevention.
- Counseling and supportive services for partner/spousal notification (See Tip Sheet for Partner Notification: What Providers Need to Know in Appendix B of this manual).
Section 4: Provider Responsibilities

Services for HIV-Infected Pregnant Women, HIV-Exposed Newborns and HIV-Infected and Affected Children and Adolescents

VNSNY CHOICE participating providers must render care that is consistent with State and Federal policies regarding methods of reducing HIV transmission and encouraging early entry into care including:

- HIV pretest counseling with clinical recommendation of testing for all pregnant women. Those women and their children must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services.
- Timely exchange of clinical information among prenatal, delivery and pediatric settings for HIV positive pregnant women, with appropriate member consent.
- Initiation of prophylaxis with antiretroviral therapy (ART) as needed.
- Nutrition screening and counseling
- STD screening
- Ongoing risk assessment for both maternal and fetal risk (including genetic, nutritional, psychosocial, historical and emergency obstetrical and medical/surgical risk factors).
- Provision of HIV viral load testing at recommended intervals (initial specimen by age 48 hours, with follow-up specimens at age two (2) weeks, age four (4) weeks, age eight (8) – ten (10) weeks and final specimen at age 16 weeks or greater to definitively diagnose or rule-out HIV infection in exposed infants. (A negative result for an infant less than 28 days old does not exclude HIV infection, particularly if the infant has been exposed to ARV in-utero or after birth.)
- Provision of routine pediatric care to all children enrolled in a VNSNY CHOICE SelectHealth in accordance with guidelines established by the American Academy of Pediatrics and EPSDT/Child Teen Health Program (C/THP). Such care must include providing and or referring members to:
  - Immunizations
  - Monitoring of growth and development
  - Routine screening (including lead screening)
  - Guidance to help parents anticipate normal changes and problems with growth, development and education
  - Adolescent health, child/teen health screenings and provision of early and periodic screening, diagnosis, treatment and referral to each participant under the age of 21 at regular intervals and as medically appropriate (including STD screening)
  - Comprehensive developmental assessments
  - Early intervention services including physical, speech and occupational therapies
  - Access to intravenous infusions
  - Oral health services
  - Linkages to clinical trials for all members under the age of 21, as appropriate

Provider Education

Primary Care Providers must annually participate in HIV-specific continuing medical education that is consistent with guidelines for HIV specialty care as determined by the New York State
Section 4: Provider Responsibilities

Department of Health AIDS Institute. This activity should ensure understanding of and familiarity with the following topics:

- New advances in HIV clinical care
- State-of-the-art diagnostic techniques including quantitative viral measures and resistance testing
- Strategies to promote treatment adherence
- Management of opportunistic infections and diseases
- Management of HIV-infected patients with co-morbid conditions
- Access to referrals to clinical trials
- Occupational exposure management, post-exposure prophylaxis protocols and infection control issues
- Care coordination and medical case management
- Patient education needs including primary and secondary prevention, risk reduction and harm reduction
- Cross-cultural care issues appropriate to the VNSNY CHOICE population
- Family-centered psychosocial issues
- Mental health and substance abuse issues
- HIV confidentiality

VNSNY CHOICE will facilitate annual educational programs for PCPs around the topics referenced above.

Provider Performance Standards and Compliance Obligations

When evaluating the performance of a participating provider, VNSNY CHOICE will review at a minimum the following areas:

- **Quality of Care**: measured by clinical data related to the appropriateness of members’ care and outcomes,
- **Efficiency of Care**: measured by clinical and financial data related to members’ health care costs,
- **Member Satisfaction**: measured by members’ reports and services regarding accessibility, quality of health care, member-participating provider relations, and the comfort of the practice setting,
- **Administrative Requirements**: measured by the participating provider’s methods and systems for keeping records and transmitting information, and
- **Participation in Clinical Standards**: measured by the participating provider’s compliance with quality of care standards.

Provider Compliance to Standards of Care

VNSNY CHOICE participating providers must comply with all applicable laws and licensing requirements. In addition, participating providers must furnish covered evidence-based services in a manner consistent with standards, including nationally recognized clinical protocols and guidelines, related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. Participating providers must
Section 4: Provider Responsibilities

also comply with VNSNY CHOICE’s standards, which include but are not limited to:

1. Guidelines established by the Federal Center for Disease Control Prevention (or any successor entity),
2. New York State Department of AIDS Institute,
3. All federal, state, and local laws regarding the conduct of their profession,
4. Participation on committees and clinical task forces to improve the quality and cost of care,
5. Referral Policies,
6. Preauthorization and notification requirements and timeframes,
7. Participating provider credentialing requirements,
8. Care Management Program referrals,
9. Appropriate release of inpatient and outpatient utilization and outcomes information,
10. Accessibility of member medical record information to fulfill the business and clinical needs of VNSNY CHOICE,
11. Cooperating with efforts to assure appropriate levels of care,
12. Maintaining a collegial and professional relationship with VNSNY CHOICE personnel and fellow participating providers, and
13. Providing equal access and treatment to all members

Compliance Process

The following types of non-compliance issues are key areas of concern:

1. Inappropriate, out-of-network referrals/utilization,
2. Failure to obtain pre-authorization from VNSNY CHOICE for admissions and other services requiring prior authorization,
3. Member complaints/Grievances that are determined against the participating provider,
4. Underutilization, over utilization, or inappropriate referrals,
5. Inappropriate billing practices, and
6. Non-supportive actions and/or attitude.

Participating provider noncompliance is tracked on a calendar year basis. Corrective actions may be required, if areas or patterns of noncompliance are found.

Participating providers acting within the lawful scope of practice are encouraged to advise members of VNSNY CHOICE about:

1. The member’s health status, medical care, or treatment options (including any alternative treatments that may be self-administered or treatments not covered by VNSNY CHOICE), including the provision of sufficient information to provide an opportunity for the member to decide among all relevant treatment options,
2. The risks, benefits, and consequences of treatment or non-treatment, and
3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decision.
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Quality Assurance and Medical Management

All VNSNY CHOICE PCPs must cooperate with and participate in peer review, including utilization review (see Section 13), quality assurance, external audits, administrative procedures, and grievance procedures (see Section 12).

All services that you provide to members must be consistent with appropriate medical practice. They must also be in accordance with the AMA’s rules of ethics and conduct, and in accordance with the rules of any other medical governing or licensing body including HIPAA rules governing privacy of medical records.

You must notify VNSNY CHOICE immediately if your medical license or board certification or your participation in Medicare or Medicaid is revoked or restricted.

Providers agree to comply with the policies and procedures that VNSNY CHOICE has established in the following areas:

- Quality improvement/management
- Utilization management including precertification procedures, referral management and reporting of clinical encounter data
- Member complaints
- Medical/clinical care coordination
- Provider credentialing

Confidentiality and HIPAA

As a VNSNY CHOICE PCP, you must maintain medical and non-medical records. You and VNSNY CHOICE agree to maintain confidentiality in compliance with all state and federal laws and regulations that govern the practice of medicine or operation of a managed care organization. You must also comply with all HIPAA regulations related to medical information and records exchanged with VNSNY CHOICE in the process of claims, medical treatment, quality assurance functions or response to a complaint or appeal. You must also make any medical, financial, or administrative records available to VNSNY CHOICE at no charge, as requested, either for VNSNY CHOICE administrative purposes, quality assurance purposes, or to comply with state and federal law.

Americans with Disabilities Act (ADA)

VNSNY CHOICE providers are expected to comply with Title II of the Americans with Disabilities Acts (ADA). The goals of compliance with ADA Title II requirements are to offer a level of services that allows people with disabilities access to the program in its entirety and the ability to achieve the same health care results as any VNSNY CHOICE member.

VNSNY CHOICE assists participating providers, at their point of service, to identify VNSNY CHOICE members who require audio, visual, mobility aids and other accommodations. In addition, VNSNY CHOICE offers training for providers regarding compliance with Title II requirements, such as access requirements for door widths, wheelchair ramps, accessible diagnostic/treatment rooms and equipment; communication issues, and attitudinal barriers related to disability.
Section 4: Provider Responsibilities

Laws Regarding Federal Funds

Payments that participating providers receive for furnishing services to VNSNY CHOICE members are, in whole or part, from Federal funds. Therefore, participating providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans With Disabilities Act.

Sanctions Under Federal Health Programs and State Law

Participating providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by the participating provider.

Participating providers must disclose to VNSNY CHOICE whether the participating provider or any staff member or subcontractor has any prior violation, fine, suspension, or termination, has been disbarred from or had other administrative action taken under Medicare or Medicaid laws, the rules or regulations of New York, the federal government, or any public insurer. Such individuals shall not be allowed to provide services to VNSNY CHOICE members.

Participating providers must notify VNSNY CHOICE immediately if any such sanction is imposed on participating provider, a staff member or subcontractor.

Informed Consent and Confidentiality

All participating providers must provide information to members necessary to give informed consent prior to the start of any procedure or treatment. In addition, all participating providers are subject to confidentiality requirements outlined by the New York State Department Health and the Centers for Medicare and Medicaid Services.

Providers are obligated to, among other things:

- Conduct initial and annual in-service education of staff and contractors;
- Identify staff allowed access to confidential information and the limits of that access;
- Establish procedures to limit access to confidential information to trained staff (including contractors);
- Develop protocols for secure storage of confidential information (including electronic storage);
- Develop procedures for handling requests for HIV-related information; and
- Develop protocols to protect persons with or suspected of having HIV infection from discrimination.

Please see “HIV Related Confidentiality” in Appendix B.

Closing of Provider Panel

When closing a practice to new VNSNY CHOICE members, participating providers are required to:
Section 4: Provider Responsibilities

- Give VNSNY CHOICE 60 days prior written notice that the practice will be closing to new members as of a specified date,
- Keep the practice open to new VNSNY CHOICE members who were patients before the practice closed,
- Uniformly close the practice to all new patients, including private payers, commercial or government insurers, and
- Give VNSNY CHOICE prior written notice of the re-opening of the practice, including a specified effective date.

Compensation

Participating providers must look only to VNSNY CHOICE for compensation for services rendered to VNSNY CHOICE members. VNSNY CHOICE providers agree not to bill/collect payment for services rendered to VNSNY CHOICE members except for applicable copayments, coinsurance or deductibles or services not covered by the VNSNY CHOICE contract for which the member has been advised, prior to the provision of service, that the service is not covered and the member will be liable for the cost of the service.

Marketing Guidelines for Providers

Providers of VNSNY CHOICE Medicare Advantage Plans

Participating providers may not develop and use any materials that market VNSNY CHOICE Medicare Advantage plans without the prior written approval of VNSNY CHOICE in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization and its participating providers may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are prior approved by CMS or are submitted to CMS and not disapproved within 45 days.

Providers must make member records and encounter data available to VNSNY CHOICE to the extent permitted by law and necessary for pre-authorization and concurrent utilization review activities, quality assurance, claims processing and payment to the NYSDOH, NYC Human Resources Administration and The Centers for Medicare and Medicaid Services (CMS), at no charge to these agencies, for the purpose of inspection and copying related to quality of care, monitoring, audit and enforcement and any other legally authorized purpose.

Providers of VNSNY CHOICE SelectHealth

The VNSNY CHOICE SelectHealth is contracted with the New York City Department of Health (NYCDOH) and is subject to contractual terms and conditions including comprehensive marketing guidelines. By CDOH definition, marketing encompasses written literature and conversations with a potential SNP member that may persuade the potential member to choose a particular SNP.

1. Written Marketing Materials
   - Written marketing materials generated by providers must be approved by CDOH, Division of Health Care Access.
Section 4: Provider Responsibilities

- Written marketing materials must contain certain specified information to ensure that potential HIV SNP members receive basic information. The CDOH has developed a model letter for use by providers to communicate information about HIV SNPs to their patients. No further review is required if the model letter is used. Any modifications to this letter, however, must be approved by CDOH.

2. Marketing Encounters
- Marketing encounters are defined to be any conversation or activity with a potential SNP member for the purpose of persuading that person to enroll in a particular HIV SNP.
- All marketing encounters must communicate at least the following information:
  - A statement that participation in an HIV SNP is voluntary and that persons with HIV/AIDS may choose instead to join or remain in a mainstream Medicaid managed care plan
  - The potential member has a choice among several alternative HIV SNPs
  - Upon enrollment in a SNP, the member is required to use his/her HIV Specialist PCP and other plan providers exclusively for medical care, except in certain limited circumstances.
  - Newborns of a mother enrolled in a SNP are automatically enrolled in the mother’s HIV SNP. The infant may be disenrolled at any time at the mother’s request.
- Providers may market to persons enrolled in the mainstream health plan operated by the same organization as the HIV SNP, but must inform the member that the change is optional and the members who change from a mainstream health plan to an affiliated SNP must sign a new enrollment form.
- Providers who wish to let their patients know of their affiliation with one or more HIV SNPs must list each HIV SNP with whom they hold contracts.

3. Marketing Conduct
- Marketing encounters are to be conducted in a manner that does not disclose nor breach the confidentiality of the potential member’s HIV status.
- Providers may not give mailing lists of patients to HIV SNPs.
- Providers may not target mailings to HIV/AIDS patients or patients with a significant probability of having HIV/AIDS unless the patient has consented in writing to mail contact. This is to protect patient confidentiality. Some providers, such as facilities specializing in HIV/AIDS care, should consider handouts of literature rather than a mailing to avoid confidentiality problems.
- Providers should inquire as to whether the prospective member is currently enrolled in another HIV SNP. If so, providers may not market to persons who are enrolled in another HIV SNP.

Providers of VNSNY CHOICE Managed Long Term Care Members

VNSNY CHOICE MLTC, a Medicaid Managed Long Term Care Plan, is contracted with the New York State Department of Health (NYSDOH) and is subject to contractual terms and conditions including comprehensive marketing guidelines.

Written materials must be approved by the New York State Department of Health prior to distribution
Network Specialist Participation Guidelines

In becoming a VNSNY CHOICE specialist, you and your staff agree to follow and comply with VNSNY CHOICE’s administrative, patient referral, utilization review, quality assurance, disease management, and reimbursement policies and procedures. As a Participating Specialist with VNSNY CHOICE, you must:

1. Treat all your patients equally.
2. Not discriminate because of race, sex, religion, place of residence, health status, or status as a Medicare or Medicaid Member.
3. Observe, protect, and promote the rights of VNSNY CHOICE members as patients.

For your reference, a copy of VNSNY CHOICE’s Member Rights and Responsibilities is included in Section 3 of this provider manual.

A Participating Specialist may serve as the member’s PCP if the following conditions are met:
- The Participating Specialist satisfies the credentialing requirements for a PCP
- VNSNY CHOICE approves the request
- The Participating Specialist agrees to fulfill the role

Responsibility to Your Patients

1. Work closely with PCPs to ensure continuity of care for VNSNY CHOICE members.
2. Advise the PCP, in writing, about ongoing treatment of the PCP’s patient.
3. Confer with the member’s PCP before referring the member to another specialist, except in a serious, life-threatening emergency. Similarly, if a member under specialist care must enter the hospital, the specialist must get Prior Authorization (except in an emergency), of the admission from VNSNY CHOICE’s Medical Management Department and must notify the member’s PCP of the admission.
4. Maintain certain standards for your office, service, and medical records. See below for specific requirements.

Access Requirements – Appointment Availability Standards

VNSNY CHOICE Medicare Advantage Plan Specialists

Providers must agree to comply with the following appointment availability standards:

1. Telephone Coverage After Hours
   All providers must have either an answering service or a telephone recording that directs a member to call a special telephone number or 911 in the event of an urgent or emergent situation. (Be sure that if the special number is a beeper number, members understand how to punch in the telephone number.)

2. Covering Providers
   All providers on extended leave (vacation, illness, etc.) must arrange with a fellow VNSNY CHOICE physician, or a non-VNSNY CHOICE provider who agrees to accept
Section 5: Network Specialist Responsibilities

the contracted rate, to provide 24-hour coverage for your patients. The covering provider must also have 24-hour telephone coverage. This telephone coverage should not routinely direct members to 911, except in the event of an emergency or urgent situation.

3. Appointments
Providers must make every effort to see a member within the following timeframes:

- Emergent – Member should be directed to 911 or the emergency room for treatment. Specialists are required to have arrangements for coverage 24 hours a day, 7 days a week
- Urgent – Within 24 hours
- Routine/Symptomatic – Within 7 days
- Wellness/Non-Symptomatic – Within 30 days
  o Routine conditions are usually conditions that are chronic in duration. Preventive health care services are associated with keeping the member healthy. Preventive health services include, but are not limited to: physicals, mammography, digital rectal exams and colon screenings.

4. Office Waiting Time
Office waiting time for visits should not exceed 30 minutes.

VNSNY CHOICE SelectHealth Specialists

The VNSNY CHOICE SelectHealth participating specialists provide direct medical care for VNSNY CHOICE members upon referral from the primary care provider. The specialist makes recommendations to the PCP, as necessary, for referral of members for other specialty care services and/or admission to health care facilities. The specialist may directly refer members to other in-network specialty providers without a referral and to out-of-network specialty providers, as medically indicated, upon receiving authorization from VNSNY CHOICE Medical Management Department. To assure appropriate care coordination, we ask that specialists communicate with the referring physician within seven (7) days of seeing a VNSNY CHOICE SelectHealth member for a routine consultation and as soon as possible for urgent/emergent conditions.

Please see Section 4 for appointment availability standards for VNSNY CHOICE SelectHealth PCPs.

Quality Assurance and Medical Management

All VNSNY CHOICE physician specialists must cooperate with and participate in peer review, including utilization review (see Section 13), quality assurance programs, external audit programs, administrative procedures, and grievance procedures (see Section 12).

All services that you provide to members must be consistent with appropriate medical practice. They must also be in accordance with the AMA’s rules of ethics and conduct, and in accordance with the rules of any other medical governing or licensing body including HIPAA rules governing privacy of medical records.
Section 5: Network Specialist Responsibilities

You must notify VNSNY CHOICE immediately if your medical license or board certification or your participation in Medicare or Medicaid is revoked or restricted.

Confidentiality and HIPAA

As a VNSNY CHOICE physician, you must maintain medical and non-medical records. You and VNSNY CHOICE agree to maintain confidentiality in compliance with all state and federal laws and regulations that govern the practice of medicine or operation of a managed care organization. You must also comply with all HIPAA regulations related to medical information and records exchanged with VNSNY CHOICE in the processing of claims and medical treatment. You must also make any medical, financial, or administrative records available to VNSNY CHOICE, as requested, either for VNSNY CHOICE’s administrative purposes, quality assurance purposes, or to comply with state and federal law.
Section 6: Provider Credentialing and Termination

Provider Credentialing

The Credentialing/Recredentialing processes are components of the organization’s Quality Improvement Program. These processes were designed to protect members and provide continued assurance that potential and/or current participating providers meet the requirements necessary for the provision of quality care and service.

The objectives of the VNSNY CHOICE Credentialing Program are to ensure that:
• Members who join VNSNY CHOICE will have their care rendered by appropriately qualified providers
• Each provider applicant has equal opportunity to participate
• Adequate information pertaining to education, training, relevant experience and other credentialing criteria is reviewed by the appropriate individuals prior to approval or denial by the Credentialing Subcommittee.

Credentialing is required for all physicians who provide services to VNSNY CHOICE members and all other health professionals and facilities who are permitted to practice independently under State law and who provide services to VNSNY CHOICE members, with the exception of hospital based health care professionals. Hospitals and freestanding facilities are required by law to credential providers exclusively operating within their setting. As such, VNSNY CHOICE does not credential providers that practice exclusively within the inpatient hospital or a freestanding facility setting but instead relies on the hospital’s credentialing program/appointment process for these providers. Providers in this category include, but are not limited to, providers employed by or contracted with the hospital who do not practice outside of the hospital.

Hospitals and other facilities must be licensed by and demonstrate good standing with state and federal regulatory agencies.

VNSNY CHOICE does not discriminate in terms of participation or reimbursement against any physician or health care professional that is acting within the scope of his or her license.

Providers are obligated to submit their credentialing applications (and supporting documents) for initial and recredentialing in a timely manner.

Delegation of Credentialing

VNSNY CHOICE may choose to delegate provider credentialing and recredentialing in accordance with established policies. However, VNSNY CHOICE is ultimately responsible for credentialing and recredentialing of providers and maintains the responsibility for ensuring that the delegated functions are being performed according to VNSNY standards.

Application Process

VNSNY CHOICE completes credentialing activities and notifies providers within 90 days of receipt of a completed application. The notification to the provider includes whether they are credentialed, whether additional time is needed for review or that VNSNY CHOICE is not in need of additional providers. If additional information is required, VNSNY CHOICE will
Section 6: Provider Credentialing and Termination

notify the provider within 90 days of receipt of the application.

Initial Credentialing

The applicant is responsible for supplying all requested documentation in a form that is satisfactory to the Credentialing Subcommittee.

A signed VNSNY CHOICE Provider Application is required in addition to applicable credentialing documents and certifications. Examples of requested information includes:

- New York State License and Registration
- Valid and Current DEA certification (physicians only)
- Board Certification
- Insurance Coverage (Participating providers are required to carry malpractice coverage amounts as specified in their contract. Non-medical providers must carry general business liability coverage as specified in their contracts.)
- Malpractice History
- Federal and/State Sanctions
- Medicaid Participation Status
- Curriculum Vitae (CV)
- Hospital Privileges (Physicians only)
- HIV Specialist PCP Addendum
- Audited financial statements
- IRS-W9 Form
- New York City Vendex rating letter (for city contractors only)

The Credentialing Subcommittee will consider all information gathered on the Provider Application and evaluate it in light of the criteria. For more information on Credentialing Criteria please call Provider Services at the telephone number listed in Section 1 of this provider manual. The Credentialing Subcommittee will then make a determination to recommend either approval or disapproval of the provider’s application.

VNSNY CHOICE will provide written notice to a provider whom VNSNY CHOICE declines to include in the network, setting forth the reason for its decision.

Ongoing Credentialing Requirement for HIV Specialists

HIV Specialists must provide evidence of participation in at least ten hours annually of continuing medical education that includes information on the use of antiretroviral therapy in the ambulatory care setting. Providers agree to notify VNSNY CHOICE promptly in the event of any material change in the status of their licensure, Medicare provider status, hospital medical staff appointments or privileges, physical or mental impairment or any other credentialing criteria that would affect their ability to practice.

Recredentialing

Participating Providers must be recredentialed every 3 years. Procedures for recredentialing include updating information obtained in initial credentialing and consideration of performance
Section 6: Provider Credentialing and Termination

indicators.

All HIV Primary Care Physicians must complete an annual assessment to confirm that they still meet the requirements to be an HIV PCP.

Office-Based Surgery

"Office-based surgery" means any surgical or other invasive procedure, requiring general anesthesia, moderate sedation, or deep sedation, and any liposuction procedure, where such surgical or other invasive procedure or liposuction is performed by a licensee in a location other than a hospital, excluding minor procedures and procedures requiring minimal sedation. Pursuant to New York State Public Health Law section 230-d, "Licensees" (physicians, physician assistants and specialist assistants) who perform invasive or surgical procedures using more than minimal sedation must practice in an accredited setting.

The New York State Commissioner of Health designated The Joint Commission, the American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF) and the Accreditation Association for Ambulatory Health Care (AAAHC) as the organizations which are authorized to perform the accreditation of practices which meet the definition of Office Based Surgery. A licensee who fails to practice in an accredited setting after July 14, 2009 may be guilty of professional misconduct. Further information can be obtained from the New York State Department of Health.

Accordingly, it is incumbent on those practitioners who wish to perform Office-based Surgery in their practice offices or other non-hospital settings to provide proof of accreditation to VNSNY CHOICE.

VNSNY CHOICE will not pay for office-based surgical procedures performed in non-accredited settings from July 14, 2009 onward.

Confidentiality

At all times, information relating to a provider obtained in the credentialing/re-credentialing process is considered confidential.

Off-Cycle Credentialing

In the event information obtained by the VNSNY CHOICE Credentialing Unit may indicate a need for further inquiry, the Credentialing Subcommittee may decide to conduct an off-cycle review of a provider’s credentialing status. Information obtained during an off-cycle review includes, but is not limited to, changes in: licensure, DEA certification, malpractice coverage, New York State OPMC actions, and Medicare and Medicaid sanctions.

Notwithstanding the above, providers who have had their licenses revoked or suspended, or who have been excluded from participation or who have opted out of the Medicare/Medicaid programs will be terminated immediately.
Provider Termination and Disciplinary Action

Discipline of Providers

The Credentialing Subcommittee has responsibility for recommending suspension or termination of a participating provider for substandard performance or failure to comply with the requirements outlined in the VNSNY CHOICE Provider Agreement.

In the event that the Credentialing Subcommittee recommends suspension or termination of a participating provider, written notification is sent to the provider. The provider may then request a hearing in accordance with applicable law and regulations.

Examples of disciplinary action include, but are not limited to the following:
- Require the provider to submit and adhere to a corrective active plan
- Monitor the provider for a specified period of time, followed by a Peer Review or Credentialing Subcommittee determination as to whether substandard performance or noncompliance is continuing
- Require the provider to use medical or surgical consultation for specific types of care
- Require the provider to obtain training in specific types of care
- Cease enrolling new VNSNY CHOICE members under the care of the provider
- Temporarily suspend the provider’s participation status
- Terminate the provider’s participation status with VNSNY CHOICE

The Medical Director of VNSNY CHOICE may determine at his/her sole discretion that the health of any VNSNY CHOICE member is in imminent danger because of the actions or inactions of a participating provider, or that the provider is committing fraud or has received a final disciplinary action by a state licensing or governmental agency that impairs the provider’s ability to practice (“Immediate Action Events”) and in such case the Medical Director may immediately suspend or restrict the provider’s participation status, during which time the Credentialing Subcommittee will investigate to determine if further action is required.

Provider Sanctions

All providers must comply with all laws and the rules, regulations and requirements of all federal, state and municipal governments.

Any provider who has been sanctioned, debarred, excluded or terminated by Medicare or Medicaid and has been prohibited from serving Medicare or Medicaid recipients or receiving payment from the Medicare or Medicaid program is excluded from participating in the VNSNY CHOICE provider network.

VNSNY CHOICE’s initial and ongoing credentialing process consists of a review of all federal and state sanctions including medical license or practice privilege probation, revocation, restriction, sanction or reprimands. VNSNY CHOICE’s review of sanctions also includes Medicare and Medicaid reprimands, censure, disqualification, suspension or fines, as well as conviction of or indictment for a felony. Additionally, VNSNY CHOICE reviews the General Service Administration’s Excluded Parties List System (GSA EPLS) for parties which are excluded from receiving Federal contracts and subcontracts, and certain Federal financial and
nonfinancial assistance and benefits.

On confirmation of suspension, encumbrance or revocation by a duly authorized government agency, VNSNY CHOICE immediately imposes the same suspension, encumbrance or revocation on the provider’s participation in VNSNY CHOICE.

**Appeal of Disciplinary Action**

The provider may appeal any formal disciplinary action, except that providers participating only in VNSNY CHOICE Managed Long Term Care Plans and/or VNSNY CHOICE HIV Special Needs may not appeal a formal disciplinary action taken based on Immediate Action Events. Requests for appeal must be submitted in writing and sent by certified mail, return receipt requested to the Credentialing Subcommittee within 30 days after the provider receives notice from the Subcommittee of its proposed action.

**Procedure for Provider Termination**

The Credentialing Subcommittee may recommend termination of the participation of a provider. Consideration of termination may be initiated by any information the Credentialing Subcommittee deems appropriate including, but not limited to the following:

- The provider fails to meet one or more of the administrative requirements or professional criteria as outlined in the VNSNY CHOICE Credentialing program;
- The provider rendered(s) care to a member in a harmful, potentially harmful, personally offensive, or unnecessary or inefficient manner; or fails to provide access to care to an extent that continuity of care is provided to enrolled patients is adequate;
- The provider engaged(s) in abusive or fraudulent billing practices, including but not limited to submitting claims for payment that were false, incorrect or duplicated;
- The provider fails to comply with VNSNY CHOICE’s policies and procedures, including those for utilization management, quality management or billing;
- The provider’s privileges at a network institution, or any other institution, are lost or restricted for any reason;
- The provider’s license or DEA certification are limited, suspended or revoked by any agency authorized to discipline providers;
- The provider is censured, suspended, debarred, excluded or terminated as a Medicaid or Medicare provider;
- The provider is indicted or convicted of a felony;
- The provider fails to comply with the application, selection or recredentialing process, or submits false, incomplete or misleading information with respect to credentials or fails to comply with any provision of the Program Agreement;
- The provider renders professional services outside the scope of his/her license or beyond the bounds of appropriate authorization;
- The provider fails to maintain malpractice insurance that meets approved guidelines; or
- The provider experiences physical or mental impairment, including chemical dependency, which affects his/her ability to provide care to patients or fails to meet the criteria of the plan’s Provider Impairment Policy or the relevant policies of network institutions.
Section 6: Provider Credentialing and Termination

A provider cannot be prohibited for the following actions and VNSNY CHOICE may not terminate or refuse to renew a contract solely for provider performance of the following actions:

- Advocacy on behalf of a member
- Filing a complaint against VNSNY CHOICE
- Appealing a determination made by VNSNY CHOICE
- Providing information or filing a report with an appropriate government body regarding prohibitions of plans
- Requesting a hearing or review

If the Credentialing Subcommittee receives information which it believes suggests that the discipline or termination of a provider may be warranted for reasons relating to the provider's professional competence or conduct, it will request the Medical Director to investigate the matter.

If the Credentialing Subcommittee believes that further information is needed, it may obtain it from the provider or other sources. The Subcommittee may request or permit the provider to appear before the Credentialing Subcommittee to discuss any issue relevant to the investigation.

In the event that the Subcommittee’s recommendation is to impose any disciplinary action, including, but not limited to, termination of the provider, the Subcommittee shall provide to the provider a written explanation of the reasons therefore and notice of the opportunity for review and/or hearing. Such review shall take place prior to submission of the recommendation to the Board and implementation of any disciplinary action unless the reasons therefore involve imminent harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the provider’s ability to practice, in which cases the Credentialing Subcommittee may immediately suspend or restrict the provider’s participation in the VNSNY CHOICE provider network.

Subject to the provider’s rights to appeal, the Credentialing Subcommittee’s recommendations will be forwarded to the Board of VNSNY CHOICE for final approval.

Review Procedure

The procedure for termination or denial of recredentialing will apply to providers who are terminated or denied recredentialing in one or more specific specialties or subspecialties, as well as those who are terminated or denied recredentialing in terms of their total participation in the plan.

Upon reaching a recommendation that adverse action be taken against a provider, the Credentialing Subcommittee shall notify the provider that he or she has a right to request a hearing or review, at the provider’s discretion, of said recommendation; however, providers in the VNSNY CHOICE Managed Long Term Care Plan and VNSNY CHOICE SelectHealth who are having an adverse action taken against them because of an Immediate Action Event do not have a right to appeal.

VNSNY CHOICE shall include in the termination notice:
- The reason for the proposed action (and if the appeal is for a VNSNY CHOICE Medicare
Section 6: Provider Credentialing and Termination

- Advantage provider, only if relevant, the reasons must include, the standard and profiling data used to evaluate the provider and the number and mix of providers needed by VNSNY CHOICE:
- Notice that the provider has the right to request a hearing or review, at his or her discretion, before a panel appointed by the Medical Director;
- The provider has 30 days within which the provider may submit to the Medical Director a written request for a hearing and/or review; and
- A time limit for a hearing date, which must be held within 30 days after the date of the Credentialing Subcommittee receipt of a request for a hearing.

Except for Immediate Action Events of VNSNY CHOICE Managed Long Term Care Plans and VNSNY CHOICE HIV Special Needs providers, the termination shall not be effective earlier than 60 days from the provider’s receipt of the notice of termination.

Upon receipt of a request for hearing or review, the Medical Director shall inform the Credentialing Subcommittee members and shall select a review panel consisting of three (3) persons (the “Review Panel”), at least one of whom is a clinical peer in the same discipline and same or similar specialty as the provider under review, at least one other clinical peer, and none of whom are members of the Credentialing Subcommittee. The Medical Director may appoint more than three (3) persons to the Review Panel; provided that for appeals by providers in the VNSNY CHOICE Managed Long Term Care Plans and VNSNY CHOICE SelectHealth at least one-third of the Review Panel must be clinical peers of the provider under review and for appeals by providers in the VNSNY CHOICE Medicare Advantage plan, the majority of the Review Panel must be clinical peers of the provider under review. The Board shall appoint one of the Review Panel members as chairperson (“Review Panel Chairperson”).

Within fourteen (14) days of receipt of a provider’s written request for hearing, the Medical Director will notify the provider of the time and place of the hearing, which shall be no more than thirty (30) days after receipt by the Medical Director of the request for hearing, unless the parties mutually agree upon a later date. In addition, said notice shall include the witnesses, if any, to be called by the Credentialing Subcommittee in support of its recommendation, and a list of the members of the Review Panel.

The Hearing

The Credentialing Subcommittee will be represented by its Chairman or his or her designee during the appeal process. The Credentialing Subcommittee will be responsible for documentation and minutes of the hearing. The Review Panel Chairperson will facilitate the hearing and ensure the following procedure is followed:

- **Chairman’s Statement of the Procedure:** Before evidence or testimony is presented the Chairman of the Review Panel will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.
- **Presentation of Evidence by Credentialing Subcommittee:** The Credentialing Subcommittee may present any oral testimony or written evidence it wants the Review Panel to consider. The provider or the provider’s representative will have the opportunity to cross-examine any witness testifying on the Credentialing Subcommittee’s behalf.
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- **Presentation of Evidence by Provider:** After the Credentialing Subcommittee submits evidence, the provider may present oral testimony or written evidence to rebut or explain the situation or events described by the Credentialing Subcommittee. The Credentialing Subcommittee will have the opportunity to cross-examine any witnesses testifying on the provider's behalf.

- **Credentialing Subcommittee Rebuttal:** The Credentialing Subcommittee may present additional written evidence to rebut the provider's evidence. The provider will have the opportunity to cross-examine any additional witnesses testifying on the Credentialing Subcommittee's behalf.

- **Summary Statements:** After the parties have submitted their evidence, first the Credentialing Subcommittee and then the provider will have the opportunity to make a brief closing statement. In addition, the parties will have the opportunity to submit written statements to the Review Panel. The Review Panel will establish a reasonable time frame for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.

- **Examination by Review Panel:** Throughout the hearing, the Review Panel may question any witness who testifies.

**Evidentiary Standards**

The evidence must reasonably relate to the specific issues or matters involved in the recommended action. The Review Panel has the right to refuse to consider evidence that it deems irrelevant or otherwise unnecessary to consider. An individual who objects to the presentation of any evidence must state the grounds for the objection and the Review Panel has the sole discretion to determine whether the evidence will be admitted.

**Review Panel Determination**

The Review Panel may, at its sole discretion, uphold, reject or modify the recommendation of the Credentialing Subcommittee. The decision of the Review Panel will be made in a timely manner and based upon the affirmative vote of a majority of the Review Panel members. The Review Panel’s decision may include (i) reinstatement of the provider; (ii) provisional reinstatement subject to conditions set forth by the Review Panel; or (iii) termination of some or all privileges of participation in the plan. The provider will be notified in writing by the Review Panel Chairperson of the decision and the basis therefore. If a provider is terminated or his or her privileges are curtailed, the Credentialing Subcommittee will ensure that patients or clients of the plan who have or are currently obtaining services from the provider are notified and that access to alternative providers within the plan is made available to them. Decisions of termination will be effective not less than thirty (30) days after receipt by the provider of the hearing panel’s decision.

**Provider Terminations and Continuity of Care**

In the case of any provider termination, VNSNY CHOICE will provide for continuity of care for members.

Providers who terminate participation with VNSNY CHOICE are obligated to the continuation
Section 6: Provider Credentialing and Termination

of treatment and hold harmless provisions specified in their contracts.

Termination of hospital contracts will comply with Section 4406-c (5-c) of the NYS Public Health Law, which requires that the contracted hospital and VNSNY CHOICE, continue to cover all services covered under the contract and abide by the terms of the contract, including reimbursement rates, for a period of two months from the effective date of termination or non-renewal. The exception to this requirement applies when both parties agree to the effective date of the scheduled termination or non-renewal, or when either the contracted hospital or VNSNY CHOICE, requests a waiver of the “cooling off” period from DOH. The hospital will collaborate with VNSNY CHOICE, so that an impact/disruption analysis with regard to enrollee access to care is submitted to the NYS Department of Health within the Department’s required timeframes.

Duty to Report

The VNSNY CHOICE Managed Long Term Care Plan and VNSNY CHOICE SelectHealth are legally obligated to report to the New York State Department of Health or appropriate disciplinary agency within 30 days of the following:

- Termination of a health care provider for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare;
- The voluntary/involuntary termination of a contract/employment or other affiliation with such organization to avoid the imposition of disciplinary measures;
- The termination of a health care provider contract in the case of a determination of fraud or in the case of imminent harm to patient health

VNSNY CHOICE Managed Long Term Care Plans and VNSNY CHOICE SelectHealth are legally obligated to report to the New York State Department of Health or appropriate disciplinary agency within 60 days of the following:

- The date VNSNY CHOICE obtains knowledge of any information that reasonably appears to show that a health care professional is guilty of professional misconduct as defined in Education Law

VNSNY CHOICE Medicare Advantage Plans are legally obligated to report to State licensing and/or disciplinary bodies if it suspends or terminates a provider because of deficiencies in the quality of care.

VNSNY CHOICE shall, in its sole discretion, report to other oversight bodies any provider that it believes has committed an act of fraud or abuse, including, without limitation, the Office of Inspector General, the Office of the Medicaid Inspector General or the New York State Department of Financial Services.

Triennial Recredentialing

In order to ensure ongoing compliance with all eligibility criteria, every provider will be subject to a triennial (every three (3) years) recredentialing process. (Note: HIV Specialists must provide evidence of participation in at least ten (10) hours annually of continuing medical
Section 6: Provider Credentialing and Termination

education that includes information on the use of antiretroviral therapy in the ambulatory care setting.

The recredentialing process requires that providers submit updated applications to VNSNY CHOICE or its designated agent. VNSNY CHOICE will contact the provider at least three (3) months prior to the provider’s recredentialing due date. In addition to the provider’s recredentialing application, VNSNY CHOICE may consider the following as part of its recredentialing process:

- Member complaints
- Quality of services
- Utilization management (compliance with protocols, standards, and procedures)
- Member satisfaction (access, availability, and waiting time)
- Medical record reviews
- Disciplinary actions, including Medicare and Medicaid sanctions
- Current list of hospitals where provider has privileges
- Maintenance of credentials, including specialized training, e.g. HIV specialist

VNSNY CHOICE will make available on a periodic basis, and upon the request of the provider, the information, profiling data and analysis used to evaluate provider performance. Upon receipt of profiling data, providers are afforded the opportunity to discuss the unique nature of their patient population that may have bearing on the data and to work cooperatively with VNSNY CHOICE to improve performance. VNSNY CHOICE conducts medical record audits and measures performance using commonly accepted standards of care. HIV Primary Care Providers are also evaluated using HIVQUAL standards.
Medical records are monitored for appropriate documentation of administrative and clinical requirements. The criteria for this review are based on requirements and standards from the Centers for Medicare and Medicaid Services (CMS) and the New York State Department of Health, including those of the Department of Health AIDS Institute.

**Medical Record Review**

A VNSNY CHOICE representative may visit the participating provider’s office or request that a record be sent to VNSNY CHOICE offices to review the medical records of VNSNY CHOICE members to obtain information regarding medical necessity and quality of care. Medical records and clinical documentation will be evaluated based on the Standards for Medical Records listed below.

**Standards for Medical Record Documentation Criteria**

The following criteria are considered essential elements in the documentation of care and services:

- Medical records must be readily accessible and available for review by the provider.
- The record must be legible to someone other than the writer.
- A separate medical record must be maintained for each member.
- Medical records must be maintained for a period of six (6) years after date of service, and in the case of a minor, three (3) years after majority or six (6) years after the age of majority, whichever is later.
- Medical records must include entries that are current, legible, signed and dated by the person making the entry and authenticated.
- Medical records must include, as appropriate: name, identification number, age, sex and date of birth, consent forms, past medical history and physical examinations, record of immunizations, screening for chemical dependency (drug use) including history and current usage, notation of allergic or adverse reactions to medications, quantitative assessment of antiretroviral treatment adherence monitoring, physical examination reports, diagnostic procedures/test reports, consultative findings, diagnosis or medical condition, medical orders, psychosocial assessment and reassessment, case management information, documentation of services required and referrals made, progress notes and follow-up plans.
- The medical record must include relevant information concerning emergency room treatment, services rendered by specialists and/or non-participating providers and any hospitalizations.
- For members receiving prenatal care only: the obstetrical care provider must maintain centralized medical records for the provision of prenatal care and all other services.
- Presenting complaints, diagnoses and treatment plans
- A return visit date and follow up plan that is documented for each encounter
- Prescribed medications, including dosages and date of initial or refill prescriptions
- Identification of all providers participating in the member’s care and information on services furnished by these providers
- Necessary treatments and potential risk factors relevant to member and treatment
- Information on Advanced Directives or documentation of discussion of advanced care planning with the member.
Section 7: Medical Record Documentation

- Clinical progress notes describing patient services and events

Providers must make member records and encounter data available to VNSNY CHOICE to the extent permitted by law and necessary for pre-authorization and concurrent utilization review activities, quality assurance, claims processing and payment to the NYSDOH, NYC Human Resources Administration, United States Department of Health and Human Services, the Controller of the State of New York, the Controller General of the United States and The Centers for Medicare and Medicaid Services (CMS), at no charge to these agencies, for the purpose of inspection and copying related to quality of care, monitoring, audit and enforcement and any other legally authorized purpose.

Confidentiality of Medical Records

Providers are expected to ensure the confidentiality of VNSNY CHOICE members. Information contained in the medical record should only be disclosed in a manner that complies fully with HIPAA standards and as necessary to provide medical care, conduct quality assurance functions or respond to a complaint or appeal.

Participating providers must comply with all state and federal laws concerning confidentiality of health and other information about members. Participating providers must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

Medical Records Duplication

The participating provider is responsible for any costs associated with duplicating and mailing a member’s medical records when referring the member to a consulting physician or other provider where medical records are required. The participating provider shall not charge the member for the cost of copying the medical records that will be used during the member’s course of treatment with a referral physician.

If a member is requesting copies of medical records to be sent to another medical professional as a result of the member’s election to transfer to another PCP, the member may not be charged for copying of the medical record.

When a member, or the member’s representative, requests copies of medical records for reasons other than those stated above, the participating provider may charge a fee for copying the medical record. The member or member’s representative must provide to the provider such request for copies of the medical record in writing. In this case the provider may charge a fee not to exceed seventy-five cents ($0.75) per page.

If VNSNY CHOICE requests copies of medical records, the participating provider may charge a fee for copying the medical record. VNSNY CHOICE follows the New York State Department of Health guidelines regarding reimbursement for the costs associated with copying member records. VNSNY CHOICE will reimburse the provider the rate as determined by the New York State Department of Health.
Section 8: Referral Management

VNSNY CHOICE endorses the philosophy that clinical care is best rendered when a member’s PCP is given the authority and responsibility for coordinating the overall healthcare of a member.

The following section applies to providers of all VNSNY CHOICE Medicare Advantage Plan and VNSNY CHOICE Medicare Advantage Special Needs Plan members

General Referral Process

Members of VNSNY CHOICE Medicare Advantage, Medicare Advantage Special Needs plans, and the VNSNY CHOICE Integrated Medicare Advantage Special Needs Plan and Medicaid Managed Long Term Care plan may access participating specialists without a referral.

Please be sure that you are referring members to VNSNY CHOICE network physicians, ancillary facilities and providers. If a required specialty is not represented in VNSNY CHOICE’s Provider Directory or Directory Addendum, call VNSNY CHOICE Medicare’s Provider Services Department at the telephone number listed in Section 1 of this provider manual.

Continuation of Care

Continuation of Care is the process used to review and evaluate authorizations to non-participating providers during a transitional period.

Continuation of Care will be considered:

a) When a newly enrolled VNSNY CHOICE member is under active treatment at the time of enrollment with a provider who does not participate in the VNSNY CHOICE network. OR
b) When a current member’s healthcare provider has left the VNSNY CHOICE network (except when the provider was terminated from participation under circumstances involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governing agency that impairs the health care professional’s ability to practice).

The out of network provider must agree to accept VNSNY CHOICE reimbursement as payment in full and agrees to comply with all of VNSNY CHOICE UM/QI policies and procedures.

A request for continuity of care may be made utilizing our “Transitional Care Request Form” and must be submitted to our Medical Management Department.

The following section refers to providers of VNSNY CHOICE SelectHealth members:

PCPs and specialists, as previously mentioned, may directly refer to in-network providers
without the need to obtain prior authorization from the Plan.

If the network does not include an available provider with the appropriate training and experience to meet the needs of the member or medically necessary services are not available through network providers, the PCP can arrange for an out-of-network referral. Potential referrals to out-of-network providers can be obtained, as medically indicated, upon receiving authorization from VNSNY CHOICE's Medical Management Department. Utilization Management can be reached at the telephone number listed in Section 1 of this provider manual. To assure appropriate care coordination, we ask that specialist consultants communicate with the referring physician within seven (7) days of seeing a VNSNY CHOICE SelectHealth member for a routine consultation and as soon as possible for urgent/emergent conditions.

**General Referral Process**

Upon determination that specialty care is required, a PCP, or appropriate staff, may utilize VNSNY CHOICE’s Provider Directory to identify a network specialty provider and directly schedule an appointment. Alternatively, PCPs, or appropriate staff, may chose to contact VNSNY CHOICE to coordinate and schedule the visit. VNSNY CHOICE will schedule the referral on behalf of the PCP/office, communicate the appointment information to the member, and arrange for transportation - if necessary. Generally, this service is restricted to use with private specialty providers, as referrals to hospital based specialty clinics are most efficiently processed by HIV clinic based administrative staff.

To initiate coordination of referrals, providers should call VNSNY CHOICE at the telephone number listed in Section 1 of this provider manual to initiate a referral.

Referring providers should ensure that all necessary clinical information is forwarded to the consulting specialist in advance of the member’s scheduled appointment.

**Referrals to Specialty Care Centers**

Members with a life-threatening or a degenerative or disabling disease or condition, which requires prolonged specialized medical care, may be referred to an accredited or designated specialty care center. Every effort should be made to refer the member within VNSNY CHOICE’s provider network. These referrals are made pursuant to a treatment plan developed by the specialty care center and approved by VNSNY CHOICE in consultation with the PCP (or specialist provider approved by VNSNY CHOICE to coordinate a member’s primary and specialty care) and the member or the member’s designee.

**Specialist as Coordinator of Primary Care**

Members with a life-threatening or degenerative and disabling disease or condition, which requires prolonged specialized medical care, may receive a referral to a specialist who will then function as the coordinator of primary and specialty care for that member. These referrals are made in consultation with the PCP or specialist provider approved by VNSNY CHOICE to
Section 8: Referral Management

coordinate a member’s primary and specialty care, and the member or the member’s designee.

If the specialist does not meet the qualifications of an HIV Specialist, a co-management model will be employed in which an HIV Specialist assists the PCP in an ongoing consultative relationship as part of routine care and continues with primary responsibility for decisions related to HIV-specific clinical management in coordinating with the other specialist.

Direct Access for OB/Gyn Care

Female members have direct access to primary and preventive obstetrics and gynecology services, follow-up care as a result of a primary and preventive visit and any care related to pregnancy from VNSNY CHOICE OB/Gyn network providers without referral from the PCP.

Self-Referrals

Members may self-refer for the following services:

- Outpatient mental health and substance abuse: A member may self refer to an in-network provider for an initial evaluation session at which time a treatment plan is developed and communicated to VNSNY CHOICE.
- Routine refraction for vision services.
- Diagnosis and treatment of tuberculosis by public health agency facilities.
- Family planning and reproductive health services. Family planning services include but are not limited to emergency contraception and follow up; sterilization and abortion. Members may receive HIV counseling, HIV testing, referral, and partner notification services as part of the family planning visit. Other HIV pre- and post-test counseling may be performed regardless of whether the provider participates in the VNSNY CHOICE network. Enrollees may receive family planning services from any qualified Medicaid provider regardless of whether the provider is a participating or a non-participating provider without a referral from the member’s PCP and without approval from VNSNY CHOICE.

Referrals to Non-Participating Providers

In the event that a PCP determines, in conjunction with VNSNY CHOICE’s Medical Management Department, that a specific physician resource is either not available within the network, or that the most appropriate choice of a specialist exists out-of-network, the PCP and/or VNSNY CHOICE will make a referral to an appropriate non-participating provider. The resulting treatment plan will be reviewed and approved by VNSNY CHOICE in consultation with the PCP, the non-participating provider and the member or the member’s designee. Approval from VNSNY CHOICE is required for all out-of-network referrals.

Continuation of Care Services

Members Whose Health Care Provider Leaves the Network

VNSNY CHOICE permits members whose provider leaves the plan’s network, for reasons other than imminent harm to patient care, or a determination of fraud or a final disciplinary
Section 8: Referral Management

action by a state licensing board that impairs the health professional’s ability to practice, to continue an ongoing course of treatment with that provider during a transitional period.

The transitional period may continue up to 90 days and begins on the date the provider’s contractual obligation to provide services to VNSNY CHOICE SelectHealth members terminates or if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery through 60 days post-partum.

During this transitional period, the non-participating provider agrees to:

- Accept reimbursement from VNSNY CHOICE at rates established as payment in full.
- Adhere to VNSNY CHOICE’s quality assurance requirements and agrees to provide to VNSNY CHOICE necessary medical information related to such care
- Otherwise adhere to VNSNY CHOICE policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by VNSNY CHOICE.

New Members

If a new member has an existing relationship with a health care provider who is not a member of the VNSNY CHOICE network, VNSNY CHOICE permits the member to continue an ongoing course of treatment by the non-participating provider during a transitional period of up to 60 days from the member’s effective date of enrollment if (1) the member has a life-threatening disease or condition or a degenerative and disabling disease or condition, or (2) the member has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery up until 60 days postpartum.

The non-participating provider must agree to adhere to the conditions outlined in the above paragraph “Members Whose Health Care Provider Leaves the Network” above in order for VNSNY CHOICE to authorize continuation of care for a new member whose current provider does not participate in the VNSNYCHOICE network.

The following section applies to providers of VNSNY CHOICE Managed Long Term Care (MLTC) members

General Referral Process

Upon enrollment, every member is assigned to a VNSNY CHOICE Care Manager (a nurse or social worker). The Care Manager works closely with the member, his/her family and physician to develop a plan of care, which include all required covered services and medical services. The Care Manager helps members obtain these services from network providers, including making appointments and arranging for transportation.
Section 8: Referral Management

Specialty Care

VNSNY CHOICE Managed Long Term Care coordinates the member’s medical, home and community-based services. The plan of care is developed in collaboration with the member, providers and an interdisciplinary team.

Physician and hospital services are not part of the VNSNY CHOICE MLTC covered services and members may continue to utilize their existing providers under the Medicare and/or Medicaid programs.

For those services that are VNSNY CHOICE Managed Long Term Care covered benefits, VNSNY CHOICE will help members obtain these services from network providers, including making appointments and arranging transportation.

Self Referral Services

Members may self-refer for the following services:
• Dental: Up to 2 routine dental check-up examinations per year.
• Vision Care: Routine eye exam once a year and eyeglasses every 2 years.

As with all covered services, it is important that members inform their VNSNY CHOICE Care Manager of self referred services.

Referrals to Out-of-Network Providers

VNSNY CHOICE MLTC has a network of providers available to meet its members’ needs. It is recognized, however, that under defined circumstances, members may need to utilize out-of-network providers for covered services.

Members may not elect to use a non-participating provider unless no such provider exists in the network or the network providers are unable to provide the service. In all such cases, when VNSNY CHOICE is the primary payer, the member must get prior approval before accessing out-of-network services. The member should consult with his/her Care Manager who will coordinate the referral with the non-participating provider, health plan, and member’s physician (if appropriate), incorporate it into the approved treatment plan and document appropriately to ensure proper follow-up and payment.

When an approved referral to an out-of-network provider for covered services is made, VNSNY CHOICE will enter into a member-specific letter of agreement (LOA) with the provider to specify payment terms, period of coverage, and quality assurance measures.

VNSNY CHOICE has an established policy and procedure that specifies those instances in which a referral to an out-of-network provider for covered services may be made, including:

• Continuation of care
• Emergent/urgent care
• Clear and compelling medical service need that can only be met by an out-of-network provider
Section 8: Referral Management

- Provider in the process of being contracted
- Additional service capacity needed
- Covered services which are also covered by Medicare

Standing Referrals

In those cases in which a member will need a standing referral/order with a provider, the member should notify the Care Manager. Care Managers will advise the Member Service Representative to enter the ongoing order in the VNSNY CHOICE systems.

Examples of covered services for which standing orders may exist are: social and medical day programs, transportation, home delivered meals, and chores.

Continuation of Care for New Enrollees

Upon enrollment, a member may be under care for audiology, dental services, optometry, or podiatry services with a provider who is not included in the VNSNY CHOICE network. The member will be given the option of completing this course of treatment with the current out-of-network provider for a maximum of sixty (60) days, or transitioning at the time of enrollment to a VNSNY CHOICE provider.

The member will be informed of the need to transfer to a network provider upon completion of the current course of treatment, even if there is a medical need for additional services. This transition will take place within sixty (60) days after the enrollment date.

Continuation of Care for Members when a Provider Terminates Participation in the Network

VNSNY CHOICE will ensure that all required services are available for its members. When a provider leaves the network (either voluntarily or through the termination of a subcontractor) the program will assist members in changing to another service provider.

Members who are in the process of a course of treatment with a provider who is terminating participation in the network may continue to receive care from this provider until the course of treatment is completed, or 90 days, whichever is sooner.

VNSNY CHOICE will notify members of providers who terminate their participation in the plan within 15 days of learning of the termination.
Section 9: Claims and Billing

Instructions for Submitting Claims

Service providers are responsible for submitting claims to VNSNY CHOICE.

Provider claims should be submitted either on a CMS-1500 form or UB-04 form or the related electronic format (837P or 837I). Claims for non-HIPAA covered services may be submitted on a non-standard form at the approval of VNSNY CHOICE. For exceptions to the standard form, please contact your Account Manager. Our Payer ID is 77073.

Claims may be submitted by mail to the VNSNY CHOICE Claims Department at the address listed in Section 1 of this provider manual.

Timely Filing and Prompt Payment of Claims

- Providers are expected to submit claims within the timelines specified in their contract. This will be applied to the date of service (or discharge for inpatient services.) Claims received after the Timely Filing Limit may be denied.
- “Clean Claims,” those submitted fully according to VNSNY CHOICE standards, will be paid or denied according to State or Federal Prompt Payment requirements.
- For Medicare lines of business, other claims, including those with incomplete information from non-network providers, will be paid or denied within 60 calendar days.
- Network providers will be paid according to the terms of their contract.
- Non-network providers will be paid according to CMS or New York State Medicaid regulations.

The prompt payment of your claim is contingent on VNSNY CHOICE’s receipt of complete and legible claims information. Missing or incomplete information may delay payment.

All claim submissions must include the providers National Provider Identification (NPI) and Tax ID number on the claim.

Electronic Claims Submissions

VNSNY CHOICE encourages providers to submit clean claims to us electronically. Electronic claims submission can offer you the following benefits:

- More efficient claims payment
- Improved cash flow
- Increased convenience: one universal form to complete for all carriers
- Greater reliability than paper systems
- Decreased postage and mail time
- Reduced paperwork for office staff
Section 9: Claims and Billing

VNSNY CHOICE providers may elect to submit claims through electronic data interchange (EDI) to VNSNY CHOICE. If you are a provider currently using a software vendor, clearinghouse or billing agent to submit claims electronically for any other payer, you may do one of the following:

- Contact your software vendor, clearinghouse, or billing agent and request that they activate VNSNY CHOICE (Payer ID No. 77073) for electronic submission.
- If your office is looking to set up an electronic claims submission system you may contact Emdeon Business Services at 1-866-369-8805 or other clearinghouses.
- We offer a custom format for non-HIPAA covered services. Please contact your Account Manager to discuss submitting these claims electronically.

VNSNY CHOICE Medicare Advantage Plan Providers

Payment for Administration of Covered Part D Vaccines

Administration costs for covered Part D vaccines are reimbursed under Medicare Part D. Please submit a CMS 1500 form if you have dispensed a vaccine that is covered under Medicare Part D and/or administered the vaccine in your office. Please refer to the sample CMS 1500 claim form, included in Appendix A, which demonstrates the required information necessary for processing these claims correctly. It is especially important that you include the drug name and NDC separately for each vaccine administered. The claim must be submitted to CVS/Caremark for reimbursement by submitting the CMS 1500 form to the address listed in Section 1 of this provider manual.

If you have any questions concerning reimbursement for Part D vaccines, please contact CVS/Caremark at the telephone number listed in Section 1 of this provider manual.

Payment for Emergent Care, Urgent Care and Out-of-Area Dialysis

VNSNY CHOICE will pay for emergent and urgently needed services, without prior authorization, until the member is stabilized.

VNSNY CHOICE will pay for renal dialysis services for all members except those enrolled in VNSNY CHOICE Managed Long Term Care.

Office-Based Surgery

VNSNY CHOICE will not pay for office-based surgical procedures performed in non-accredited settings from July 14, 2009 onward. “Office-based surgery” means any surgical or other invasive procedure, requiring general anesthesia, moderate sedation, or deep sedation, and any liposuction procedure, where such surgical or other invasive procedure or liposuction is performed by a licensee in a location other than a hospital, excluding minor procedures and procedures requiring minimal sedation.
Section 9: Claims and Billing

Coordination of Benefits and Balance Billing

If a member has coverage with another plan that is primary to VNSNY CHOICE, please submit a claim for payment to the other plan first. The amount payable by VNSNY CHOICE will be determined by the amount paid by the primary plan, Medicare secondary payer law and policies, or New York State Medicaid standards for coinsurance payments. Please submit a copy of the primary carrier’s Explanation of Payment with your claim to VNSNY CHOICE. Any cost sharing for a member that is considered Dual Eligible must be billed to Medicaid or other insurer. Please refer to Page 2-3, “Member Co-Insurance”.

a. You may not bill a member for a non-covered service unless:

1) You have informed the member in advance that the service is not a covered service; and

2) The member has agreed in writing to pay for the non-covered service.

b. If a member loses his/her Medicaid eligibility while they are enrolled in a VNSNY CHOICE “dual-eligible” plan, he/she will be deemed temporarily eligible to remain in the plan for up to 6 months because he/she may regain Medicaid eligibility. During this time the member is able to receive the same benefits as any other member. If a participating provider receives a denial from Medicaid for such member’s cost sharing for services provided during this period, the provider will look to the plan for reimbursement. Providers should contact Provider Services to initiate such reimbursement.

Reimbursement

Participating providers are paid based on the terms of their contract.

Participating providers must look only to VNSNY CHOICE for compensation for services rendered to VNSNY CHOICE members. VNSNY CHOICE providers agree not to bill/collect payment for services rendered to VNSNY CHOICE members except for applicable copayments, coinsurance or deductibles or services not covered by the VNSNY CHOICE contract for which the member has been advised, prior to the provision of service, that the service is not covered and the member will be liable for the cost of the service.

Claims payments are accompanied by a “Provider Remittance Advice”.

Claims Inquiries

If you have questions regarding the status of a claim or other inquiries, contact the Claims telephone number listed in Section 1 of this provider manual.

Please have the following information available:

- Provider’s name and NPI
- Member’s name and members identification number
Section 9: Claims and Billing

- Date of service and date of claim submission

Claims Disputes

a. Provider Dispute Resolution

It is VNSNY CHOICE’s policy to ensure fair, appropriate resolution and timely handling of providers’ disputes. The provider dispute resolution process and the provider’s contract provide a mechanism by which participating providers may submit disputes resulting from claim adjustments or denials.

The following is an example of an issue that is excluded from the provider dispute resolution process:

- An Independent Medical Review initiated by or on behalf of a member through the Member Appeals Process does not qualify for the Provider Dispute Resolution process.

b. Provider Dispute Process

Disputes for VNSNY CHOICE Managed Long Term Care (MLTC) claims should be addressed by contacting the telephone number listed under Billing/Claim Inquiries in Section 1.

The following applies to Medicare or Medicaid Advantage claims.

<table>
<thead>
<tr>
<th>Dispute Type</th>
<th>Submission Timeframe</th>
<th>Necessary Information to be Provided (in writing*)</th>
</tr>
</thead>
</table>
| Standard reconsideration request of a denial of payment or Medical Necessity | Please refer to your provider contract | • Provider Dispute Resolution Form  
• Copy of denied claim  
• Copy of remittance  
• Any requested or substantiating documentation not previously provided |

*Disputes may be faxed or mailed to the Provider Dispute address indicated in Section 1 of this provider manual.
**Section 9: Claims and Billing**

The following applies to Medicaid Managed Long Term Care (MLTC) Program claims.

<table>
<thead>
<tr>
<th>Dispute Type</th>
<th>Submission Timeframe</th>
<th>Necessary Information to be Provided (in writing*)</th>
</tr>
</thead>
</table>
| Standard reconsideration request for a denial of payment due to Medical Necessity | Please refer to your provider contract. | • Provider Dispute Resolution Form  
• Copy of denied claim  
• Copy of remittance  
• Any requested or substantiating documentation not previously provided |
| Requests for a denial of payment due to claim coding issues. | Please refer to billing/claims contact number in Section 1. Please refer to the Regional Office contact numbers in Section 1. | • Any requested or substantiating documentation not previously provided. |
| Requests for a denial of payment due to no authorization. | | |

*Disputes may be faxed or mailed to the Provider Dispute address indicated in Section 1 of this provider manual.

1. **Dispute Submission**

   All disputes must be submitted within 90 days of the date of the Explanation of Benefits (EOB) or according to the timeframes indicated in the contract of the participating provider’s agreement with VNSNY CHOICE.

   The following procedures are applicable for the participating provider who wishes to submit a provider dispute for evaluation and review by VNSNY CHOICE:

   All Provider disputes must be in writing and must include the following:

   (a) Provider name, National Provider Identifier (NPI) and contact information,

   (b) The VNSNY CHOICE member’s Identification number,

   (c) The specific item in dispute,

   (d) Clearly stated reason for contesting the determination and the justification as to why the service should be paid or approved, and

   (e) Copies of all relevant information and supporting documentation required for review of the provider’s concerns (e.g., claims include claim number, medical records, authorizations, etc).

   The Provider must either fax his/her dispute to the number indicated in Section 1, for Provider Disputes, or mail the dispute to the address designated for Provider Dispute Resolution. (Sample “Provider Dispute Resolution Request” document is included in Appendix A).
Section 9: Claims and Billing

2. Dispute Review Process and Timeframes

VNSNY CHOICE will thoroughly review the provider’s request and all supporting information and documentation.

Written determination of the resolution of a dispute will be issued within 60 calendar days of receipt. If the resolution requires a claim payment, the payment will be issued by the 60th calendar day of the determination.

If additional information is needed, a request will be sent to the provider within 15 business days. To resolve the dispute, the provider has 10 days from the date of requested information to submit additional information or the decision will be made based on the information provided on initial dispute.

3. Dispute Resolution

If VNSNY CHOICE decides in the provider’s favor on a request for payment, VNSNY CHOICE will pay for the service by the 60th day from the date of the dispute receipt date.

If VNSNY CHOICE decides against the provider, VNSNY CHOICE will notify the provider in writing as to the rationale for the decision by the 60th day from the date of the dispute receipt date.
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

To ensure prompt payment for the services provided by the VNSNY CHOICE subcontractor please follow the instructions outlined below.

Claim Submission Instructions

VNSNY CHOICE encourages providers to submit their claims in a standardized electronic format.

1. Electronic submission of HIPAA services:
   - For example: Durable Medical Equipment, Orthotics and Ambulance services. Nursing Home providers should refer to their specific instructions included in the manual.
     1. Contact your software vendor, clearinghouse, or billing agent and request that they activate VNSNY CHOICE (Payer ID No. 77073) for electronic submission.

2. Electronic submission of Non-HIPAA services:
   - For example: Meals on Wheels, Social Day Care, Medical Day Care. Transportation providers should refer to their specific instructions included in the manual.
     1. Contact our Provider Relations Department and request the “Electronic Claims Filing Instructions for Non-Standard HIPAA EDI Transactions”.

3. Paper submission of all claims
   - Your claim must be submitted using a standard form such as the CMS-1500 or UB-04. If you are unable to utilize either form please contact VNSNY CHOICE to determine the appropriate billing form. Please send all paper claims to the address listed in Section 1 of this provider manual.

4. Invoices must be submitted on a regular basis for all services provided. Please be mindful of your contractual timely filing terms, as well as the timeframe afforded to you to resubmit a claim.

Procedure Codes and Modifiers

Please refer to your contract for the list of codes and modifiers that are required in your claim submission.
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

Billing Instructions

1. Claims should contain the following information:
   - Complete Name, Address, and Telephone Number of the Provider
   - Contact Person
   - Provider ID (assigned by VNSNY CHOICE)
   - Tax Identification Number
   - Authorization Number (3 digits to the right of the member’s VNSNY CHOICE ID/Case Number on the order)
   - Date of Service
   - Procedure Code (refer to your contract for list of codes)
   - Modifier for code, if applicable. (Refer to your contract for list of codes)
   - Member ID Number
   - Member Full Name (first, middle and last)
   - Date of Birth
   - Invoice Number (provider’s internal number)
   - Units billed
   - Total charges for each service
   - Total dollar amount of the invoices

2. VNSNY CHOICE will reconcile each claim to the services that were authorized and the rates that are outlined in the provider's contract.

3. VNSNY CHOICE adheres to the prompt payment provision of Section 3224-a of the New York State Insurance Law. It is the policy of VNSNY CHOICE to pay providers in accordance to NYS Prompt Pay Laws after the receipt of a "clean" claim for services.

4. Once your claims have been adjudicated, VNSNY CHOICE issues a Remittance Advice with payment informing you of the decision made on the claims submitted. Remittance Advices will also be issued for denied claims, indicating the reason for the denial.

5. If there are questions about any aspect of the VNSNY CHOICE billing requirements, please contact VNSNY CHOICE’s Provider Relations Department at the telephone number listed in Section 1 of this provider manual.

6. Questions about specific claims may be directed to the Claims telephone number listed in Section 1 of this provider manual.

Billing Instructions for Transportation Providers

1. Electronic filing of claims is available and encouraged. Any provider interested in filing electronically should contact the VNSNY CHOICE Provider Relations Department at the telephone number listed in Section 1 of this provider manual. (See page 9-14 for billing instructions for electronic filing.)
Section 9a: Additional Claims and Billing Information
for VNSNY CHOICE Managed Long Term Care Providers

2. For paper claims, ambulette and ambulance providers should submit invoices on a CMS-1500 form. Car service providers will be given a VNSNY CHOICE invoice format at the time of contracting.

3. Claims must be submitted on a regular basis and contain the following information:
   - Complete Name, Address, and Telephone Number of the Provider
   - Provider ID (assigned by VNSNY CHOICE)
   - Provider Tax Identification Number
   - Invoice Number (provider’s internal number)
   - Date of Service
   - Member ID (VNSNY Case Number, 9 digits including leading zeroes)
   - Member Full Name (first, middle and last)
   - Member Date of Birth
   - Authorization Number (the 3 digits to the right of the member’s case number on the VNSNY-issued transportation order)
   - NYSDOH base codes for each service (see separate list)
   - VNSNY CHOICE specific code modifiers, if applicable (see below)
   - Total charge for each service line item
   - Pick-up address
   - Destination address
   - Total dollar amount of the invoice

4. Once your claims have been adjudicated, a Remittance Advice will be issued with a check informing you of the decision made on the claims submitted. Remittance Advices will also be issued for denied claims, indicating the reason for the denial.

Valid Transportation Codes and Modifiers (subject to change)
New York State Medicaid utilizes a limited set of transportation-related codes and modifiers. VNSNY CHOICE provider contracts may have more variations. To accommodate the variations but also to facilitate reporting to the New York State Medicaid program, VNSNY CHOICE has created additional modifiers which may be utilized in provider-specific contracts.

Please refer to your contract for the list of codes and modifiers that are required in your claim submission.

Billing Instructions for Nursing Home Providers

1. All nursing homes must submit invoices to VNSNY CHOICE no later than 90 days after the end of the month in which services are provided or from the date of the Medicare explanation of benefits (EOB), whichever is greater.

2. If payment is obtained from other sources to offset some or all of VNSNY CHOICE billing responsibilities, documentation of these payments must be included with the claim.

3. VNSNY CHOICE MLTC will pay all undisputed claims in accordance with New York State Prompt Pay regulations.
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

4. Medicare rules are unchanged, even if an individual is a member of VNSNY CHOICE MLTC.

Bedhold

VNSNY CHOICE follows New York State Medicaid Program policy regarding payment for bedholds. Upon member admissions to nursing facilities when VNSNY CHOICE is the primary payer, VNSNY CHOICE representatives provide the Care Manager with contact names and numbers. See Section 1 of this provider manual for contact information. It is essential that a nursing home notify the appropriate VNSNY CHOICE regional office when a member is hospitalized. This allows the Care Manager to discuss bedhold with the facility and to follow the member’s care while in the hospital. The member must be in the facility for a minimum of thirty (30) days to be eligible for bedhold payment, subject to a vacancy rate on the first day of the member’s absence of not more than 5%. VNSNY CHOICE must be notified at the time of member hospitalizations in order to authorize and approve bedhold payments.

Payment to a facility for reserved bed days provided for temporary hospitalizations may not exceed twenty days. The twenty days are reset based on when the member’s 12-month period began.

General Procedure:

1. On a monthly basis, the nursing home submits claims to VNSNY CHOICE for services provided on a UB-04 CMS (HCFA)-1450.

2. A separate invoice must be submitted for each member. For members enrolled in Medicare or Medicare Managed Care Organizations (“MCO”), the Explanation of Benefits (EOB) must also be attached.

3. If Medicare or a Medicare MCO was NOT billed prior to billing VNSNY CHOICE, then the Nursing Home must attach a copy of the "Ineligibility for Medicare Benefits" form to the invoice.

4. Depending on the type of health insurance the member has and the location of the member immediately prior to the nursing home admission, one of the following procedures should be followed:

If the member is admitted from a hospital, AND:

A. The member has both Medicare Part A and Institutional Medicaid

   • If the member was an inpatient of a hospital for at least 3 consecutive days and was admitted to the nursing home within 30 days of hospital discharge, then Medicare is usually the primary payer and VNSNY CHOICE is the secondary payer. Medicare rules do not change when an individual is a member of VNSNY CHOICE
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

- The nursing home evaluates the member to determine if he/she meets Medicare coverage criteria. If so, Medicare or the Medicare MCO should be billed following the nursing home’s standard procedures.
  
a. During days 1 through 20, Medicare covers 100 percent of the charges, with no co-payment.
b. During days 21 through 100, Medicare pays a portion of the charges. For these days, VNSNY CHOICE is responsible for all co-payments. The nursing home should submit an invoice to VNSNY CHOICE and attach the Medicare or Medicare MCO remittance advice showing the co-payment that is due. If this is not attached, the invoice will be denied and returned to the nursing home with a request that Medicare be billed first.
c. It is understood that Managed Medicare plans may have a different cost sharing structure than Medicare fee for service. In those cases, the Managed Care’s Remittance Advice will be used to determine what if any cost sharing will be reimbursed by VNSNY CHOICE MLTC.

B. The member has Institutional Medicaid and there is no other eligible payer (including individuals who do not have Medicare Part A and those who are assessed as having no rehabilitation potential)
  
- If the member does not have Medicare Part A or is not expected to benefit from rehabilitation therapies, then VNSNY CHOICE is responsible for paying all nursing home costs, beginning on the date of admission. The nursing home should submit its invoice to VNSNY CHOICE at their current rate. The nursing home should submit documentation of its Medicaid rate as updated by the New York State Department of Health. The "Ineligibility for Medicare Benefits" form should be attached to the invoice.

C. The member does not have Institutional Medicaid
  
- A member without Institutional Medicaid is only eligible for nursing home care if they have Medicare Part A and meet the conditions for coverage under the Medicare program. The nursing home should bill Medicare or the Medicare MCO for its services and VNSNY CHOICE for any co-payments, as described in section A above. If nursing home services are required beyond 100 days, the member will be required to disenroll from VNSNY CHOICE and his/her family will have to pay privately for any ongoing care.

- A member without Institutional Medicaid is not eligible for long term nursing home care through the VNSNY CHOICE program. If a nursing home placement is the only appropriate setting to care for this member, he/she will be required to disenroll from VNSNY CHOICE and his/her family will have to pay privately for nursing home care.
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

If the member is admitted from the community, AND:

D. The member has Institutional Medicaid

- VNSNY CHOICE is responsible for paying all nursing home costs, beginning on the date of admission. The nursing home should submit its invoice to VNSNY CHOICE at the agreed upon rate. The "Ineligibility for Medicare Benefits" form should be attached to the invoice.

E. The member is not eligible for Institutional Medicaid

- A member ineligible for Institutional Medicaid is not eligible for long term nursing home care through the VNSNY CHOICE program. If a nursing home placement is the only appropriate setting to care for this member, he/she will be required to disenroll from VNSNY CHOICE and his/her family will have to pay privately for nursing home care.

Completing the UB-04 Form – Key Fields Required

To expedite claims processing, VNSNY CHOICE requires that all nursing homes/skilled nursing facility claims include the following information.

Please note: All facilities are contractually obligated to submit their current New York State Department of Health Medicaid Rate Sheets to VNSNY CHOICE. When adjudicating claims, VNSNY CHOICE will use the most current Medicaid rate sheet we have on file for each facility.

All of these are required fields for each claim submission.

<table>
<thead>
<tr>
<th>UB-04 Box No.</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name</td>
<td>Your facility’s name</td>
</tr>
<tr>
<td>3</td>
<td>Patient Control No.</td>
<td>Your patient identifier</td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period (must include a FROM and THROUGH date)</td>
<td>Dates</td>
</tr>
<tr>
<td>12</td>
<td>Patient Name</td>
<td>Last Name, First Name</td>
</tr>
<tr>
<td>17</td>
<td>Admission Date</td>
<td>Date</td>
</tr>
<tr>
<td>22</td>
<td>Status</td>
<td>Valid values are the same as you would use for billing Medicare</td>
</tr>
<tr>
<td>23</td>
<td>Medical Record No. (an ID assigned by your facility)</td>
<td>Alphanumeric</td>
</tr>
<tr>
<td>35</td>
<td>Occurrence Code</td>
<td>Valid value: 70</td>
</tr>
</tbody>
</table>
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

| 35 | Occurrence Span (must include a FROM and THROUGH date) | Dates of the most recent hospitalization regardless of the age of the last hospitalization. Must be populated. |
| 42 | Revenue Code | Please refer to your contract for a list of codes. |
| 45 | Service Date (must include a FROM and THROUGH date) | Date of Admission |
| 46 | Service Units (1 unit = 1 day) | Number |
| 47 | Total Charges | $ amount |
| 51 | Provider No. (assigned to you by VNSNY CHOICE) | 3 alpha characters followed by 6 digits: ex. SNF000000 |
| 60 | CERT. - SSN - HIC. - ID NO. | Patient’s Social Security Number |
| 63 | Treatment Authorization Codes (Include this if provided by VNSNY CHOICE) | Alphanumeric |
| 67 | Principal Diagnosis Code Valid ICD-9 code. | Valid ICD-9 code. Diagnosis must be coded to the highest level of specificity. |
| 68-75 | Other Diagnosis Codes | As above. Duplicate diagnosis codes are not allowed. |
| 76 | Admitting Diagnosis Code | As above. |

Medicaid Eligibility and NAMI

Nursing Home Medicaid Eligibility

The New York City Human Resources Administration (HRA) published guidelines addressing nursing home admissions when a resident is a member of a Managed Long Term Care (MLTC) program. The guidelines direct the MLTC programs to coordinate Medicaid eligibility functions with the nursing facility.

In order for HRA to properly capture NH days/stays, it is advised that your facility submit a Medicaid conversion for every long-term (permanent) placement admission and a discharge form when appropriate. (This is the same process that nursing homes use for all Medicaid admissions.) This will allow HRA to track admissions and days for MLTC members. HRA will process the admission, but the member will remain on VNSNY CHOICE’s roster. The resident will not appear on the nursing home’s Medicaid roster.

VNSNY CHOICE is the payer for the Medicaid portion of the nursing home bills of its members instead of Medicaid. As such, VNSNY CHOICE coordinates all other Medicaid eligibility activities for its members with HRA, such as annual recertification. VNSNY CHOICE may coordinate some of the necessary documents for financial recertification with the nursing home’s staff but, again, VNSNY CHOICE staff will manage the Medicaid eligibility issues with HRA.
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

Net Available Monthly Income (NAMI)

VNSNY CHOICE will continue to collect any Medicaid surplus for its members placed in nursing homes until the placement becomes permanent. Once it is confirmed that the member is to remain in the nursing home for long-term care, the nursing home will be notified of the NAMI application and to begin the process of re-routing monthly income. VNSNY CHOICE determines the NAMI amount and will coordinate with the nursing home’s billing department regarding the timing and amount of the NAMI.

Each month, VNSNY CHOICE sends contracted nursing homes a roster listing members who were residents in the facility during the previous month. The roster indicates:

- Member name
- Placement status, e.g. short-term or long-term
- NAMI amount (if applicable)
- VNSNY CHOICE Care Manager’s name
- Contact telephone numbers for VNSNY CHOICE regional staff and Claims Department.

Submitting Electronic Claims

This section is intended for providers who wish to bill VNSNY CHOICE MLTC electronically for services that are not covered under the HIPAA EDI Transaction Standards. This includes non-emergency transportation (i.e. ambulette, car service, van service).

The following information will provide you with instructions on how to bill VNSNY CHOICE electronically, i.e non-paper claims. Doing so affords the provider prompt acknowledgement of receipt of claims, prompt identification of any errors on the claim and improved turnaround time in claims processing. If you bill us electronically for services, you will still be able to bill multiple VNSNY CHOICE MLTC members in the same submission.

To bill VNSNY CHOICE MLTC members electronically, you will need the following information:

- A computer with spreadsheet software such as Microsoft Excel. (VNSNY CHOICE will supply you with a “shell” Excel file on a diskette if you wish, but you must have a spreadsheet program to use in completing your bill each time.)
- Internet connection (can be dial-up or broadband) with ability to upload a file to the VNSNY CHOICE MLTC-specified website.

If you would like to submit electronically, follow the following steps:

- Sign and return the Trading Partner Security Agreement.
- VNSNY CHOICE will issue an ID and Password to the provider for access to the secure website – https://www.vnsnychoice.org/OPSWEB/login.html.
- Submit a test file to verify upload
- VNSNY will advise you of acceptance and will notify the provider to proceed with file submission.
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

If you have any questions, please contact the VNSNY CHOICE Provider Relations Department at the telephone listed in Section 1 of this provider manual.

General Claims Layout Information and Provider Codes

Procedure Codes and Modifiers

Please refer to your contract for the list of codes and modifiers that are required in your claim submission.

Chore Services Providers

A. Claims Layout

<table>
<thead>
<tr>
<th>Column</th>
<th>Field Name</th>
<th>Description</th>
<th>Field Length</th>
<th>Data Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Provider's Invoice Number</td>
<td>The provider's own invoice number. You can use whatever combination of letters and numbers you wish, either generated by your billing</td>
<td>Up to 20 characters</td>
<td>Text &amp;/or numeric</td>
</tr>
<tr>
<td>B</td>
<td>Member ID</td>
<td>VNSNY CHOICE Member ID, for example: V12345678, total of 9 positions, 1st left most position always should equal a “V” (must be upper case). Next right most 8 positions must be numeric.</td>
<td>9 characters</td>
<td>Alpha numeric</td>
</tr>
<tr>
<td>C</td>
<td>Member Last Name</td>
<td>VNSNY CHOICE member’s (patient’s) last name (Not case sensitive)</td>
<td>Up to 35 characters</td>
<td>Text</td>
</tr>
<tr>
<td>D</td>
<td>Member First Name</td>
<td>VNSNY CHOICE member’s (patient’s) first name (Not case sensitive)</td>
<td>Up to 35 characters</td>
<td>Text</td>
</tr>
<tr>
<td>E</td>
<td>DOS</td>
<td>Date of Service (the date the provider performed the service)</td>
<td>8 characters</td>
<td>Date format mm/dd/yy</td>
</tr>
<tr>
<td>F</td>
<td>TOS</td>
<td>Type of service. You must specify CHORE.</td>
<td>5 characters</td>
<td>Text</td>
</tr>
<tr>
<td>G</td>
<td>Auth. No.</td>
<td>Authorization Number. This is the 3-digit number from the VNSNY CHOICE “Order Processing” Order Entry form to the right of the “Agency Name”, e.g. 2769659 005. The left group of numbers represent the member’s VNSNY case number (ID) and to the right, is a 3-digit “sequence number.” You must include only the digits to the right. Note: An authorization number may remain the same for multiple dates of service for the same member.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

Adult Day Care Providers

A. Claims Layout

<table>
<thead>
<tr>
<th>Column</th>
<th>Field Name</th>
<th>Description</th>
<th>Field Length</th>
<th>Data Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Provider’s Invoice Number</td>
<td>The provider’s own invoice number. You can use whatever combination of letters and numbers you wish, either generated by your billing system or manually created, e.g. 20060615A.</td>
<td>Up to 20 characters</td>
<td>Text &amp;/or numbers</td>
</tr>
<tr>
<td>B</td>
<td>Member ID</td>
<td>VNSNY CHOICE Member ID, for example: V12345678, total of 9 positions, 1st left most position always should equal a “V” (must be upper case). Next right most 8 positions must be numeric.</td>
<td>9 characters</td>
<td>Alpha numeric</td>
</tr>
<tr>
<td>C</td>
<td>Member Last Name</td>
<td>VNSNY CHOICE member’s (patient’s) last name (Not case sensitive)</td>
<td>Up to 35 characters</td>
<td>Text</td>
</tr>
<tr>
<td>D</td>
<td>Member First Name</td>
<td>VNSNY CHOICE member’s (patient’s) first name (Not case sensitive)</td>
<td>Up to 35 characters</td>
<td>Text</td>
</tr>
<tr>
<td>E</td>
<td>DOS</td>
<td>Date of Service (the date the provider performed the service)</td>
<td>8 characters</td>
<td>Date format mm/dd/yy.</td>
</tr>
<tr>
<td>F</td>
<td>TOS</td>
<td>Type of Service. You must specify SDY. If the member is being transported by ambulette, LETTE would be specified in the line below next to procedure code NY 217 or NY 218.</td>
<td>3 to 5 characters</td>
<td>Text</td>
</tr>
<tr>
<td>G</td>
<td>Auth. No.</td>
<td>Authorization number. This is the 3-digit number from the VNSNY CHOICE “Order Processing” Order Entry form to the right of the “Agency Name”, e.g. 2769659 005. The left group of numbers represent the member’s VNSNY case number (ID) and to the right, is a 3-digit “sequence number.” You must include only the digits to the right.</td>
<td>3 digits</td>
<td>Numbers</td>
</tr>
</tbody>
</table>

NOTE: An authorization number may remain the same for multiple dates of service for the same member.

Transportation Providers

A. Claims Layout

<table>
<thead>
<tr>
<th>Column</th>
<th>Field Name</th>
<th>Description</th>
<th>Field Length</th>
<th>Data Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Provider’s Invoice Number</td>
<td>The provider’s own invoice number. You can use whatever combination of letters and numbers you wish, either generated by your billing system or manually created, e.g. 20060615A.</td>
<td>Up to 20 characters</td>
<td>Text &amp;/or numbers</td>
</tr>
</tbody>
</table>
## Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
<th>Format</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Member ID</td>
<td>VNSNY CHOICE Member ID, for example: V12345678, total of 9 positions, 1st left most position always should equal a “V” (must be upper case). Next right most 8 positions must be numeric.</td>
<td>9 characters</td>
</tr>
<tr>
<td>C</td>
<td>Member Last Name</td>
<td>VNSNY CHOICE member’s (patient’s) last name (not case sensitive)</td>
<td>Up to 35 characters</td>
</tr>
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<td>D</td>
<td>Member First Name</td>
<td>VNSNY CHOICE member’s (patient’s) first name (not case sensitive)</td>
<td>Up to 35 characters</td>
</tr>
<tr>
<td>E</td>
<td>DOS</td>
<td>Date of Service (the date the provider performed the service)</td>
<td>8 characters</td>
</tr>
<tr>
<td>F</td>
<td>TOS</td>
<td>Type of Service. You must specify one of the values indicated below:</td>
<td>3-5 characters</td>
</tr>
<tr>
<td>G</td>
<td>Auth. No.</td>
<td>Authorization number. This is the 3-digit number from the VNSNY CHOICE “Order Processing” Order Entry form to the right of the “Agency Name”, e.g. 2769659 005. The left group of numbers represent the member’s VNSNY case number (ID) and to the right, is a 3-digit “sequence number.” You must include only the digits to the right.</td>
<td>3 digits</td>
</tr>
<tr>
<td>H</td>
<td>Procedure Code</td>
<td>This is a code from the list of services you provide to VNSNY CHOICE. Samples: CAR A0100 = One-way inside CMMA A0100 TN = One-way outside CMMA AMBULETTE A0130 = One-way inside CMMA A0130 TN = One-way outside CMMA VAN A0110 = Group Ride one way ambulatory per person A0110 HE = Group Ride one way wheelchair per person AMBULANCE A0428 = Basic Life Support Miscellaneous A0170 usage specific to provider contract</td>
<td>5 characters</td>
</tr>
</tbody>
</table>
## Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

| I | Modifier 1 | This is a modifier code from the list of services you provide to VNSNY CHOICE that further refines the procedure code. A modifier is not applicable to all services and therefore, may be blank. Note: modifiers must be submitted in the same order as arranged on the billing codes list provided with this document; generally, modifier order follows alphabetic order. | 2 characters (or blank) | May be letters and/or numbers. |
| J | Modifier 2 | Same as for Modifier 1 | 2 characters (or blank) | May be letters and/or numbers. |
| K | Modifier 3 | Same as for Modifier 1 | 2 characters (or blank) | May be letters and/or numbers. |
| L | Modifier 4 | Same as for Modifier 1 | 2 characters (or blank) | May be letters and/or numbers. |
| M | Charges | The total dollar amount you are billing for the line item. This should be the contracted amount. | Up to 6 characters, including decimal point. | Numbers with decimal point. No dollar ($) sign needed. |
| N | Units | The number of trips on this service date (see DOS, item E above) to and from the same destination. Round trip between member’s home and doctor’s office is considered 2 units (1 going/1 returning) so you would enter “2” for the number of units. One way trip from hospital to home = 1 unit. | 1-3 characters | Numbers |
| O | Pick Up Address | Enter the address where the trip originated. This can be a combination of numbers and letters with street address separated from city with a comma. Abbreviate Street/Road/Avenue wherever possible. Neither State nor Zip Code are required, but may be included. | Up to 35 characters | Numbers and letters. |
| P | Destination Address | Enter the address where the trip ended. This can be a combination of numbers and letters with street address separated from city with a comma. Abbreviate Street/Road/Avenue wherever possible. Neither State nor Zip Code are required, but may be included. | Up to 35 characters | Numbers and letters. |
### Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

#### Home Delivered Meals Providers

**A. Claims Layout**

<table>
<thead>
<tr>
<th>Column</th>
<th>Field Name</th>
<th>Description</th>
<th>Field Length</th>
<th>Data Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Provider's Invoice Number</td>
<td>The provider’s own invoice number. You can use whatever combination of letters and numbers you wish, either generated by your billing system or manually created, e.g. 20060615A.</td>
<td>Up to 20 characters</td>
<td>Text &amp;/or numbers</td>
</tr>
<tr>
<td>B</td>
<td>Member ID</td>
<td>VNSNY CHOICE Member ID, for example: V12345678, total of 9 positions, 1st left most position always should equal a “V” (must be upper case). Next right most 8 positions must be numeric.</td>
<td>9 characters</td>
<td>Alpha numeric</td>
</tr>
<tr>
<td>C</td>
<td>Member Last Name</td>
<td>VNSNY CHOICE member’s (patient’s) last name (not case sensitive)</td>
<td>Up to 35 characters</td>
<td>Text</td>
</tr>
<tr>
<td>D</td>
<td>Member First Name</td>
<td>VNSNY CHOICE member’s (patient’s) first name (not case sensitive)</td>
<td>Up to 35 characters</td>
<td>Text</td>
</tr>
<tr>
<td>E</td>
<td>DOS</td>
<td>Date of Service (the date the provider performed the service)</td>
<td>8 characters</td>
<td>Date format mm/dd/yy.</td>
</tr>
<tr>
<td>F</td>
<td>TOS</td>
<td>Type of Service. You must specify MOW.</td>
<td>5 characters</td>
<td>Text</td>
</tr>
<tr>
<td>G</td>
<td>Auth. No.</td>
<td>Authorization number. This is the 3-digit number from the VNSNY CHOICE “Order Processing” Order Entry form to the right of the “Agency Name”, e.g. 2769659 005. The left group of numbers represent the member’s VNSNY case number (ID) and to the right, is a 3-digit “sequence number.” You must include only the digits to the right.</td>
<td>3 digits</td>
<td>Numbers</td>
</tr>
</tbody>
</table>

**NOTE:** An authorization number may remain the same for multiple dates of service for the same member.

#### Uploading Files to VNSNY CHOICE

*Please note: Your first submission to VNSNY CHOICE must be a test file. Once the test file has been successfully processed, you will be advised that you may proceed with sending actual files.*

1. Prepare your file with the required information. See the instructions above.

2. Save the file as a Text/Tab Delimited file, naming the file as follows:

   Provider Name (up to 1st 8 characters) followed by YYYYMMDD and letter “a” (no characters other than letters, numbers, periods (_) or underscore (_) are allowed.

   Example – DayCare20070512a, Chore20070512a, MOW20070512a, BigCar20060512a.

   The YYYYMMDD should be the date of the invoice that you are submitting.
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

The letter “a” following the date is used to indicate the first invoice submitted for that date. If you submit a second invoice with the same invoice date, you would use letter “b” after the date. A third invoice would be letter “c”, and so on. In most cases, you will only have a single invoice for a date so the file name will usually end in an “a”.

3. Access the internet and go to the following web address – https://vnsny.org/OPSWeb/login.html

4. Enter your User ID

5. Click on “Manage Files” on the left-hand side of the screen.

6. Click on “Browse” to find the file you wish to send to VNSNY CHOICE MLTC.

7. A list of files and folders will appear. You will need to find the file you wish to upload to VNSNY CHOICE by searching on your computer (in the folder where you stored the file).

8. Once you have found the file you wish to upload (send) to VNSNY CHOICE MLTC, double click on the file to select the file. Or, you may highlight the file and click “Open”.

9. Once you have completed this, the file and its directory will appear in the box next to the word “Browse”. (This may be chopped off so you will only see the beginning of the file path.)

10. Click on “Upload” to send the file to VNSNY CHOICE MLTC.

11. Once you have completed this, the file should be listed under the green bar labeled “File Name/FileSize/File Date”.

12. If you wish to delete a file, click on the red “X” which is under the green bar. You may delete files from your “mailbox” whenever you wish. Files will be automatically be deleted at least every 30 days.

13. If you wish to add an additional file, you may do so by using “Browse” and repeating the steps listed above.

14. Remember to click on “Logout” once you are finished uploading your files.

Miscellaneous Notes

- VNSNY CHOICE retrieves submitted files at least hourly. Shortly thereafter, a response is issued to indicate success or non-success of the claims submission.
Section 9a: Additional Claims and Billing Information for VNSNY CHOICE Managed Long Term Care Providers

- If the claim has data which fails to upload – for example, 2 rows out of 100 fail – the claim lines (rows) which fail will be identified in a message posted back to your secure web mailbox.

- You may correct the errors and resubmit those claim lines:
  - With the same or a different invoice number on the line item, but:
  - Separate file (adding a different letter suffix) should be created for just those line items. For example:
    BigCar20060512a = 1st File
    BigCare2006512b = 2nd File

- For Transportation Providers: On occasion, if you provide a specially-negotiated transport (for example, out of area), you will be instructed to use the normal procedure code with an “ME” modifier. This modifier will trigger a manual review to verify the rate that was mutually agreed upon but does not exist in your contracted fee schedule.
Section 10: Laboratory Services

This section does not apply to providers of VNSNY CHOICE Managed Long Term Care members. This section does apply to all other providers.

VNSNY CHOICE requires that all laboratory testing be conducted by participating laboratories.

1. Lab Exams That Can Be Performed in the Provider Office

   VNSNY CHOICE allows participating physicians to perform laboratory work in their office(s) pursuant to the terms of the Clinical Laboratory Improvement Amendment (CLIA). In order to be reimbursed for laboratory tests provided in the office, the office must have the appropriate CLIA Certificate/Registration or waiver on file with VNSNY CHOICE. Reimbursement will be made according to the VNSNY CHOICE participating physician agreement.

2. Participating Laboratories

   VNSNY CHOICE has contracts with several clinical laboratories to which members may be referred, including laboratories which perform phlebotomy in the home. Participating hospital laboratories may also be utilized. Consult the VNSNY CHOICE Quick Reference Card, Provider Directory, or online provider directory for a listing of participating laboratories.
Quality Improvement Program

VNSNY CHOICE’s Quality Improvement mission is to exceed the expectations of the customer and to continually improve the quality of healthcare for our members. This is accomplished by providing access to affordable, appropriate and timely health care and services, which is routinely assessed for compliance with established standards. VNSNY CHOICE will develop its Quality Improvement standards in consultation with participating providers. Participating providers must comply with all VNSNY CHOICE Quality Management policies, procedures and programs.

The overriding principle of the VNSNY CHOICE Quality Improvement Program (QIP) is to develop an integrated and comprehensive approach to continuously improving care and service to meet or exceed our members’ expectations.

Program Description

The VNSNY CHOICE QIP provides a framework for the evaluation of the delivery of health care and services provided to members. This framework is based upon the philosophy of continuous quality improvement and includes:

- Development of quality improvement initiatives,
- Quality measurement and evaluation,
- Corrective action implementation and evaluation,
- Communication with and education of our members and providers, and
- Annual evaluation of the program’s effectiveness.

Program Scope

The goal of the QIP is to improve the health outcomes of care to our membership by accessing pertinent data, utilizing proven management and measurement methodologies, and continuously evaluating and improving organizational service processes that are either directly or indirectly related to the delivery of care.

The QIP encompasses both clinical care and non-clinical activities, which have either direct or indirect influence on the services members receive from VNSNY CHOICE participating providers and on the quality of care.

Authority

As the governing body of the plan, the Board of Directors is accountable for the QIP. The President of VNSNY CHOICE is responsible for its implementation. The plan’s Chief Medical Officer in conjunction with the Director of Quality Management has overall responsibility for the plan’s quality improvement strategies and activities. The Vice President of Clinical Operations plays a key role in operationalizing the quality improvement clinical activities. The Board of Directors receives written reports on the progress of the QIP Work Plan for all product lines.
Section 11: Quality Management

Program Objectives

- Implement a Quality Improvement structure that will facilitate the identification, development and implementation of improvement activities throughout VNSNY CHOICE,
- Improve organizational processes to evaluate their ability to support VNSNY CHOICE’s current or new health care products, by identifying, developing and implementing strategies to facilitate improvement,
- Improve organizational communication, by identifying, developing and implementing strategies to facilitate improvement,
- Improve data collection and analysis for the purpose of identifying and developing improvement activities,
- Collaborate with the Centers for Medicare and Medicaid Services (CMS), the New York State Department of Health (NYSDOH), and the NYSDOH AIDS Institute for establishing and reporting quality improvement.
- Assess the health care delivery system’s access and availability of services, and identification, development and implementation of strategies to facilitate improvement,
- Evaluate the QIP’s effectiveness by performing an annual evaluation of the activities generated by the program, and
- Develop an annual QIP Work Plan based upon the results obtained from the prior year’s evaluative process.
- Establish thresholds and evaluate patterns or trends through the analysis of data for all products.

Confidentiality

- All member clinical information is considered confidential information and will be kept confidential by VNSNY CHOICE staff and committee members.
- All committee discussions are considered confidential. No clinical information will be sent outside of VNSNY CHOICE without express consent of the member or legal guardian except in accordance with regulatory requirements of the NYSDOH, CMS, or where compelled by court order.

QI Work Plan

On an annual basis, the Quality Improvement Committee (QIC) will oversee the development of the QIP Work Plan. The QIP Work Plan outlines the quality improvement monitoring and evaluation activities for the coming year. The QIP Work Plan is a document in progress and activities can be re-evaluated or updated as needed. The QIP Work Plan is presented to the QIC for recommendations and approval. The QIP Work Plan is then presented to the Board of Directors for final approval.

Each year VNSNY CHOICE will develop an annual QIP Work Plan that includes specific quality improvement initiatives and measurable objectives for each scheduled initiative. The QIP Work Plan activities are derived from: i) the opportunities for improvement that were identified during the previous year, ii) analysis of data reports, iii) analysis of customer satisfaction surveys and iv) any other activities that are required by state, federal and accreditation entities.
The following are some of the issues monitored through the QIP plan:

- Member satisfaction
- Member complaints and compliments
- Medical record documentation
- Utilization management
- Access and availability of services
- Medical and psychosocial case management
- Provider credentialing/recredentialing
- Network compliance, quality, and provider issues

**Annual Review and Evaluation**

The QIP and Work Plan are reviewed on an annual basis for its effectiveness. The results of this evaluation process are contained within a document known as the Quality Improvement Program Evaluation (QIPE). The QIPE is presented to the Quality Improvement Committee for review and to establish VNSNY CHOICE’s quality improvement activities for the following year. Due to the dynamic process of continuous quality improvement, the need to comply with external accrediting organizations, regulatory requirements and business decisions, the QIP and Work Plan can be subject to change at any time during the year to improve care and service to its members. This QIPE will elicit the information necessary to assist in development of the QIP Work Plan for subsequent years.

**Clinical and Investigational Studies**

The Medical Management Department makes recommendations to the QIC concerning proposed clinical studies. The QIC, with oversight by the Board of Directors, is responsible for allocating resources, assigning responsibilities and determining methods for communicating results to providers and staff.

VNSNY CHOICE conducts an internal study addressing services provided to its adult members and an internal study addressing services to its pediatric/adolescent members on an annual basis.

**Standards of Care**

VNSNY CHOICE has adopted practice guidelines to support the medical, utilization and care management of its members enrolled in various products. These guidelines are evidence based and consistent with prevailing standards of medical practice. These standards are established and consistent with a products Federal and State requirements. These standards include, but are not limited to, CMS and the National Committee for Quality Assurance (NCQA) Special Needs Plan, NYSDOH Medicaid Managed Care, the New York State Department of Health AIDS Institute (e.g., the provision and monitoring of antiretroviral therapy) and/or the U.S. Department of Health and Human Services. VNSNY CHOICE clinical practice guidelines comply with the recommendations of professional specialty groups. Clinical practice guidelines are reviewed annually and updated as necessary. Guidelines are disseminated to providers, with all relevant updates, as they are released by the state or federal government.
Section 11: Quality Management

Conflict of Interest

To ensure that all quality issues are reviewed, without bias, and actions taken are in the best interest of VNSNY CHOICE members, VNSNY CHOICE mandates the following policies:

- To avoid actual or perceived conflicts of interest, VNSNY CHOICE requires all committee members to provide appropriate disclosure,
- Any committee member who has an interest in any recommendation of a committee shall make a prompt and full disclosure of his or her interest to the committee before it makes such recommendation. Such disclosure shall include any relevant and material facts known to such member about the recommendation in question, which might reasonably be construed as adverse to the VNSNY CHOICE’s interests. This includes, but is not limited to, situations in which a committee member is a competitor of the provider in question.
- If the committee determines that a conflict of interest exists, it shall require the disclosing member to excuse him or herself from voting on the issue at hand.

Access and Availability Standards

All Primary Care and Specialist Services provided by participating providers are to be provided by duly licensed, certified or otherwise authorized professional personnel in a culturally competent manner and at physical facilities in accordance with i) the generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment; ii) the provisions of VNSNY CHOICE’s QIP and Medical Management Program; iii) the requirements of State and Federal Law; and iv) the standards of accreditation organizations such as NCQA and the Joint Commission for Accreditation of Healthcare Organizations.

Each participating provider is required to provide advance written notice to VNSNY CHOICE in the event of any change in the capacity of the participating provider to continue services under the terms of the participating provider’s agreement with VNSNY CHOICE.

Participating providers are solely responsibility for the medical care and treatment of members and will maintain the physician-patient relationship with each member. Nothing contained in the participating provider’s agreement is intended to interfere with such physician-patient relationship, nor is the participating provider agreement intended to discourage or prohibit participating providers from discussing treatment options or providing other medical advice or treatment deemed appropriate by participating providers.

VNSNY CHOICE assesses that its panel of participating providers can meet the racial, ethnic, cultural, and linguistic needs of its members. VNSNY CHOICE also requires that network providers assist members with limited English speaking proficiency and physical disabilities.

Please refer to Section 4 and Section 5 for telephone access standards and appointment access to PCPs and participating specialists.
Section 11: Quality Management

Evaluation Frequencies and Methodology

On at least an annual basis, all PCPs and high volume participating specialists will be included in an accessibility audit/review for all categories and appointment types. Member complaints may also trigger an ad hoc measurement of a provider’s accessibility. Data will be analyzed on a system wide and individual provider level for the development of system wide and/or individual improvement activities. VNSNY CHOICE participates in established AIDS Institute research on access to care, member satisfaction and quality of life and other specific QI studies developed by the AIDS Institute.

Quality Management Subcommittee Structure

The full organizational structure of committees reporting to the VNSNY CHOICE Quality Improvement Committee is available by contacting the plan and requesting this information. Below are the committees most important to providers:

Pharmacy and Therapeutics Subcommittee

The Pharmacy & Therapeutic Subcommittee’s responsibilities include overall oversight of the delegated relationship with the contracted Pharmacy Benefits Manager (PBM) for the Medicare Part D Plan and the New York State Medicaid Pharmacy Benefit for the HIV Special Needs Plan, the development of the formulary, required reporting for regulatory compliance with the drug plan and monitoring the utilization of Part B drugs. The committee will review new drugs that enter the market to determine if they will be covered. The committee will also track all regulatory changes to Medicare Part D and the New York State Medicaid Pharmacy Benefit and report regularly to the Quality Improvement Committee on these changes as they affect plan members. This includes recommendations for benefit and formulary revisions and development/implementation of utilization management protocols.

Medical Advisory Subcommittee

The role of the Medical Advisory Subcommittee is to review clinical guidelines, disease state management protocols, authorization policies and other chronic care improvement efforts to ensure they are consistent with established evidenced based best practice standards.

In addition, the Medical Advisory Subcommittee, or a subgroup of the subcommittee, will be responsible for peer review activities and/or review of quality of care issues, on an ad hoc basis. Physicians who perform peer review within the health plan are required to be credentialed providers within the plan, unless an external peer review is required as determined by the QIC.

Inter-rater review of the peer reviewers’ performance is carried out with established policies and procedures. All documents reviewed and all documentation developed and maintained in the peer review process is a product of “medical peer review” which provides protection, within the extent of the law, from discoverability.

The Chief Medical Officer (CMO) is the Chairperson of the Medical Advisory and responsible for the peer review activities performed by the subcommittee structure within VNSNY CHOICE as well as ad-hoc utilization management peer review activities.
Section 11: Quality Management

Utilization Management (UM) Subcommittee

The responsibilities of the Utilization Management Subcommittee are to:

- Review and analyze utilization data from claims, encounters, referrals, authorizations and denials to determine potential over and underutilization,
- Review quality of care issues
- Target utilization management efforts accordingly
- Develop and provide recommendations for corrective action plans
- Assist in the development of baseline data measurements of utilization and determine outlier thresholds
- Monitors results and reports the findings to the QIC

Out-of-plan utilization will be reviewed on a monthly basis to identify possible areas of under/over utilization. This data will be member and population specific categories to identify possible patterns of under-utilization, over utilization and/or inappropriate utilization within those categories. Benchmarks and goals for performance are developed for utilization measures and action plans are developed to respond appropriately to under/over utilization and inappropriate medical services. The CMO is the Chairperson of the Utilization Management Subcommittee.

Credentialing Subcommittee

The responsibilities of the Credentialing Subcommittee are to recommend approval or denial of providers and facilities for either initial or continued participation in the healthcare delivery system to the plan QIC. The CMO is the Chairperson of the Credentialing Subcommittee.

Member Advisory Subcommittee

The Member Advisory Subcommittee strives to continuously improve the quality of care and the delivery of services to VNSNY CHOICE members. The Subcommittee was created to provide a venue for members to participate in the quality improvement program. Members are encouraged to verbalize concerns, make inquiries and suggestions that would assist the health plan to improve services, benefits and member satisfaction. Subcommittee functions include:

- Reviewing, evaluating and updating policies and procedures related to members’ rights and responsibilities (including those in accordance with guidelines put forth by the New York State Department of Health AIDS Institute.)
- Identifying opportunities for improvement through evaluation of internal statistics, member complaints, medical record reviews, and satisfaction surveys. Results will be reported to the QIC regularly for corrective action.
- Reviewing member complaints and recommending corrective action to the QIC.
- Analyzing member satisfaction data and making recommendations for improved quality of care and delivery of service to the QIC.
- Reviewing member information materials and documents so that they are comprehensible, well designed and available in the languages members speak.
Psychosocial Subcommittee

The Psychosocial Committee exists to integrate and coordinate the delivery of psychosocial case management services for VNSNY CHOICE SelectHealth members. Its responsibilities include:

- To review, evaluate and update policies and procedures related to psychosocial case management including those in accordance with guidelines prescribed by the New York State Department of Health AIDS Institute.
- To identify opportunities for improvement through evaluation of encounter information, member/provider complaints and satisfaction surveys. To report results to the QIC regularly for corrective action.
- To evaluate the effectiveness of implemented quality improvement initiatives and to assess the compliance with case management guidelines throughout the plan.
- To ensure optimal communication between the member’s medical and psychosocial care teams.
- To evaluate and make recommendations to the QIC concerning proposed quality studies.

Data and Reporting

VNSNY CHOICE complies with all Federal and State reporting requirements.

HEDIS Reporting

The Healthcare Effectiveness Data and Information Set (formerly known as the Health Plan Employer Data Information Set - HEDIS), developed by NCQA, is the most widely used set of performance measures in the managed care industry. VNSNY CHOICE collects and reports HEDIS data for its Medicare lines of business on an annual basis for the purpose of tracking and developing performance improvement activities related to care and service.

QARR Reporting

The NYSDOH Quality Assurance Reporting Requirements (QARR) are an integral component of the VNSNY CHOICE Quality Improvement Program. The NYSDOH uses QARR data to work with HIV-AIDS Special Needs Plans and providers to enhance the health care outcomes of managed care enrollees through performance feedback, quality improvement programs, technical assistance and highlighting of best practices. VNSNY CHOICE must report QARR data to the NYSDOH on an annual basis.

Submission and Oversight

To submit data for HEDIS and QARR, VNSNY CHOICE relies on accurate and timely encounter data from its providers. VNSNY CHOICE staff may also conduct chart reviews to obtain documentation for the selected HEDIS and QARR measures for the year’s report requirements or as part of its internal auditing responsibilities.
Section 11: Quality Management

Oversight of HEDIS and QARR reporting remains the responsibility of the QIC. Day to day operational management and reporting of HEDIS data rests with the Quality Management Department and Health Economics Unit.

Diseases and Conditions Data

Physicians are required by Article 11 of the New York City Health Code to report certain diseases, conditions and events to the New York City Department of Health and Mental Hygiene (NYC DOHMH).

Section 11.03 of the New York City Health Code requires the immediate reporting by telephone of a suspected outbreak among three or more persons of any disease or condition (whether or not it is listed among reportable conditions), and of any unusual manifestation of disease in an individual.

VNSNY CHOICE Account Managers are available to assist providers with identification and implementation of New York City Department of Health regulations regarding the reporting of mandated diseases. Educational literature will be made available to providers about reporting diseases and conditions specified in NYC Health Code. The necessary literature and forms will be made available to providers through a newsletter, the VNSNY CHOICE web site, and in Appendix D of this Provider Manual.

Reporting Requirements

Participating providers must cooperate with VNSNY CHOICE in meeting its data reporting obligations by providing VNSNY CHOICE with the information required to meet its obligations. For example, CMS regulations require VNSNY CHOICE to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program and to establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes VNSNY CHOICE quality and performance indicators such as disenrollment rates for members electing to receive benefits through VNSNY CHOICE for the previous two years, information relating to member satisfaction and health outcomes data. Additionally, participating providers that furnish diagnostic data (e.g., encounter data) to assist VNSNY CHOICE in meeting its reporting obligations to CMS must certify (based on best knowledge, information and belief) the accuracy, completeness, and truthfulness of the data.

Providers must maintain medical or service records and patient charts in accordance with their existing policies and in compliance with all regulations for each patient receiving services from the provider. Patient charts shall contain all clinical progress notes describing patient services and events. Upon request, the provider will make copies of a member’s records available to VNSNY CHOICE, the NYSDOH, the United States Department of Health and Human Services, the Comptroller of the State of New York, the Comptroller General of the United States, and or their respective designated representatives, for inspection, evaluation and audit, through six (6) years from the final date of the subcontract, the date of providing service to a VNSNY CHOICE member, or the date of completion of any audit by any of the above-mentioned parties, whichever is later.
Fraud and Abuse Prevention

Visiting Nurse Service of New York (VNSNY) and VNSNY CHOICE are committed to preventing and detecting any fraud, waste, or abuse in the organization, related to Federal and State health care programs. To this end, VNSNY maintains a vigorous compliance program and strives to educate our workforce, members and providers on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments.

All VNSNY CHOICE employees, board members, administrators, members, providers, volunteers and those with which we do business are required to comply with the organization’s Compliance Program.

What are the rules that must be followed?

The standards set forth in the Code of Conduct provide an overview of the laws and rules that our providers and their staff are expected to follow. A copy of the Code of Conduct is available upon request from the Compliance Officer. In short, we expect everyone to conduct themselves pursuant to the highest ethical, business, and legal standards. As part of our Compliance Program, if you suspect that someone is doing anything that is illegal or unethical, you must report it.

Examples of what needs to be reported

- Questionable billing, coding or medical record documentation practices;
- Giving or accepting something of value in exchange for patient referrals or other business;
- Quality of care issues;
- Stealing from VNSNY or a member;
- Altering medical or business records;
- Assisting in or ignoring fraud, waste or abuse concerns; and/or
- Any activity or business practice that could possibly be interpreted as unethical or illegal.

How to Report Compliance Violations

If you suspect insurance fraud, abuse, or suspicious activity has occurred, is occurring, or will occur, please report it immediately through any of the following:

- Contact VNSNY CHOICE Compliance via email at CHOICECompliance@vnsny.org
- Call the Compliance Hotline at the telephone number listed in Section 1 of this provider manual
- Send a written report to the address listed in Section 1 of this provider manual

Please be assured that there will be no intimidation of, or retaliation against, anyone who in good faith raises a compliance issues. All reported compliance issues will be investigated. You may raise the issue anonymously if you wish.
Submitting False Claims

VNSNY prohibits the knowing submission of a false claim for payment from a Federally or State funded health care program. Such a submission is a violation of Federal and State law and can result in significant administrative and civil penalties under the Federal False Claims Act, a Federal statute that allows private citizens to help reduce fraud against the United States government. In addition, in New York State the submission of a false claim can result in civil and criminal penalties under portions of the New York Social Services Law and Penal Law.

What Can You Do to Promote a Culture of Compliance?

- Commit to “Doing the Right Thing”
- Obey the regulations and policies that apply to you
- Put the VNSNY CHOICE Code of Conduct in an accessible spot
- Lead by example
- If in doubt, check it out
- Attend training sessions
- Notify your supervisor of possible wrongdoings
- Communicate openly and honestly
- Ethics is part of all activities

Deficit Reduction Act of 2005

On February 8, 2006, the President signed into law the Deficit Reduction Act of 2005 (DRA 2005). Some of the savings that the government anticipates from the DRA 2005 will result from changes to federal health care programs, including changes designed to reduce fraud, waste and abuse. Certain provisions in the DRA 2005 reflect congressional desire to enlist States’ and employers’ help in combating fraud, waste and abuse in the Medicaid program. The DRA introduced incentives for the States to enact False Claims Act statutes and established compliance program and educational requirements for health care entities that receive $5 million or more annually in Medicaid reimbursement or payments (including VNSNY CHOICE). Because compliance with the DRA provisions is a condition of payment, entities that do not update their compliance policies and educational materials risk otherwise qualified reimbursement and potential False Claims Act liability.

Specifically, Section 6032 of DRA 2005 provides that, effective January 1, 2007, any entity that makes or receives at least $5 million in annual payments under a State Medicaid program must undertake certain measures. These measures include:

a. Establishing written policies for all of their employees that furnish information on the federal False Claims Act, federal administrative remedies under that act, applicable State false claims acts, and whistleblower protections under these laws;

b. Including provisions as part of those policies in the entity's policies and procedures for detecting and preventing fraud, abuse, and waste; and

c. Including in employee handbooks and provider handbooks a specific discussion of these various laws, the rights of employees to be protected as whistleblowers, and the entity's policies for detection and prevention of fraud, abuse, and waste.
Section 11: Quality Management

Federal False Claims Act

The False Claims Act (FCA) permits any person who discovers a fraud on federal government to report it through the law’s specialized procedures. If the government collects from the fraudulent contractor, it permits the whistleblower to share in the proceeds. http://www.usdoj.gov/opa/pr/2002/December/02_civ_720.htm. The FCA is the major law utilized to “ferret out fraud against the federal government.” It was enacted during the Civil War to “control fraud” in federal contracts” and was subsequently amended in 1986 to encourage whistleblower protection.

The law contains two sections highly relevant to whistleblowers. The first is a qui tam provision which permits private citizens and “original sources” (i.e. whistleblowers) to file suit on behalf of the United States to recover damages incurred by the federal government as a result of contractor fraud or other false claims. In return for filing the suit, the whistleblower is entitled to a significant portion of the proceeds, should they prevail. The whistleblower can obtain a large monetary award if he or she follows the “complex” procedures set forth in the FCA when seeking to enforce the anti-fraud law.

The second section contains an anti-retaliation provision that prohibits the discharge or harassment of a whistleblower who makes FCA-protected disclosures or files a qui tam suit. The anti-retaliation section permits the whistleblower to file a wrongful discharge suit for double back pay and other damages. The anti-retaliation provision was modeled after other whistleblower laws and operates under the basic principles underlying employment discrimination cases.

Risk Management Program

The Risk Management Process is concerned with reducing, preventing, and eliminating situations that could lead to member risk and/or financial loss. The Risk Management Program is an ongoing, integral component of the Quality Assessment & Improvement Program. It is designed to identify and resolve potential and/or actual administrative, clinical and service related risk issues of the organization.

Issues that have the potential to cause immediate and/or significant adverse health outcomes(s) may be referred to the Medical Director for review. The Chief Medical Officer or designee, using an educational approach, will collaborate with the provider to develop and document a Corrective Action Plan (CAP) addressing the areas of concern for the provider to implement.

Clinical issues that result in individual provider monitoring will also be considered during re-credentialing. Providers who are noncompliant with required corrective action(s) may be subject to further action(s). A decision to suspend or terminate a VNS participating provider is subject to approval by the Quality Improvement Committee of the Plan. If the provider is suspended or terminated, he or she has the right to appeal the decision.
Overview and Scope

The objective of VNSNY CHOICE’s member Grievance and Appeals Process is to provide members with processes for resolving complaints. The concerns may relate to service, quality of care, benefits or any aspect of member satisfaction. VNSNY CHOICE manages complaints, grievances and reconsiderations (Appeals) in accordance with its policies and procedures, which are based on CMS and NYSDOH regulatory requirements. VNSNY CHOICE informs each member of the process and their right to file a complaint, grievance or appeal according to the plan-type regulatory requirements.

All participating providers must cooperate with VNSNY CHOICE in the administration of the Grievance and Appeals process.

All VNSNY CHOICE plans adhere to the following:

- Determinations of all clinical complaints involving clinical decisions are made by qualified clinical personnel.
- All complaints are handled confidentially. If requested, member anonymity is also ensured.
- VNSNY CHOICE will not retaliate nor take any discriminatory action against a member because he/she has filed a complaint.
- There will be no change in a member’s services because a complaint has been filed.
- The member is informed of the toll-free number to call in order to file a complaint and of their right to complain to the appropriate regulatory agency.
- VNSNY CHOICE will give our members any help that is needed to file a complaint. This includes interpreter services or help for those with a vision and/or hearing problem.
- Members may call Member Services and speak to a Member Services Representative to file a complaint. After hours, they member may leave a message that will be responded to no later than the next business day. The Member Services Representative is available to assist in filing complaints as necessary.

Please refer to the following subsections for an explanation of the Grievance and Appeals process for providers of all VNSNY CHOICE Medicare Advantage Plans, VNSNY CHOICE SelectHealths and VNSNY CHOICE Managed Long Term Care.
Members enrolled in one of the VNSNY CHOICE Medicare Advantage plans have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “Grievances” are the two different types of complaints.

- An “Appeal” is the type of complaint a member makes when the member wants VNSNY CHOICE to reconsider and change an initial decision (by VNSNY CHOICE or a PCP) about what services are medically necessary or are covered services.

- A “Grievance” is the type of complaint a member makes regarding any other type of problem with VNSNY CHOICE or a participating provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating provider’s facilities are grievances.

**Prospective Coverage Decisions**

**Standard Decisions**

VNSNY CHOICE will make decisions regarding authorization of care that a member has not yet received within 14 days of a request.

** Expedited Decisions**

In the event that the standard 14-day time frame would seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, VNSNY CHOICE will issue an expedited decision within 72 hours of a request for an expedited decision. The member or a participating physician can request an expedited decision if the member or the member’s physician believes that waiting for a standard decision could seriously harm the member’s health or ability to function.

If a participating physician asserts in writing that this standard is met, VNSNY CHOICE will issue an expedited decision within 72 hours of the request. If the member makes a request for an expedited decision without the support of his or her treating physician, VNSNY CHOICE will, in its sole discretion, determine whether the standard has been met for an expedited decision.

**Retrospective Coverage Decisions**

VNSNY CHOICE will make decisions regarding payment for care that members have already received within 30 days.

If VNSNY CHOICE does not make a decision within the timeframe and does not notify the member regarding why the timeframe must be extended, the member can treat the failure to respond as a denial and may appeal, as set forth below.
Section 12a: Grievance and Appeals  
VNSNY CHOICE Medicare Advantage Plans

Participating Provider Obligations

Organization Determinations

At each patient encounter with a VNSNY CHOICE member, the participating provider must notify the member of his or her right to receive, upon request, a detailed written notice from VNSNY CHOICE regarding the member’s services. The participating provider’s notification must provide the member with the information necessary to contact VNSNY CHOICE and must comply with any other requirements specified by CMS. If a member requests VNSNY CHOICE to provide a detailed notice of a participating provider’s decision to deny a service in whole or part, VNSNY CHOICE must give the member a written notice of the determination.

Appeals

Participating providers must also cooperate with VNSNY CHOICE and members in providing necessary information to resolve appeals within the required time frames. Participating providers must provide the pertinent medical records and any other relevant information. In some instances, participating providers must provide the records and information on an expedited basis (no more than 48 hours, including weekends and holidays) in order to allow VNSNY CHOICE to make an expedited decision.

Please refer to Section 1 of this provider manual for Appeals and Grievance contact information.

Medicare Appeal Levels

Members have several levels of appeal rights, both internally and externally. Below is a list of the appeal levels that a member has a right to:

- Appeal initial decision by VNSNY CHOICE.
- Review by an Independent Review Organization.
- Review by an Administrative Law Judge. The dollar value of the contested benefit must be consistent with the threshold established by CMS.
- Review by a Medicare Appeals Court.
- Federal Court. The dollar value of the contested benefit must be consistent with the threshold established by CMS.
- A member may request an expedited review and ask for the participating provider’s support in requesting an expedited review.

Part D Exception Requests

A member may request an exception to a coverage rule regarding prescribed medications not covered in our formulary. A statement by the physician must support the exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request (please see “Exception Request Form” located in Appendix B).
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SNF/HHA/CORF Provider Service Terminations - Medicare

VNSNY CHOICE would like to advise you of some important changes that have taken place with respect to the appeals process and delivery of the notification of termination of covered services. As a VNSNY CHOICE provider, some of these changes will affect you and your practice directly.

As part of a settlement agreement between CMS and Medicare beneficiaries, the federal rules governing Medicare appeals were revised for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) providers. Pursuant to 42 CFR Section 422.624, the provider of services is responsible for delivering the Notice of Medicare Non-Coverage to Medicare managed care members prior to the cessation of services, regardless of the reason for cessation. The delivery must be made to the managed care member two (2) days prior to the termination of the covered services and will not be considered valid until the patient signs and dates the notice. If the member is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the member's legal authorized representative. If no authorized representative has been appointed, then the facility should seek the requested signature from the caregiver on record (i.e. the family member involved in the plan of treatment). Although the caregiver is not a legal authorized representative, he/she has assumed responsibility for the member's medical treatment. If the member has no legal authorized representative or caregiver on record, then the facility should annotate the notice and sign on behalf of the member.

Request of Immediate Quality Improvement Organization (QIO) Review (QIO Appeal) of SNF/HHA/CORF Provider Service Terminations

A member receiving provider services in a SNF, HHA or CORF who wishes to appeal a VNSNY CHOICE decision to terminate such services because care is no longer necessary must request an immediate QIO review of the determination in accordance with CMS requirements.

When to Issue Detailed Explanation of Non-Coverage (DENC)

Once the QIO receives an appeal, it must issue a notice to VNSNY CHOICE that a member appealed the termination of services in SNF/HHA/CORF settings. Upon receipt of this notice, VNSNY CHOICE is responsible for issuing the DENC, a written notice that is designed to provide specific information to Medicare members regarding the end of their SNF, HHA or CORF care is ending.

VNSNY CHOICE must issue a DENC to both the QIO and the member no later than the close of business when the QIO notifies VNSNY CHOICE that a member has requested an appeal.

VNSNY CHOICE is also responsible for providing any pertinent medical records used to make the termination decision to the QIO, although the QIO will seek pertinent records from both the provider and VNSNY CHOICE.
Immediate QIO Review Process of SNF/HHA/CORF Provider Service Terminations

On the date that the QIO receives the member’s request, the QIO must notify VNSNY CHOICE and the provider that the member has filed a request for immediate review. The SNF/HHA/CORF must supply a copy of the Notice of Medicare Non-Coverage and any other information that the QIO requires to conduct its review. The information must be made available by phone, fax or in writing by the close of the business day of the appeal request date.

VNSNY CHOICE must supply a copy of the “Notice of Medicare Non-Coverage”, DENC and any medical information that the QIO requires to conduct its review. The information must be made available by phone, fax or in writing by the close of the business day that the QIO notifies VNSNY CHOICE of an appeal. If a member requests an appeal on the same day the member receives the “Notice of Medicare Non-Coverage”, then VNSNY CHOICE has until close of business the following day to submit the case file.

The QIO must solicit the views of the member who requested the immediate QIO review. The QIO must make an official determination of whether continued provider services are medically necessary, and notify the member, the provider, and VNSNY CHOICE by the close of the business day after it receives all necessary information from the SNF/HHA/CORF, VNSNY CHOICE or both. If the QIO does not receive the information it needs to sustain the VNSNY CHOICE decision to terminate services, then the QIO may make a decision based on the information at hand, or it may defer its decision until it receives additional required information. If the QIO defers its decision, then coverage of the services by VNSNY CHOICE will continue and the QIO will refer violations of notice delivery to the CMS regional office.

A member should not incur financial liability if, upon receipt of the “Notice of Medicare Non-Coverage”:

- The member submits a timely request for immediate review to the QIO that has an agreement with the provider;
- The request is made either in writing, by telephone or by fax, by noon (12 p.m.) of the next day after receiving the notice; and
- The QIO either reverses the VNSNY CHOICE termination decision or the member stops receiving care no later than the date that the member receives the QIO’s decision. The member will incur one (1) day of financial liability if the QIO upholds the VNSNY CHOICE termination decision and the member continues to receive services until the day after the QIO’s decision. This should be the same date as the VNSNY CHOICE initial decision to terminate services.

A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration/appeal with VNSNY CHOICE. VNSNY CHOICE will expedite the request for an expedited reconsideration/appeal if the QIO receives a request for an immediate QIO review beyond the noon (12 p.m.) filing deadline and forwards that request to VNSNY CHOICE. VNSNY CHOICE would generally make an expedited decision about the services within seventy-two (72) hours. Financial liability applies in both the immediate QIO review and VNSNY CHOICE expedited review situations.
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Where VNSNY CHOICE has authorized coverage of the inpatient hospital admission of a Medicare member, either directly or by delegation (or the admission constitutes an emergency or urgently needed care), VNSNY CHOICE is required to issue the member a written notice of non-coverage only under the circumstances described below.

Hospital Discharge Notification Process

Hospitals must notify Medicare enrollees who are hospital inpatients about their in-patient hospital discharge appeal rights. Hospitals use ‘An Important Message from Medicare About Your Rights’ (IM) a statutorily-required notice, to explain the enrollee’s rights as a hospital in-patient, including discharge appeal rights. Hospitals must issue the IM (see Appendix A) up to 7 days before admission, or within 2 calendar days of admission, must obtain the signature on the form and provide the member with a copy of the signed notice. Hospitals may also need to deliver a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

Hospitals must follow the procedures listed below in delivering the IM. Valid notice consists of the “Use of Standardized Notice”. Hospitals must use the standardized form (CMS-R-193), dated 05/07. The notices are also available on www.cms.hhs.gov/bni at the Link for Hospital Discharge Appeal Notices. Hospitals may not deviate from the content of the form except where indicated. The OMB control number must be displayed on the notice.

Delivery Timeframe: If the IM is not given prior to admission, hospitals must deliver the IM to the enrollee at or near admission, but no later than 2 calendar days following the date of the enrollee’s admission to the hospital as an in-patient (The hospital may deliver the IM within seven days of admission but only in those cases where an enrollee has a scheduled inpatient visit, such as elective surgery). Hospitals may not deliver the IM to an enrollee who is in an outpatient or observation setting on the chance that the patient may end up receiving inpatient care.

In-Person Delivery: The IM must be delivered to the enrollee in person. However, if the enrollee is not able to comprehend the notice, it must be delivered to and signed by the enrollee’s representative.

Notice Delivery to Representatives: CMS requires that notification of an enrollee who is not competent be made to a representative of the enrollee. A representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary’s behalf (e.g., the enrollee’s legal guardian, or someone appointed in accordance with a properly executed “durable medical power of attorney”).

Otherwise, a person (typically, a family member or close friend) whom the enrollee has indicated may act for him or her, but who has not been named in any legally binding document may be a representative for the purpose of receiving the notices described in this section. Such representatives should have the enrollee’s best interests at heart and must act in a manner that is protective of the enrollee and the enrollee’s rights. Therefore, a representative should have no relevant conflict of interest.
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Regardless of the competency of an enrollee, if the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him or her of the enrollee’s rights as a hospital in-patient, including the right to appeal a discharge decision.

When direct phone contact cannot be made, the hospital should send the notice to the representative by certified mail, return receipt requested or any method in which delivery may be tracked and verified (e.g., UPS, FedEx, etc). The date that someone at the representative’s address signs (or refuses to sign) the receipt is the date received. The hospital should place a copy of the notice in the enrollee’s medical file, and document the attempted telephone contact with the member’s representative. The documentation should include: the name of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called. If both the hospital and the representative agree, hospitals may send the notice by fax or e-mail. However, hospitals must meet the HIPAA privacy and security requirements when transmitting the IM by e-mail or fax.

Ensuring Enrollee Comprehension: Notices should not be delivered during an emergency. Hospitals must make every effort to ensure the enrollee comprehends the contents of the notice before obtaining the enrollee’s signature. This includes explaining the notice to the enrollee if necessary and providing an opportunity for the enrollee to ask questions. The hospital should answer all the enrollee’s questions orally to the best of its ability. The enrollee should be able to understand that he or she may appeal a discharge decision without financial risk, but may have to pay for any services received after the discharge date if he or she stays in the hospital and does not appeal.

These instructions do not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee is able to comprehend the notice, but either is physically unable to sign it or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting use of such assistance.

Enrollee Signature and Date: (Unless an appropriate reason for the lack of signature is recorded on the IM.) The IM must be signed and dated by the enrollee to indicate that he or she received the notice and understands its contents.

If a member disputes (appeals) the discharge and contacts the Quality Improvement Organization (QIO) for an immediate review, VNSNY CHOICE will complete and fax the “Detailed Notice of Discharge” (DND) to the hospital administrator or nursing director on duty (the member’s medical record must be faxed to VNSNY CHOICE by 4 p.m. that day). The hospital must deliver a copy of the DND to the member. The hospital may not create its own DND and deliver it to the member without VNSNY CHOICE’s approval. VNSNY CHOICE will also fax a copy of the DND to the QIO for review and/or an expedited reconsideration. The QIO and/or VNSNY CHOICE will work with the hospital and attending physician to determine if discharge is appropriate.

If an appeal occurs during a weekend, a VNSNY CHOICE Manager or Director will contact the nursing office or hospital administrator on duty to facilitate the delivery of the “Detailed Notice of Discharge”.

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Template documents to be used for this new process are available on the CMS web site at http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage.

Requesting Immediate Quality Improvement Organization (QIO) Review of Inpatient Hospital Care

A member remaining in the hospital who wishes to appeal the VNSNY CHOICE discharge decision that inpatient care is no longer necessary must request an immediate QIO review of the determination in accordance with CMS requirements. A member will not incur any additional financial liability if he/she:

- Remains in the hospital as an inpatient;
- Submits the request for immediate review to the QIO that has an agreement with the hospital;
- Makes the request either in writing, by telephone or fax; and
- Makes the request before the end of the day of discharge.

Notification to Members of Non-Coverage of Inpatient Hospital Care

The following rules apply to the immediate QIO review process:

- On the date that the QIO receives the member's request, the QIO must notify VNSNY CHOICE that the member has filed a request for immediate review;
- VNSNY CHOICE and/or the hospital must supply any information that the QIO requires to conduct its review. This must be made available by phone, fax or in writing by the close of business of the first full working day immediately following the day the member submits the request for review;
- In response to a request from VNSNY CHOICE, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day VNSNY CHOICE makes its request;
- The QIO must solicit the views of the member who requested the immediate QIO review; and
- The QIO must make an official determination of whether continued hospitalization is medically necessary, and notify the member, the hospital, and VNSNY CHOICE by close of business of the first working day after it receives all necessary information from the hospital, VNSNY CHOICE, or both.

- A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration with VNSNY CHOICE. VNSNY CHOICE is encouraged to expedite the request for an expedited reconsideration. Likewise, if the QIO receives a request for immediate QIO review beyond the noon (12 p.m.) filing deadline and forwards that request to VNSNY CHOICE. Thus, VNSNY CHOICE would generally make an expedited decision about the services within seventy-two (72) hours. However, the financial liability rules governing immediate QIO review do not apply in an expedited review situation.
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Liability for Hospital Costs

The presence of a timely appeal for an immediate QIO review as filed by the member in accordance with this section entitles the member to automatic financial protection by VNSNY CHOICE. This means that if VNSNY CHOICE authorizes coverage of the inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, VNSNY CHOICE continues to be financially responsible for the costs of the hospital stay until noon (12 p.m.) of the calendar day following the day the QIO notifies the member of its review determination.

Dual Eligible Members Only

Members enrolled in the VNSNY CHOICE Medicare Advantage and Medicaid Advantage or Managed Long Term Care Plans have different options when filing an appeal for services covered under the benefit package. For VNSNY CHOICE services funded by the State contract, members must follow Medicaid appeal rules. For services funded through the Medicaid program, members must follow Medicare appeal rules. For services covered by both Medicaid and Medicare funding, members can follow either Medicaid or Medicare rules. If a member chooses to pursue Medicaid appeal rules to challenge an organization determination or action, he/she has sixty (60) calendar days from the date on the “Notice of Denial of Coverage” issued by VNSNY CHOICE to pursue Medicare appeal, regardless of the status of the Medicaid appeal. However, if a member chooses to pursue Medicare rules, they may not file an appeal under Medicaid rules. VNSNY CHOICE determines whether Medicaid, Medicare, or both cover a particular service.

Additional Information on Appeals and Grievances

For more information on Member Rights for submitting Complaints, Grievances and Appeals please see our Evidence of Coverage or Member Handbook, which is available online at www.vnsnychoice.org. You can also call the Appeals and Grievances telephone number listed in Section 1 of this provider manual.
Section 12b: Grievance and Appeals
VNSNY CHOICE SelectHealth

The objective of the VNSNY CHOICE SelectHealth’s member Grievance and Appeals Process is to provide members with formal and informal processes for resolving complaints, both genuine and perceived concerns. The concerns may relate to service, quality of care, benefits or any aspects of member satisfaction.

The Complaint Process

Complaints

A Complaint is defined as a written or verbal contact to VNSNY CHOICE in which the member, his/her designee, or a provider on behalf of a member with his/her consent, describes a concern with any aspect of his or her care other than an Action (defined below under the “Action” section):

- A determination made by VNSNY CHOICE, other than a determination of medical necessity or a determination that a service is considered experimental or investigational,
- Treatment experienced through VNSNY CHOICE, its providers or contractors,
- Any other concern with VNSNY CHOICE, its benefits, employees or providers, or
- Anytime VNSNY CHOICE denies access to a referral, denies or reduces benefits or services or determines that a requested benefit is not covered by the VNSNY CHOICE benefits package.

If VNSNY CHOICE immediately resolves a verbal Complaint to the member’s satisfaction, that complaint is considered resolved without any additional written notification to the member.

VNSNY CHOICE provides written acknowledgement of the Complaint including the name of the person working on the complaint, how to contact this person, and if more information is needed in order for a determination to be made, within 15 days of receipt of the Complaint (except in cases of imminent health risk).

Complaints are resolved whenever a delay would significantly increase the risk to a member’s health within forty-eight (48) hours after receipt of all necessary information and no more than seven (7) days from receipt of the Complaint (expedited).

All other Complaints are resolved within 45 days after the receipt of all necessary information and no more than 60 days from receipt of the Complaint.

Determinations by VNSNY CHOICE are made in writing to the member or his/her designee. The determination includes:

- The detailed reasons for the determination
- The clinical rationale for the determination, if applicable
- The procedures for filing an appeal of the determination (a Complaint Appeal)
- The member’s option to also contact the New York State Department of Health at 1 (800) 206-8125 with their complaint
- The notice containing fair hearing rights.
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If VNSNY CHOICE is unable to make a Complaint determination because insufficient information was presented or available to reach a determination, VNSNY CHOICE sends a written statement that a determination could not be made to the member on the date the allowed time for resolution has expired.

In cases where delay would significantly increase the risk to an enrollee’s health, VNSNY CHOICE provides a notice of determination by telephone directly to the member, or to the member’s designee, with written notice to follow within three business days.

Complaint Appeals

If the member is not satisfied with the decision we make concerning a Complaint, a second review of the issue can be requested by filing a Complaint Appeal. As with the original Complaint, a provider may request a Complaint Appeal on behalf of the VNSNY CHOICE member, with his/her consent. All Complaint Appeals must be filed in writing and must be filed within 60 business days of receipt of our initial decision about the Complaint.

- Within 15 business days of receipt of the Complaint Appeal, VNSNY CHOICE provides written acknowledgement of the appeal including the name, address and telephone number of the individual designated to respond to the appeal. VNSNY CHOICE indicates what additional information, if any, must be provided for VNSNY CHOICE to render a decision.
- Complaint Appeals of a clinical matter are decided by personnel qualified to review the appeal including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom will be a clinical peer reviewer. The clinical peer reviewer is a physician or other healthcare provider who typically manages the medical condition, procedure or treatment under review.
- Complaint Appeals of non-clinical matters are determined by qualified personnel at a higher level than the personnel who made the original complaint determination.
- Complaint Appeals are decided and notification provided to the member no more than:
  - One (1) business day after the receipt of all necessary information when a delay would significantly increase the risk to a member’s health (expedited appeal)
  - Thirty (30) business days after the receipt of all necessary information in all other instances (standard appeal).
- The notice of appeal determination includes:
  - The detailed reasons for the determination;
  - The clinical rationale for the determination in cases where the determination has a clinical basis;
  - Information notifying the member of his/her option to also contact the New
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York State Department of Health at 1 (800) 206-8125 with his/her complaint. In New York City, members may call New York Medicaid Choice at (800) 505-5678. The member can also write to the NYS Department of Health, Bureau of Managed Care Certification and Surveillance, ESP Corning Tower Room 1911, Albany, NY 12237.

- Instructions for any further Appeal, if applicable.

Actions

An Action is an activity of VNSNY CHOICE that results in:

- the denial or limited authorization of a service authorization request, including the type or level of service;
- the reduction, suspension, or termination of a previously authorized service;
- the denial, in whole or in part, of payment for a service;
- failure to provide services in a timely manner as defined by State law and regulation; or
- failure to act within the timeframes for resolution and notification of determinations regarding Complaints, Action Appeals and Complaint Appeals.

Action Appeals

An Action Appeal is any appeal of an Action. If a member, or his or her designee, is not satisfied with an action taken by VNSNY CHOICE, an Action Appeal may be filed within 90 calendar days after receiving notice of the Action. A member may file an Action Appeal in writing or by telephone at the address and telephone number provided in Section 1 of this provider manual. Oral Action Appeals must be followed by a written, signed Action Appeal.

An Action Appeal will be reviewed under an expedited process if:

- A member or the member’s physician requests an expedited review, and the physician explains how a delay will cause harm to a member’s health; or
- If a member’s request was denied when the member requested that he or she continue receiving care that the member is currently getting, or needs to extend a service that has been provided; or
- If member’s request was denied when the member asked for home health care after being in the hospital.

Expedited Action Appeals can be requested by phone and do not have to be followed up in writing.
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VNSNY CHOICE SelectHealth

What happens after we get an Action Appeal?

- Within 15 days, we will send the member a letter to let him/her know we are working on their appeal.
- Action Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- A member can also provide information to be used in making the decision in person or in writing.
- Members will be provided explanation for our decision and our clinical rationale, if it applies. If members are still not satisfied, any further appeal rights will be explained to them.

Timeframes for Action Appeals

**Standard appeals:** If we have all the information we need, we will tell the member our decision within thirty (30) days from the appeal. A written notice of our decision will be sent within two (2) business days from when we make the decision.

**Expedited appeals:** If we have all the information we need, fast track appeal decisions will be made in two (2) business days from the appeal. We will tell the member in three (3) business days after receipt of the appeal if we need more information. We will tell the member our decision by phone and send a written notice later.

Timeframes for Action Appeal resolution may be extended for up to fourteen (14) days if: (1) the member, his or her designee, or the provider requests an extension orally or in writing; or (2) we can demonstrate or substantiate that there is a need for additional information and the extension is in the member’s interest. We must send notice of the extension to the member.

**Right to an External Appeal**

A VNSNY CHOICE SelectHealth member, his/her designee or, in connection with retrospective or concurrent adverse determinations, the member’s health care provider, are eligible to request an external review under the following conditions:

- When the member has had coverage of a health care service, which would otherwise be a covered benefit denied on appeal on the grounds that such health service is not medically necessary, and
- VNSNY CHOICE has rendered a final adverse determination with respect to such health care service or both VNSNY CHOICE and the member have jointly agreed to waive any internal appeal; or

The member has had coverage of a health care service denied on the basis that such service is in VNSNY CHOICE’s benefit package or be experimental or investigational treatment, clinical trial or treatment for rare disease, and such denial has been upheld on
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appeal or both VNSNY CHOICE and the member have jointly agreed to waive any internal appeal, and

- the member’s attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard health service or procedure covered by VNSNY CHOICE, or (c) for which there exists a clinical trial or rare disease treatment and

- the member’s attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member’s life threatening or disabling condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of experimental or investigational) that, based on two (2) documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. Any physician certification provided must include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

- the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for VNSNY CHOICE’s determination that the health service or procedure is experimental or investigational.

Providers appealing on their own behalf have 45 calendar days of the date of the notice of final adverse determination.

Fair Hearings

Members have the right under certain circumstances to request a Fair Hearing to have a State Administrative Law Judge review matters related to VNSNY CHOICE:

- Members may access the fair hearing process in accordance with applicable federal and state laws and regulations.
- Members may request a fair hearing concerning adverse local Department of Social Services determinations concerning enrollment, disenrollment and eligibility, and regarding the termination, suspension or reduction of a clinical treatment or other benefit package service by VNSNY CHOICE.
- For issues related to disputed services, members must have received an adverse determination from VNSNY CHOICE.
- A member may also seek a fair hearing for a failure by VNSNY CHOICE to comply with the timeframes established for review of complaints, appeals and utilization management determinations.

Aid Continuing

Members have a right for services to continue and may request “aid continuing” in some situations while an appeal or fair hearing is pending. The member may be required to repay VNSNY CHOICE for the cost of services rendered if the appeal or fair hearing decision is adverse to the member.
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VNSNY CHOICE Managed Long Term Care

As a Medicaid Managed Long Term Care plan, VNSNY CHOICE is obligated to provide services in compliance with all applicable state and federal requirements, as they apply to the scope of covered services, the authorization of services, utilization review (including decisions to deny or limit the services that are provided to specific members), and grievances. VNSNY CHOICE will try its best to address its members’ concerns or issues as quickly as possible and to their satisfaction, and all members are informed of the ways to access our grievance and appeal process.

The Grievance Process

A grievance can be filed either orally or in writing. The person who receives a grievance will record it, and appropriate plan staff will oversee the review of the grievance. We will send the member a letter confirming that we received his or her grievance and a description of our review process. If a grievance is filed by a provider on behalf of a member, we will review the grievance and give the member and you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to the member’s health, we will decide within 48 hours after receipt of necessary information.
2. For all other types of grievances, we will notify the member and you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance. The review period can be increased up to 14 days if you or the member requests it or if we need more information and the delay is in the member’s interest.

Our answer will describe what we found when we reviewed the grievance and our decision about your grievance.

1. Grievances may be voiced directly to the provider or made to VNSNY CHOICE staff. VNSNY CHOICE is committed to resolving all member complaints at the lowest level possible and in the most expeditious manner to identify potential areas for improvement of program services. Each member has the right to complain when he/she is dissatisfied with the services provider.
2. VNSNY CHOICE MLTC providers are required to report all member complaints within 24 hours of notification. Reports can be telephoned to Member Services.
3. Providers are expected to report, investigate and resolve all member complaints and grievances as outlined in the agreement between VNSNY CHOICE and the provider (see Contract Schedule A-2 “Complaint and Grievance Procedures”).
4. If quality trends are noted, the Account Manager may arrange to meet with the provider and regional staff representatives to discuss the complaints and provide orientation and ongoing education regarding VNSNY CHOICE procedures.
5. Excessive rates of complaints or evidence that the provider is not improving performance could result in termination of the contract.

Appealing a Grievance Decision

If the member is not satisfied with the decision we make concerning the grievance, a second review of the issue can be requested by filing a grievance appeal. As with the original
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grievance, a provider may request an appeal on behalf of the VNSNY CHOICE member, with
his/her consent. All appeals must be filed in writing and must be filed within 60 business days
of receipt of our initial decision about the grievance.

Once we receive the appeal, we will send the member and you a written acknowledgement
telling you the name, address and telephone number of the individual we have designated to
respond to the appeal. All grievance appeals will be conducted by appropriate professionals,
including health care professionals for grievances involving clinical matters. Also, all grievance
appeals will be conducted by individuals who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within 30 business days after we
receive all necessary information to make our decision. If a delay in making our decision would
significantly increase the risk to the member’s health, we will use the expedited grievance
appeal process. For expedited grievance appeals, we will make our appeal decision within 2
business days of receipt of the necessary information. For both standard and expedited
grievance appeals filed by a provider, we will provide the member and you with written notice
of our decision. The notice will include the detailed reasons for our decision and, in cases
involving clinical matters, the clinical rationale for our decision.

Actions

When VNSNY CHOICE does one of the following, these decisions are considered plan
“actions:”

• Denies or limits services requested by a member or his/her provider;
• Denies a request for a referral;
• Decides that a requested service is not a covered benefit;
• Reduces, suspends or terminates services that we already authorized;
• Denies payment for services;
• Doesn’t provide timely services; or
• Doesn’t make grievance or appeal determinations within the required timeframes.

An action is subject to appeal. (See “Filing an Appeal of an Action?” below for more
information.)

Timing of Notice of Action

If we decide to deny or limit services that a provider requested or decide not to pay for all or
part of a covered service, we will send the member and provider a notice when we make our
decision. If we are proposing to reduce, suspend or terminate a service that is authorized, our
letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to a member and provider about an action will:

• Explain the action we have taken or intend to take;
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- Cite the reasons for the action, including the clinical rationale, if any;
- Describe the member’s and provider’s right to file an appeal with us (including whether the member may also have a right to the State’s external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by the member or provider in order for us to render a decision on appeal.

If we are reducing, suspending or terminating an authorized service, the notice will also inform the member about his/her right to have services continue while we decide on the appeal and how to request that services be continued. The notice also informs members that if the initial action is not overturned on appeal, the member could be responsible for payment for these services if they are continued while we were reviewing the appeal.

Filing an Appeal of a Action

If the member or provider does not agree with an action that we have taken, the member or provider may appeal. When you file an appeal on behalf of a member, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. Any appeal request must be filed within 45 calendar days of the date on our letter notifying you of the action. If you call us to file your request for an appeal, you must also send a written request unless you ask for an expedited review.

For Some Actions, The Member May Request to Continue Services During the Appeal Process

If the appeal concerns a reduction, suspension or termination of services that the member is currently authorized to receive, the member may request that these services continue while we are deciding the appeal. We must continue the service or services if the member makes a request to us no later than 10 days from our mailing of the notice about our intent to reduce, suspend or terminate services, or by the intended effective date of our action, as long as the original period covered by the service authorization has not expired. The member’s services will continue until the appeal is withdrawn, or until the original authorization period for services has been met, or until 10 days after we mail the notice about our appeal decision, if our decision is not in the member’s favor, unless the member has requested a New York State Medicaid Fair Hearing with continuation of services. (See “If the Plan Denies An Appeal, What Can the Member Do” section below.)

Although the member may request a continuation of services while an appeal is under review, if the appeal is not decided in the member’s favor, the member may be required to pay for these services if they were provided only because he/she continued to receive them while your appeal was being reviewed.
How Long Will it Take the Plan to Decide An Appeal of an Action?

Unless the member or provider asks for an expedited review, we will review the appeal of the action taken by us as a standard appeal and send the member and provider a written decision as quickly as the member’s health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if the member requests an extension or we need more information and the delay is in the member’s interest.) During our review you will have a chance to present your case in person and in writing. For appeals made by a provider, we will send the member and you a notice about the decision we made about the appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while the appeal was pending, we will provide the member with the disputed services as quickly as his/her health condition requires.

Expedit ed Appeal Process

If the member or provider feels that taking the time for a standard appeal of an action could result in a serious problem to the member’s health or life, the member or provider may ask for an expedited review of the appeal of the action. We will respond to both the member and provider with our decision as quickly as possible after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days after we receive the appeal. (The review period can be increased up to 14 days if the member or provider requests an extension or we need more information and the delay is in the member’s interest.)

If we do not agree with the request to expedite the appeal, we will make our best efforts to contact the member in person to let him or her know that we have denied the request for an expedited appeal and will handle it as a standard appeal. Also, we will send the member and provider a written notice of our decision to deny the request for an expedited appeal within 2 days of receiving it.

If the Plan Denies An Appeal, What Can the Member Do?

If our decision about an appeal is not totally in the member’s favor, the notice that the member receives will explain his/her right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing. In addition, if we deny the appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice to the member will also explain how he/she can ask New York State for an “external appeal” of our decision.

New York State Medicaid Fair Hearing

New York has elected to require that a member exhaust the MLTC plan’s internal appeal process before a member may request a New York State Medicaid Fair Fair Hearing. A member may request a Fair Hearing within 60 days of the date we sent the notice about our decision on your appeal. In addition, if the appeal involved the reduction, suspension or termination of authorized services that the member is currently receiving, the member may also request to
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continue to receive these services while waiting for the Fair Hearing decision. If this occurs, the member’s services will continue until the appeal is withdrawn; or until the original authorization period for services ends; or the State Fair Hearing Officer issues a hearing decision that is not in the member’s favor, whichever occurs first.

If the State Fair Hearing Officer reverses the decision of VNSNY CHOICE, we must make sure that the member receives the disputed services promptly, and as soon as his/her health condition requires. If the fair hearing is not decided in the member’s favor, he/she may be responsible for paying for the services that were the subject of the Fair Hearing.

State External Appeals

If VNSNY CHOICE denies a member appeal because we determine the service is not medically necessary or is experimental or investigational, the member may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for VNSNY CHOICE or New York State. The reviewers are qualified people approved by New York State.

When VNSNY CHOICE makes a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide the member with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If the member wants an external appeal, the member must file the form with the New York State Department of Insurance within 45 days from the date we denied the appeal.

The member’s external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will inform the member and VNSNY CHOICE of the final decision within two business days after the decision is made.

A member can get a faster decision if his or her doctor says that a delay will cause serious harm to the member’s health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell the member and VNS CHOICE the decision right away by phone or fax. Later, a letter will be sent that informs the member of the decision.

The member may request both a Fair Hearing and an external appeal. If the member asks for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer is the decision that counts.

Service Issues

A service issue is a disruption in service that creates an inconvenience but does not pose an immediate threat to a member’s health and well-being. Service issues impact on VNSNY CHOICE’s ability to provide high quality services to its members. Service issues can occur when services are not provided in a manner that is consistent with the agreed upon procedures.
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**Procedures for Reporting a Service Issue**

- Service issues are generally reported by the member, his/her family, or the Care Manager.
- All service issues are recorded by the Regional Member Services Representative and forwarded to the Provider Relations Department for monitoring purposes.
- When possible, the Member Services Representative will contact the provider to resolve the issue and ensure that services to the member are provided.
- The Account Manager in the Provider Relations Department reviews all service issues and addresses those that have not been resolved at the regional level with the provider.
- If quality trends are noted, the Account Manager may arrange to meet with the provider and Regional staff representatives to discuss service issues and provide orientation and ongoing education regarding VNSNY CHOICE procedures.
- Excessive rates of service issues or evidence that the provider is not improving its performance could result in termination of the contract.

Examples of service issues include:

1. **Adult Day Care**
   - Services specified by VNSNY CHOICE were not provided
   - Transportation ordered but not available
   - Unacceptable service quality (e.g. meal cold/unappetizing, facility unclean, etc.)
   - Staff rude/exhibits inappropriate behavior
   - Care Manager unable to access client records or program staff

2. **Chore Services**
   - Housekeeper fails to thoroughly clean the member’s home
   - Housekeeper fails to show up or shows up late
   - Housekeeper is rude

3. **Home Delivered Meals**
   - Meal is delivered late or not at all
   - Meal is delivered cold (unintentionally)
   - Meal is not delivered to the member’s door
   - Meal is not consistent with dietary orders
   - Meal does not meet the 1/3 Recommended Daily Dietary Allowance
   - Driver is rude

4. **Nursing Home**
   - Services specified by VNSNY CHOICE were not provided
   - Transportation ordered but not available
   - Unacceptable service quality (e.g. meal cold/unappetizing, facility unclean, etc.)
   - Staff rude/exhibits inappropriate behavior
   - Nurse unable to access client records on program staff
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5. Transportation
   - Driver late or did not show up
   - Refusal to provider transportation services
   - Driver rude/exhibits inappropriate behavior
   - Driver fails to assist member when needed
   - Vehicle breakdown

Incidents

An incident is any event related to member service which places a member, employee, or the agency at risk.

Procedures for Reporting an Incident

- A member may report an incident directly to the provider or to VNSNY CHOICE staff. VNSNY CHOICE is committed to the investigation of all member incidents in order to identify actual or potential harm to members as well as identify potential areas for improvement of program services.
- VNSNY CHOICE providers are required to report all member incidents immediately or within 24 hours of notification. Reports can be telephoned to the Provider Relations Department and/or Regional Office listed in Section 1 of this provider manual.
- Providers are expected to report and investigate all member incidents and provide VNSNY CHOICE with the findings of all incident investigations. A member of the VNSNY CHOICE Quality Management team will work with the provider to ensure that a systematic and objective review of all incidents is completed.
- If quality trends are noted, the Account Manager may arrange to meet with the provider and Regional staff representatives to discuss service issues and provide orientation and ongoing education regarding VNSNY CHOICE procedures.
- Incidents that are serious in nature or evidence that the provider is not improving its performance could result in termination of the contract.

Examples of Incidents include:

1. Adult Day Care
   - Member injuries (i.e. falls, burns, injuries related to program activities or procedures).
   - Medication error related to error in administration of a drug by staff nurse, adverse drug reaction (medical model programs only).
   - Vehicular accidents that occur while transporting members.
   - Member falls
   - Allegation of theft or damage to member's property while in the facility
   - Allegation of abuse of member

2. Chore Services
   - Member allegation of assault or other misconduct
   - Housekeeper sustains an injury while performing service
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- Member allegation of theft by housekeeper
- Member allegation of damage to property by housekeeper
- Member allegation of assault or other misconduct by housekeeper

3. Home Delivered Meals Service
- Member experiences symptoms of food poisoning after ingestion of meal
- Member allegation of theft/property damage by driver
- Member allegation of assault or other misconduct by driver

4. Nursing Home Incidents
- Member injuries (i.e. falls, burns, injuries related to use of equipment or medical devices, injuries related to medical or nursing procedures)
- Medication error related to error in administration of a drug by nursing home staff nurse, pharmacy error related to dispensing, adverse drug reaction (medical model programs only).
- Development of pressure ulcer while under care
- Failure to notify VNSNY CHOICE of member discharge to hospital
- Failure to notify VNSNY CHOICE of member unplanned discharge home that results in a potentially unsafe discharge (discharges against medical advice)
- Allegation of theft or damage to member's property while in the facility
- Allegation of abuse or member

5. Transportation Incidents
- Vehicular accidents that occur while transporting member
- Member falls while being transported
- Member sustains injury after leaving vehicle
- Member allegation of theft during transport
- Member allegation of assault or other misconduct
Section 13: Medical Management

VNSNY CHOICE seeks to improve the quality of care provided to its members. VNSNY CHOICE’s intention and purpose is to avoid delivery of unnecessary or duplicated health services before they are rendered.

To accomplish these objectives, Medical Management is closely allied with VNSNY CHOICE’s network providers in the planning, organization and delivery of quality health care services. Medical Management standards and policies are developed in consultation with participating providers. Participating providers are encouraged to work with VNSNY CHOICE in its efforts to promote healthy lifestyles through member education and information sharing. VNSNY CHOICE expects participating provider participation in health promotion and disease prevention program. VNSNY CHOICE seeks to accomplish the following objectives through its Medical Management program:

1. Promote high quality care and monitor the delivery of quality care
2. Identify priority areas for improvement
3. Deliver health care in a cost-efficient, effective and safe manner within the appropriate setting without compromising quality
4. Prevent stress and implement effective management of disease in performance improvement activities including education of the member.

Participating providers must comply and cooperate with all VNSNY CHOICE Medical Management policies, procedures and programs.

Please refer to the following subsections for specific information about the Medical Management program in our VNSNY CHOICE Medicare Advantage plans, VNSNY CHOICE SelectHealth and VNSNY CHOICE Managed Long Term Care plan.
Prior Authorization

Prior Authorization is the process by which VNSNY CHOICE’s Medical Management Department reviews your request for a patient to receive medically necessary inpatient or outpatient treatment at a hospital, ambulatory care facility, physician's office, or other healthcare setting for a range of procedures determined by VNSNY CHOICE to require prior authorization. Prior Authorization also allows VNSNY CHOICE to identify members for pre-service discharge planning and to register them in our specialized programs such as disease management or care management.

Please see Section 14 for a list of VNSNY CHOICE Medicare Advantage plan services that require Prior Authorization. You can also find this list on our website – www.vnsnychoice.org.

Process/Responsibility

1. The participating PCP or Specialist who will be providing the service to the member shall make requests for services requiring Prior Authorization. If the member is receiving care from a non-participating provider, it will be the responsibility of the member to obtain the necessary prior authorization.

2. Requests can be made by contacting the VNSNY CHOICE Medical Management Department in the following ways:

   • Telephone requests should be called in to the telephone number for Medical Management located in Section 1 of the provider manual.
   • Faxed requests should be sent on a completed “Prior Authorization Request Form” to the toll free fax number for Medical Management located in Section 1 of this provider manual. A copy of this form is provided in Appendix A or on our website at www.vnsnychoice.org, or
   • By mail to the VNSNY CHOICE Medical Management Department address located in Section 1 of this provider manual.

3. Once the request for Prior Authorization is received in our office, our medical management staff will begin the process to make a Coverage Determination. In order to successfully complete this process, we will require you to provide us with some essential information regarding the clinical condition, requested treatment and history supporting the request for services. There are two components to a Coverage Determination:

   • Whether the service is a covered service under the VNSNY CHOICE Medicare Advantage plan
   • Whether the service is medically necessary. Coverage Determinations are based on Medicare coverage guidelines, nationally recognized criteria and/or locally developed VNSNY CHOICE clinical coverage policies.
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Information Required for Prior Authorization:

- Member Name
- Member Identification Number
- Member Date of Birth
- Diagnosis
- ICD-9 Diagnosis Code
- Type of Service
- Place of Service
- Dates of Service
- Procedure, if applicable
- CPT-4 Procedure Code, if applicable
- Provider Name
- Provider’s VNSNY CHOICE Identification Number
- Assistant or Co-Surgeon information, if applicable
- Potential needs upon discharge

VNSNY CHOICE will determine whether:

- The patient is an eligible VNSNY CHOICE member,
- The benefit is a covered service available under the member’s Evidence of Coverage, and
- The services are medically necessary.

Coverage Determinations

1. Definition: Coverage Determinations are based on Medicare coverage guidelines, nationally recognized criteria, or locally developed VNSNY CHOICE clinical coverage policies. A Coverage Determination requires the provision of information to VNSNY CHOICE regarding the clinical condition and treatment or services proposed for the member. There are two components to Coverage Determinations:
   a. Whether the service is a covered service under VNSNY CHOICE, and
   b. Whether the service is Medically Necessary.

2. Timeframes
   a. Prescription Drug Coverage Determination
      - Standard coverage decisions will be rendered within 72 hours of being requested
      - Expedited coverage decisions will be rendered within 24 hours of being requested
   b. Medical Coverage Determination
      - Standard decisions will generally be rendered within 14 days of being requested. The plan is allowed a 14-day extension if the time is needed review additional documentation.
      - Expedited coverage decisions will be rendered within 72 hours of being requested.
Notification Requirements

Timeframe for Notification

You must notify VNSNY CHOICE’s Medical Management Department within the following timeframes:

- **Elective Services**: 14 days prior to a scheduled service (both inpatient and outpatient) whenever possible. If notification cannot be made 14 days prior to the service, it should be made as soon as medically possible prior to the scheduled service.
- **Urgent Services**: VNSNY CHOICE should be notified prior to urgent services/admission being rendered, when possible. If circumstances do not allow for notification prior to urgent services being rendered, then notification must occur within one business day.
- **Emergent Services**: VNSNY CHOICE should be notified within one business day of emergent services/admission.

Approvals

- VNSNY CHOICE’s licensed professionals will review all requests against approved criteria and make the necessary approvals based upon eligibility and medical necessity.
- Notification will be provided to the provider and or the member

Denials

- Only VNSNY CHOICE’s Medical Directors can make decisions denying coverage for medical services for reasons of medical necessity.
- Denial letters delineate any unmet criteria, standards and guidelines and inform the provider and member of the appeal process.

Criteria

Our Medical Management staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines to guide the prior authorization, concurrent review and retrospective review processes. To the extent certain utilization review/care management functions are delegated, such delegates use criteria that are based on reasonable medical evidence and are consistent with VNSNY CHOICE’s standards and guidelines.

Inpatient Hospital Services

Emergent Admissions

The PCP, admitting physician or the member or member’s designee must notify VNSNY CHOICE as soon as possible about the emergent hospital admission. Notification requirements apply whether the emergency and treatment occurred in or out of VNSNY CHOICE’s service area. This notification allows VNSNY CHOICE’s Medical Management Department to ascertain whether there are any discharge needs and to begin the discharge planning process. Authorization of post stabilization of services will be required. You must notify us of an
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emergent admission or to request prior authorization. To do so, call Medical Management telephone number listed in Section 1 of this provider manual.

Urgent Hospital Admissions

The PCP, admitting physician or the member or member’s designee should make every attempt to contact VNSNY CHOICE prior to the urgent admission. However, if circumstances are such that prior authorization is not feasible, then VNSNY CHOICE should be notified as soon as the member is stabilized for authorization of the hospital admission. Notification requirements apply whether the urgent admission occurred in or out of VNSNY CHOICE’s service area. This notification will allow VNSNY CHOICE’s Medical Management Department to identify any discharge needs and to begin the discharge planning process. You must notify us of an urgent admission or to request prior authorization. To do so, call Medical Management at the telephone number listed in Section 1 of this provider manual.

Elective or Non-Urgent Hospital Admissions

All elective and non-urgent hospital admissions require prior authorization. See Section 14 for a list of select procedures requiring prior authorization or you can access a current list of services requiring prior authorization via the website at www.vnsnychoice.org. You must call us at the telephone number located in Section 1 to notify us of an elective or non-urgent admission or to request prior authorization.

Concurrent Review or Extended Length of Stay

You will be given a certified length of stay when you receive admission authorization following your request for Prior Authorization. You must notify us if your patient requires an extended length of stay, additional consultations, or special discharge planning that you did not originally anticipate. You must call us at the telephone number located in Section 1 to update the authorization.

1. Concurrent Review encompasses those aspects of Medical Management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment.
2. Provider requests for a routine extension of an ongoing outpatient course of treatment are handled within the same timeframe as a new preauthorization request.
3. Provider requests for extension of coverage for a course of clinically urgent inpatient or outpatient treatment are handled expeditiously as an urgent concurrent review request when a delay in authorizing the extension could result in worsening the medical condition or harm to the Member.
4. The Concurrent Review process includes:
   a. Obtaining necessary information from providers and facilities concerning the care provided to the member,
   b. Assessing the member’s clinical condition and ongoing medical services and treatments to determine benefit coverage,
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c. Notifying providers of coverage determinations in the appropriate manner and within the appropriate time frame,
d. Identifying continuing care needs early in the inpatient stay to facilitate transition to the appropriate setting,
e. Identifying the member for referral to home and community base programs

Retrospective Review

Retrospective review is the process of reviewing coverage requests for medical necessity when the member is no longer an inpatient and/or after the service has been provided.

Covered services by a participating provider without an authorization, when required, are not eligible for payment by VNSNY CHOICE, and the participating provider may not bill a member for such services. A participating provider may document special circumstances demonstrating that it was not possible for the participating provider to obtain an authorization prior to rendering services. After review of such documentation, VNSNY CHOICE may conduct a retrospective review.

Transitional Care Planning

Transitional care planning is an integral part of concurrent review. Recognizing and planning for transitional care from one setting to another begins at the time VNSNY CHOICE is notified that the member has been admitted to an inpatient facility and continues throughout the member’s stay.

Hospital Transfer From Out-of-Network Providers

VNSNY CHOICE will attempt to coordinate all out-of-network care both locally and out of the service area, including informing the network practitioner. Call the Medical Management Department at the telephone number located in Section 1 of this provider manual if you become aware that one of your patients is receiving out-of-network care. If you are called upon to facilitate transfer to an in-network facility for one of your patients, you must provide the necessary medical guidance for a safe transfer. You must notify us of an admission to an out-of-network hospital or to request our assistance with a transfer into our network. To do so, call Medical Management at the telephone number listed in Section 1 of this provider manual.

Second Opinions

VNSNY CHOICE may require that your patient see a physician, determined by VNSNY CHOICE, for a second opinion. VNSNY CHOICE reserves the right to require a second opinion for any surgical procedure or healthcare service. There is no formal list of procedures requiring second opinions. Procedures or services requiring a second opinion will be decided on a case-by-case basis.

Members may request a second opinion relating to the need for surgery or for a major nonsurgical diagnostic and therapeutic procedure. Members may obtain a second opinion from a participating provider within the VNSNY CHOICE network. In the event that the
recommendation of the first and second physician differs regarding the need for the surgery or other major procedure, a third opinion from a participating provider shall also be covered.

**Notification Requirements for Hospitals**

Hospitals are required to provide VNSNY CHOICE with notification of each admission in order to verify eligibility, confirm authorization, including level of care.

For emergency admissions, notification should occur once the member has been stabilized in the emergency department or, for members who are not stabilized, within one business day when reasonably feasible based on the member’s medical condition and information available. Proper notification is required in order to facilitate timely and accurate payment of hospital claims, prior authorization of post-stabilization services, and to initiate concurrent review and discharge planning, in accordance with the Medical Management Program.

Participating hospitals are required to notify VNSNY CHOICE on a daily basis of all hospital admissions, updates in status, and discharge dates concerning our members.

The VNSNY CHOICE Medical Management Department will fax a hospital log to the hospital on a daily basis notifying the hospital of the status of all VNSNY CHOICE members.

**Emergency Room Services**

**Definition of emergency:** An emergency is the sudden or unexpected onset of a condition requiring medical or surgical care, without which a patient could reasonably be expected to suffer serious physical impairment or death using the prudent layperson standard. In an emergency, a member should seek care as soon as possible; there is no requirement for the member to obtain an authorization from his/her physician or from VNSNY CHOICE. VNSNY CHOICE distinguishes emergency services from urgently needed services. See below for a definition of urgently needed services and procedures to follow.

**When To Use The Emergency Room**

It is appropriate for a member to use a hospital emergency room when an emergency condition exists, such as:

- Heart attack or severe chest pain, in adults
- Stroke
- Severe shortness of breath or difficulty breathing
- Cyanosis
- Hemorrhaging
- Poisonings
- Major burns
- Spinal injuries
- Shock
- Allergic reaction accompanied by swelling of the face or lips, or wheezing in the chest
- Severe or prolonged bleeding from anywhere on the body
- Loss of consciousness
- Severe or multiple injuries
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- Sudden change in mental status
- Convulsive seizures
- Other acute conditions that are determined to be emergencies

In-Area Versus Out-Of-Area Emergency Services

1. **In-Area**: No authorization is required, however, at the PCP’s discretion, the member may be met at the hospital, directed to the nearest emergency room, or recommended to be seen in the treating physician’s office. In the event the member cannot notify the PCP before seeking care in the Emergency Room, the member should call the PCP as soon as possible after the encounter to advise the PCP of the encounter and to facilitate follow up care.

2. **Out-of-Area**: Out-of-area coverage is limited to care for accidental injury, unanticipated emergency illness, or other emergency conditions. VNSNY CHOICE will cover out-of-area emergency room services and urgent care services when they are medically necessary, using a prudent layperson standard.

Notifying VNSNY CHOICE

Regardless of whether your patient is in or out of the VNSNY CHOICE service area when the emergency condition begins, the PCP or the member should contact VNSNY CHOICE as soon as possible, but no more than 48 hours after the onset of the emergency so that we may facilitate any care needed after the emergency room encounter. If the patient is unable to contact us within 48 hours as a result of a medical condition, she/he should do so at the earliest possible time.

Coverage

In most cases, hospital emergency room services are covered by VNSNY CHOICE without an authorization. Additional care after the doctor says it was not a medical emergency will only be covered at the usual coverage if an in-network provider provides the additional care. Follow-up emergency room visits, within VNSNY CHOICE’s service area, are not covered. Follow-up services are covered when they take place in the PCP’s office.

Urgently Needed Services

Urgently needed care is medical care for a condition that needs immediate attention for an unforeseen illness or injury, and it is not after reasonable, given the situation, for the member to get medical care from their PCP or other plan provider regardless of whether the member is in the VNSNY CHOICE service area at the time of service. In these cases, the patient’s health is not in serious danger or life threatening.

Members should call their PCP if they think they need urgently needed services. If a member is hospitalized after having received urgently needed services, the member (or someone on their behalf) must contact VNSNY CHOICE within one business day of the hospital admission.

If a member needs urgent care while outside the plan’s service area, we request that he/she call their PCP first, whenever possible. However, urgently needed services will be covered by the plan when the member is away. In addition, VNSNY CHOICE will cover follow-up care that is
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provided by non-plan providers outside the plan’s service area as long as the care still meets the definition of “urgently needed care”.

Mental Health/Chemical Dependency

VNSNY CHOICE has contracts for both inpatient and outpatient mental health services, and drug and alcohol-related conditions. Please note, these services must be pre-authorized, except in an emergency. If your patient requires these services, you must notify us at the telephone number located in Section 1 of this provider manual. See Section 14 for details on Prior Authorization or you can visit our website at www.vnsnychoice.org.

ValueOptions is the Behavioral Health Services benefit manager for the VNSNY CHOICE Medicare Advantage plans.

How to Refer a Patient to ValueOptions

To refer a patient to ValueOptions, for mental health or substance abuse services, please follow these simple steps:

- Call the toll free number for behavioral health services on the back of the member’s ID card or use the number indicated in Section 1 of this provider manual.
- Inform the ValueOptions Customer Service Representative or Care Manager that you are calling on behalf of your patient, a VNSNY CHOICE Medicare Advantage plan member.
- Let the ValueOptions Customer Service Representative or Care Manager know why you are referring your patient to ValueOptions so he or she can further assist you.

Your call will be directed to an appropriate ValueOptions Care Manager who will discuss the situation with you and jointly determine the most appropriate treatment setting for this patient.

We also encourage you to visit ValueOptions’ web site at www.valueoptions.com.

Skilled Nursing Facility Services

Definition

A skilled nursing facility is an institution that provides skilled nursing or skilled rehabilitation services. It can be a stand alone facility, or part of a hospital or other health care facility. A skilled nursing facility does not include institutions that mainly provide custodial care, such as convalescent nursing homes or rest homes.

Skilled nursing facility care means a skilled level of care ordered by a physician that must be given or supervised by licensed health care professionals.

In the process of working with the healthcare team, particularly the PCP, hospital discharge planners and/or the VNSNY CHOICE staff may encourage the appropriate transition of a member to a lower level of care at some point in the member’s hospitalization. The Medical Management staff will assist in the placement of members into skilled nursing facilities based
on the member’s eligibility and approved Medical Management decision-making criteria in the Medical Management Guidelines. Participating skilled nursing facilities, when available and able to provide the required service, are utilized in this process.

Requirements:

1. The patient must need daily skilled nursing or skilled rehabilitation care, or both.

2. Prior Authorization through the VNSNY CHOICE Medical Management Department is required for all admissions into a skilled nursing facility.

Certified Home Health Care

Certified home health care is Medicare-skilled nursing care, rehabilitation therapies and certain other health care services that the member gets in the home for the restorative treatment of an illness or injury. If your patient needs certified home health care services, VNSNY CHOICE Medical Management staff will arrange these services for your patient, if the requirements are met.

Requirements:

1. The participating physician must decide that medical care is needed in the patient’s home and must make a plan for that care at home. The participating physician’s plan of care should describe the services the patient needs, how often the patient needs to get them and what type of health care workers should provide the services.

2. The home health agency caring for the patient must be approved by the Medicare program, and must be a VNSNY CHOICE network provider.

3. There must be a need for at least one of the following types of skilled care:

   a. Medicare-skilled nursing care on an “intermittent” basis. Generally this means that the patient must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days.

   b. Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of wheel chair or bathtub.

   c. Durable medical equipment (DME) & medical supplies and home infusion drugs related to the home health plan of care.

   d. Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.

   e. Continuing occupational therapy, which helps the patient to do usual daily activities on his or her own.
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4. Home Health Aide

As long as some qualifying skilled services are also included, and the patient requires personal care assistance, the plan of care may include services from a Home Health Aide.

Outpatient Rehabilitative Services

Outpatient Rehabilitative Services help people with physical and developmental problems caused by injury or illness. Rehabilitative service includes:

**Physical Therapy:** helps to improve movement and function, reduce pain and increase independence. Treatments may include exercise for stretching, strengthening, coordination, balance and ease of movement.

**Occupational Therapy:** helps people perform their activities of daily living. Treatments may include hand exercises, splinting and making adaptive changes in the home or at work.

**Speech Therapy:** helps people recover from injuries affecting speech, such as stroke. Treatments include specific exercises and training to improve speaking ability.

Pre-Authorization Requirements:

1. No authorization is required for the first eight (8) visits.
2. All visits beyond eight (8) will require a pre-authorization (refer to Section 14).
3. All services must be provided by VNSNY CHOICE network providers.

Durable Medical Equipment

The Medical Management staff will assist in the process of evaluating and authorizing the use of durable medical equipment (DME) by members for the purpose of providing medically necessary services. The Medical Management staff will evaluate a member’s illness, injury, degree of disability and medical needs for the proper and timely authorization of DME. The Medical Management staff will authorize and monitor the medical necessity and appropriateness of DME and authorize usage by members according to the member’s eligibility, benefit coverage and the consistent and appropriate application of Medical Management decision-making criteria. Participating providers will supply the DME to the members.

Authorizations for selected DME (refer to Section 14) are typically made for up to two (2) months at a time. The Medical Management staff conducts monthly assessments of the member’s eligibility and benefits and of the cost of the equipment (to ensure that rental cost does not exceed purchase price).

Pharmacy Benefit (Medicare Part D)

VNSNY CHOICE beneficiaries will obtain all Medicare Part D covered medications using the CVS Caremark Pharmacy Network.
VNSNY CHOICE offers a very comprehensive 5-tier formulary that addresses all medically necessary drugs. VNSNY CHOICE’s formulary can be accessed at www.vnsnychoice.org.

Medications Requiring Prior Authorization

Certain medications require authorization to determine if their use follows acceptable medical practice or if they are being taken for a covered condition, before they are dispensed to members. In some cases, clinical documentation is necessary to review medication requests. VNSNY CHOICE reviews all requests promptly and follows Medicare requirements in communicating its decision to the physician or, when applicable, to the member.

For a list of medications requiring prior authorization, please see Section 14.

To obtain authorization for one of these medications, providers should:

- Call CVS Caremark at the telephone number listed in Section 1 of this provider manual and provide the necessary information, or
- Complete the general prior authorization form for the medication and fax it to CVS Caremark at the fax number listed in Section 1 of this provider manual.

Providers are encouraged to call for prior authorization to expedite the review process and allow for transition coverage where applicable.

Formulary exceptions

In certain cases, a provider may determine that a member requires a non-covered prescription. When this occurs, the provider may request an exception from the formulary by completing an “Exception Request Form” or by calling CVS Caremark. The “Exception Request Form” may be faxed to the fax number listed in Section 1 of this provider manual. The “Formulary Exception Request Form” is available in Appendix A or by visiting our website, www.vnsnychoice.org.

Specialty Pharmacy

VNSNY CHOICE providers must obtain all Medicare Part B covered medications for VNSNY CHOICE beneficiaries through the Specialty Pharmacy Division of CVS Caremark, our contracted pharmacy vendor.

Medicare Part B covers a limited set of drugs. Medicare Part B covers injectable and infusible drugs that are not usually self-administered and that are furnished and administered as part of a physician service, either by or under the physician’s direct supervision. If the injection is usually self-administered (e.g., Immitrex) or is not furnished and administered as part of a physician service then the drug may not be covered by Part B. In some instances, these medications may be oral medications (e.g. selected oral chemotherapeutic agents that contain the same ingredient as the injectable or infusible dosage forms that would not be considered as self-administered.) Medicare Part B also covers a limited number of other types of drugs.

VNSNY CHOICE providers shall prescribe, as usual, a Medicare Part B covered medication, adding a comment, if necessary, to highlight Medicare Part B coverage (e.g., “For treatment of ___ - cancer”). The provider will then contact CVS Caremark’s Specialty Pharmacy Division at
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the telephone number listed in Section 1 of this provider manual, to request that the medication be sent to their office. CVS Caremark will provide the necessary directions as to how to proceed with the request.

Select Part B medications will require prior authorization and will be administered by CVS Caremark using VNSNY CHOICE criteria.

Out-of-Network Services

Out-of-network services are managed by VNSNY CHOICE’s Medical Management staff in order to assist the member in obtaining their care from participating providers and participating facilities.

- VNSNY CHOICE’s Medical Management staff may initially be notified as a result of out-of-network emergency services and/or urgently needed services provided to a member.

- VNSNY CHOICE will manage and track the member’s care and arrange for transfer to a hospital that participates in the VNSNY CHOICE network.

1. Non-Participating Providers

   a. All requests for services with a non-participating provider must be submitted to VNSNY CHOICE’s Medical Management staff for authorization.

   b. Circumstances under which an authorization may be approved to a non-participating provider include:

      - If it is determined that there is no participating provider who can provide the covered services required for the member.
      - If a currently enrolled member is in active treatment with a provider who terminates his/her participation in the VNSNY CHOICE network.
      - If a newly enrolled member joins VNSNY CHOICE and is under active treatment at the time of enrollment with a provider who does not participate in the VNSNY CHOICE network.

      Item 2) and 3) above will only be covered if the non-participating provider agrees to:

      - Accept reimbursement at VNSNY CHOICE’s fee schedule,
      - Adhere to all VNSNY CHOICE Utilization Management and Quality Improvement requirements; and
      - Adhere to all VNSNY CHOICE policies and procedures.

Clinical Trial Coverage

A clinical trial is a way of testing new types of medical care (e.g. how well a new cancer drug works). Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose or treat diseases. Consistent with CMS policy, VNSNY CHOICE covers the
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cost of routine member care in clinical trials qualified under the CMS guidelines to the same extent it reimburses routine care for members not in clinical trials and in accordance with the limitations outlined below.

a. Providers will not routinely be required to submit documentation about the trial to VNSNY CHOICE, but VNSNY CHOICE can, at any time, request such documentation to confirm that the clinical trial meets current standards for scientific merit and has the relevant institutional review board approval(s),

b. All applicable VNSNY CHOICE requirements for authorization and referrals must be met,

c. All applicable plan limitations for coverage of out-of-network care will apply to routine member care costs in clinical trials, and

d. All Medical Management rules and coverage policies that apply to routine care for members not in clinical trials will also apply to routine patient care for members in clinical trials.

VNSNY CHOICE will not cover the following clinical trial costs:

a. The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials according to VNSNY CHOICE's terminal illness policy) (See benefit plan descriptions for details),

b. Costs of data collection and record keeping that would not be required but for the clinical trial,

c. Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., “protocol-induced costs”), and

d. Items and services provided by the trial sponsor without charge.

New Technologies

VNSNY CHOICE continually reviews and assesses existing and improved technology for health care services benefit applications. This includes medical and behavioral health procedures, pharmaceuticals and devices. VNSNY CHOICE criteria may change and/or expand because of these revisions and will be reflected in VNSNY CHOICE policy and procedure changes. The VNSNY CHOICE Medical Director is available for discussion of individual cases, which may benefit from improved technological changes.

Additionally, there is a process for participating providers to submit new technology for coverage review. Please contact VNSNY CHOICE for more information.
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Appeals

VNSNY CHOICE has a policy and process in place to facilitate the timely, thorough and appropriate resolution of appeals for members if a member is denied coverage through the referral and preauthorization process (see Section 12a).

Interface with Quality Management

The VNSNY CHOICE Medical Management Director or his/her designee will have substantial involvement in the coordination of the Medical Management staff and programs. Issues, which overlap the quality and utilization areas include, but are not limited to, accessibility of services, appropriateness of care and services, continuity of care, under-utilization and member compliance and risk minimization. The Medical Management Program will include continuous quality improvement processes, which are coordinated with quality improvement activities as appropriate.

Care Management

The purpose of the Care Management Program is to:

1. Increase disease prevention and reduce disease progression,
2. Promote early detection of serious medical problems,
3. Promote member outreach and education to assist members in achieving independence through self-care, and
4. Establish a collaborative relationship between VNSNY CHOICE and the providers caring for the member through information sharing.

VNSNY CHOICE Medical Management staff clinically and administratively identify, coordinate, and evaluate the services delivered to members with complex, acute and chronic needs on a case-by-case basis. The Care Management program is designed to coordinate the delivery of both short and long-term health services for those members identified with special needs because of their medical or mental status. The coordination occurs regardless of the care setting, responds to the total health needs of the member, and attempts to assure the highest quality of care is being delivered to the member in the most appropriate setting for the member’s medical condition. All Care Management activity includes collaboration with the PCP and other attending providers.

For VNSNY CHOICE Medicare Advantage plan members, care management is inclusive of utilization management where authorization of inpatient hospital admissions, acute and sub acute rehabilitation requests as well as outpatient services are reviewed using Milliman Care guidelines, a nationally recognized set of evidence based guidelines. (A list of services that requires pre-authorization is located in Section 14 of this provider manual.)
Identifying Members with Significant Potential for Health Improvement

As part of the Care Management Program, VNSNY CHOICE conducts a health risk assessment for all members within 90 days of enrollment to initially identify members with chronic diseases and special health care needs and stratifies them according to severity levels. This includes identifying members with significant potential for improvement; members with a catastrophic illness, chronic diseases, traumatic injury, special care needs involving difficult circumstances, or the need for multiple services requiring assistance. This allows our Medical Management staff to tailor education and related assistance including disease management and care management programs, when appropriate, based on the member’s specific needs.

A member may self-refer, or be referred by the member’s family, provider, or VNSNY CHOICE staff to any of our Care or Disease Management Programs. In addition, regular analysis of health care, quality and utilization data is performed to identify members with special medical needs, including but not limited to:

- Sentinel diagnoses
- Recurrent inpatient episodes of care
- Members with health care costs above a predetermined level
- Pharmacy data analysis
- Medical record and laboratory data analysis identifying members with poorly controlled medical conditions, and
- Medical coordination for those members receiving behavioral health care who are identified as having significant unmet or unstable medical problems.

Physician Collaboration

The cornerstone of the VNSNY CHOICE Care Management program is effective collaboration with participating primary physicians. These collaborative relationships will include:

1. Identification of individuals appropriate for disease management, working with participating physicians and office staff.
2. Development and implementation of member-specific care plans, using evidence-based treatment regimens that will be coordinated by the physician and care manager.
3. Patient education, focused on supporting self-care management and monitoring.
4. Care manager feedback to physicians regarding patient status and clinical needs

Medicare Model of Care

The VNSNY CHOICE Medicare Advantage Special Needs Plan model of care is a structural framework guiding care management policies and operational systems for Medicare and Medicaid beneficiaries. Our model complies with requirements of the Center for Medicare and Medicaid Services (CMS) and MIPPA (Medicare Improvements for Patients and Providers Act).
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Model of Care Goals

- Improve access to affordable care, preventive, medical, mental health and social services
- Improve coordination of care via integrated care planning
- Improve seamless transitions of care
- Assure appropriate utilization of services
- Improve beneficiary health outcomes

All beneficiaries are auto enrolled in care management upon enrollment in the SNP. The Health Risk Assessment (HRA) completed by our staff of clinicians is the evaluation tool to identify aspects of care and specialized needs of members related to medical, functional, psychosocial and cognitive/mental status.

An individualized care plan with problems, goals and interventions is developed and updated by the member’s Care Manager. It is used to manage and monitor the member’s care, needs and progress toward goals.

The Interdisciplinary Care Team (ICT) is dedicated to quality and accountability in ensuring appropriate care and services are consistent with best practice, CMS guidelines and the VNSNY CHOICE mission. The ICT collaborates to determine the best course of action to facilitate meting the medical, psychosocial, cognitive and functional needs of the beneficiary in a timely, cost effective manner.

Participants of the VNSNY CHOICE ICT include nursing professionals, hospice and palliative care professionals, senior medical management staff, and Quality Management staff. In addition, a clinical pharmacologist, a rehabilitation consultant, behavioral and social services experts, medical directors and other clinicians are also involved as appropriate.

As a participating provider, you are welcome to attend VNSNY CHOICE “rounds” discussions. For these discussions, you are invited to refer the clinical issues of your VNSNY CHOICE members to our rounds meetings. Please contact the VNSNY CHOICE Provider Relations department for further information. An overview of the VNSNY CHOICE Medicare Advantage model of care is available on our website www.vnsny.org or available by contacting the Provider Relations Department.

Complex Cases Requiring Additional Treatment Planning and Specialty Review

It is the policy of VNSNY CHOICE that each member must be provided quality care throughout the period of illness, facilitating transition between the appropriate levels of care as required, within the appropriate time frames, ensuring continuous and appropriate interventions.

Through the Utilization Management process, VNSNY CHOICE will work with its participating providers to identify individuals with complex or serious medical conditions. Once identified, the Medical Management staff will work with the member’s PCP and/or appropriate participating specialists to:

1. Assess those conditions, and use medical procedures to diagnose and monitor them on an ongoing basis, and
2. Establish and implement a treatment plan that is appropriate to the Member’s conditions.

Member Confidentiality

VNSNY CHOICE has processes in place to protect the confidentiality of member information and records in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). VNSNY CHOICE has named a Privacy Officer, adopted written policies and procedures regarding Protected Health Information (PHI), and trained staff regarding the implementation of these procedures. These measures are to ensure compliance with HIPAA timeframes and requirements.

The breach of a member’s confidentiality by an employee of VNSNY CHOICE or a member of a committee constitutes grounds for disciplinary actions that may include termination.
Utilization Management

The VNSNY CHOICE Utilization Management (UM) Program is dedicated to providing necessary medical care to plan members in the most appropriate and cost-effective setting. The UM Program strives to coordinate and cooperate with providers and network facilities in providing a comprehensive approach that meets the medical needs of VNSNY CHOICE SelectHealth members from episodic to the routine coordination of care. The toll-free number to reach Medical Management is listed in Section 1 of this provider manual and is available 24 hours a day, seven (7) days a week.

The goal of utilization management is to foster medical practice patterns that are both appropriate to the patient’s needs and entail a judicious use of resources. VNSNY CHOICE’S intention and purpose is to avoid delivery of unnecessary or duplicated health services before they are rendered. All utilization management determinations are based on the medical necessity* of the requested services with the intensity of services determined by their burden of illness. To accomplish these objectives, Utilization Management is closely allied with VNSNY CHOICE’s network providers in the planning, organization and delivery of quality health care services.

(*Medical necessity means health care services that are necessary to prevent, diagnose, manage or treat conditions in the member that cause acute suffering, endanger life, result in illness or infirmity, interfere with the member’s capacity for normal activity, or threaten some significant handicap.)

Utilization Management staff use national guidelines and resources to guide the prior authorization, concurrent review, and discharge planning process. On the basis of information collected, Utilization Management staff applies Milliman criteria. In the event VNSNY CHOICE fails to make a utilization review decision regarding medical necessity within the required time frames, such failure is deemed an adverse determination subject to appeal.

A principal activity of the Utilization Management Department is the monitoring process. By tracking the efficacy and efficiency of the services delivered, patterns of utilization are identified. When provider patterns deviate from the norm (either local or national), resources are focused on the problem.

The goals of the Utilization Management Program are to:

- Promote high quality care.
- Promote access and delivery of care at the appropriate level of care using the appropriate resources.
- Coordinate medical necessity and efficient care.
- Monitor quality of care.
- Identify over- and underutilization of resources.
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Prior Authorization

Prior authorization is the process of evaluating requested medical services before the services are rendered, in order to determine medical necessity, appropriateness of services and level of care. The prior authorization process also provides an opportunity to assess the quality of care before the care is rendered. The Medical Director is involved in all reviews for medical necessity. A second opinion may be requested before granting approval for use of a specialized medical procedure or a non-participating provider.

Prior authorization is required for all elective admissions, outpatient surgery, and outpatient treatment and testing if the services are being provided in a facility not participating with VNSNY CHOICE (an out-of-network provider). Prior authorization is required for specific procedures regardless of the providers’ participation status.

Notification/Authorization of all urgent/emergent admissions is required once the patient has stabilized but before the patient is discharged. If notification is received after the patient has been discharged, the admission may be reviewed retrospectively. Health care services provided for an emergency condition should not be delayed in order to obtain prior authorization. VNSNY CHOICE’s coverage for emergency services is defined on page 13-23 of this manual.

Please see Section 14 for a list of VNSNY CHOICE SelectHealth services that require Prior Authorization or you can visit our website at www.vnsny.org.

Prior Authorization Process:

- The referring provider submits a request for authorization of services to VNSNY CHOICE’s Medical Management Department. The request may be initiated by calling the Medical Management telephone number or faxing the request to the number listed in Section 1 of this provider manual. Requests for mental health/substance abuse services should be directed to the phone number listed in Section 1 of this provider manual.
- The provider must have the following information available when calling to authorize an admission:
  - Member ID and name
  - Date of birth
  - Admitting physician and phone number
  - Hospital name and phone number
  - Diagnosis with ICD-9 code
  - Planned procedure/treatment plan with CPT code
  - Anesthesia type
  - Admission date and time
  - Surgical date and time
  - Estimated length of stay
  - Anticipated consultant service that may be required, including assistant surgeons
  - Any further medical information required to make a determination of medical
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- Elective admissions must be pre-authorized at least five (5) days prior to the scheduled admission date when such notification is possible without delaying the member’s care.
- The Medical Management Department verifies whether the specialist/facility is in the VNSNY CHOICE network.
- Medical Management gathers clinical information to aid in determining the medical necessity and appropriateness of the referral. Clinical information may include, but is not limited to, medical records, results of diagnostic studies/treatments and consultations with providers and other specialists.
- Once all of the data is processed, the review determination, based on clinical information and criteria, is made.
- An expedited review of a service request is conducted when VNSNY CHOICE or the provider indicates that a delay would seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. The member can also request an expedited review. If the member’s request is denied, VNSNY CHOICE handles the request under the standard review timeframes.
- VNSNY CHOICE communicates the determination to the member or his/her designee and the member’s provider by phone and in writing within three (3) business days of receipt of the information needed to make the determination for expedited reviews and in all other cases, but no more than 14 days after receipt of the service request.

Concurrent Review

Concurrent review is the process of obtaining necessary information from providers and facilities for determining whether the care being provided to members is medically necessary and therefore covered under the VNSNY CHOICE benefit package. An initial or admission review is performed either within 24 hours of notification or the next business day of inpatient admission, whichever is earliest. Concurrent reviews are performed at intervals, no more than three (3) days, based on the member’s condition and treatment plan, until the patient is discharged. VNSNY CHOICE communicates the concurrent review determinations to the member or his/her designee and the member’s provider by phone and in writing within one (1) business day of receipt of the information needed to make the determination but not later than three (3) business days after receipt of the service request for an expedited review (see above) and in all other cases no later than fourteen (14) days of the service request.

Concurrent Review Process

The admission review begins with the Service Operation’s staff verification of the member’s eligibility, admitting diagnosis, type of admission, reason for admission, and plan for continued stay and any additional information to support the treatment plan and setting.

If, after initial or concurrent review of the information obtained, the information does not meet the screening criteria, the Service Operation’s staff refers the case to the VNSNY CHOICE Clinical Evaluation Manager (CEM) to initiate dialogue with the Medical Director, if appropriate. The following are typical types of cases that require physician review:
- Cases which fail to meet Milliman Guidelines or other pertinent criteria.
- Cases for which no criteria is available.
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- Cases for which the medical record lacks sufficient information to make a determination. Cases for which physician consultation or tests are not performed within one (1) working day of a specified request.
- Cases where preoperative surgical delays are greater than 24 hours, in the absence of medical necessity.
- If the VNSNY CHOICE Medical Management Department/Medical Director determines the admission and/or continued stay is appropriate, the admission/continued stay review is approved and the process continues until the patient is discharged.
- If after reviewing the medical information, the Medical Director determines that the service is not medically necessary and the member is still hospitalized, the attending physician is contacted within one (1) business day to be informed of the Medical Director’s determination and offered the opportunity to request a reconsideration of the adverse determination. If he/she is unavailable, a message is left informing the physician that if he/she wishes to discuss the case, he/she may contact the Medical Director. The Medical Director’s contact information is provided. Written notification follows within one (1) day of the telephone notification.
- The attending physician presents his/her view and resolves any questions related to medical necessity. If the Medical Director decides to uphold his/her initial adverse determination, Medical Management initiates the process for a written notice of adverse determination from VNSNY CHOICE. The attending MD is notified by phone of the determination within one (1) business day. Written notification follows within one (1) day of the telephone notification.
- If continued services are approved, the member’s provider is notified by telephone and in writing within one (1) business day of receiving all the material needed to make the determination. Notification of continued or extended services includes the number of extended services approved, the new total approved services, the date of onset of services and the next review date.
- Only a physician may make an adverse determination. Notices of adverse determinations are distributed the day the determination is made.
- Whenever the attending physician does not concur with the adverse determination made by the Medical Director, he/she may request an immediate review of the case by an independent reviewer within the same specialty.
- If VNSNY CHOICE renders an adverse determination without attempting to discuss the case with the attending physician, the provider may submit a request for reconsideration. Except in the case of retrospective review, a reconsideration occurs within one (1) business day of receipt of the request for reconsideration and is conducted between the requesting physician and the physician reviewer making the initial adverse determination.
- Criteria used to make a determination are available upon request.

Service Authorization Determination Extensions

Timeframes for the service authorization determinations for pre-authorization and concurrent review may be extended for up to 14 days if:

- The member, the member’s designee or the provider requests an extension orally or in
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• writing.
• VNSNY CHOICE demonstrates or substantiates that there is a need for additional information and determines the extension is in the member’s interest. In this case, the notification of the extension will be given to the member.

If the timeframe for review is extended, the service authorization determination and notification of the member by phone and in writing will occur as fast as the member’s condition requires. Notification will occur within three (3) business days after receipt of the necessary information for a prior authorization request, and within one (1) business day after receipt of the necessary information for concurrent review request, but in no event later than the date that the extension expires.

Emergency Care

An Emergency Medical Condition shall mean 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.

Members are always covered for emergencies. If a member needs health care services for an emergency condition, he/she is covered twenty-four (24) hours a day, seven (7) days a week. Members, members’ designees, or the member’s provider, or any other health care provider, or other person or entity are not required to call, inform or contact VNSNY CHOICE before the provision of emergency care, including emergency treatment or emergency admission.

Prior authorization is not required for services in a medical or behavioral health emergency. However, if the member is hospitalized, then notification is required once the member has stabilized. VNSNY CHOICE will not deny reimbursement for emergency services on retrospective review, provided that such services are medically necessary to stabilize or treat an emergency condition.

Care Outside the Service Area

Members traveling outside the VNSNY CHOICE service area are covered for emergency and urgently needed care. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Members are asked to phone their PCP or VNSNY CHOICE Member Services at the phone number listed in Section 1 of this provider manual within 48 hours after receiving care outside the service area.

Any care received outside of the United States, District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa will not be covered by the VNSNY CHOICE SelectHealth.
Transitional Care Planning

The transitional care planning process involves consideration of alternative settings for post-hospital treatment and care and commences at the time VNSNY CHOICE is notified of an admission. During the concurrent review process, as the actual planned date of discharge approaches, the CEM reviews the case to determine whether an alternative level of medical care should be considered. If there is specific discharge planning needs, the CEM assesses where the responsibility for coordination lies.

Whenever a need for transitional care planning is identified, VNSNY CHOICE staff contacts the primary care physician to offer assistance as a resource and to alert the physician of the need for services.

If the member requires home health care (HHC) following an inpatient hospital admission, notification of the determination will be made within one (1) business day of receipt of the necessary information or, if the day after the request for services falls on a weekend or holiday, within 72 hours of receipt of the necessary information. Please note VNSNY CHOICE does not require participating HHC agencies to receive prior approval from VNSNY CHOICE to perform an initial “evaluation” visit as long as the agency has received MD orders for the services.

Retrospective Review

Retrospective review is a process for determining whether previously provided services are medically necessary and therefore covered under the VNSNY CHOICE benefit package. VNSNY CHOICE undertakes retrospective review to determine the medical necessity of services that have already been provided as part its quality assurance and utilization management programs.

All retrospective review determinations are made within 30 days of obtaining all necessary information to make determination. The provider and member are notified in writing of the determination on the date of a payment denial, in whole or in part.

VNSNY CHOICE reserves the right to reverse a pre-authorized treatment, service or procedure on retrospective review pursuant in the following cases:

- Relevant medical information presented to VNSNY CHOICE upon retrospective review is materially different from the information that was presented during the pre-authorization review.
- The information existed at the time of the pre-authorization review but was withheld or not made available.
- VNSNY CHOICE was not aware of the existence of the information at the time of the pre-authorization review; and
- Had VNSNY CHOICE been aware of the information, the treatment, service or procedure being requested would not have been authorized.
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New Technology Request

Requests by physicians that identify the need and involve the use of new medical technologies including medical procedures, drugs and devices, are facilitated by the Medical Director. This process includes review of information from appropriate regulatory bodies and published scientific evidence. When the investigation involves new technologies that are outside the realm of the Medical Director’s area of expertise, input from relevant specialties will be employed.

Adverse Determination

An Adverse Determination is a denial of coverage for proposed or actual medical services that, based on available information, do not meet accepted criteria for coverage. Only a physician may make an adverse determination.

The written notice of adverse determination includes:
- Description of the action that VNSNY CHOICE has taken
- Dates of service
- Date after which hospitalization will not be approved
- Service/treatment being denied
- Date of service being denied (retroactive/prospective)
- The reasons for the adverse determination, including the clinical rationale used in making the determination.
- Instructions on how to initiate standard, expedited and external appeals including time frames for filing/reviewing appeals
- Note that VNSNY CHOICE will not retaliate or take any discriminatory action against the member because he/she filed an appeal
- Information required, if appropriate, to render a decision on appeal
- Notice of availability of the clinical criteria used to render the decision
- The right of the member to request a fair hearing and the form to initiate the request
- The right of the member to complain to the Department of Health with the telephone number (1-800-206-8125)
- Statement that notice is available in other formats and languages and member should contact VNSNY CHOICE to obtain.
- The right to an “Aid Continuing” request by contacting the Appeal’s Coordinator at the phone number listed in Section 1 of this provider manual.

VNSNY CHOICE sends the notice of denial on the date the review timeframes expire. If a decision is not reached within the service authorization time frames described, it is considered an adverse determination and VNSNY CHOICE will send an Adverse Determination to the member/attending physician/member’s PCP on the date the timeframe expires.

A log is maintained of all adverse determinations, as well as an individual case file of all adverse determinations made.
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Appeals Process

In the event a request for coverage is denied, the member, his/her designee or a provider may appeal this determination through the appeals process and, depending on the specific circumstances, to an external utilization review organization that uses independent physician reviewers or a governmental agency.

UR Appeals should be submitted to the address listed in Section 1 of this provider manual.

Participating providers can contact Provider Relations Department at the number listed in Section 1 of this provider manual to initiate the appeal process and discuss the denial of a claim.

Claims Appeals should be submitted to the address listed in Section 1 of this provider manual.

Expedited appeal

- Appeal of a utilization management determination may be made directly by the member, his/her designee, or the requesting/attending physician to the Medical Director. An expedited review may be requested for continued or extended health care services, procedures, treatments or additional services for a member undergoing a course of continued treatment prescribed by a health care provider, a denial for home health services following a discharge from a hospital admission, and/or when a health care provider believes an immediate appeal is warranted.
- If additional information is necessary for making a determination, VNSNY CHOICE immediately notifies the member and the member’s provider by telephone or fax and requests the necessary information, followed by a written notice requesting the information.
- Reasonable access is provided to a clinical peer reviewer within one (1) business day of receiving notice of the appeal.
- Expedited appeals are determined by VNSNY CHOICE within two (2) business days of receipt of the necessary information to conduct the review but no more than three (3) business days of receipt of appeal. This time may be extended for up to 14 days upon member or provider request or if VNSNY CHOICE demonstrates more information is needed and the delay is in best interest of member and so notifies member. If VNSNY CHOICE denies the request for an expedited review, VNSNY CHOICE will notify the member or his/her designee by phone immediately followed by written notice in two (2) business days of the when the decision was made.
- Expedited appeals of adverse determinations concerning medical necessity not resolved to the satisfaction of the appealing party may be further appealed via the standard appeal process (described below) or through the external review process (described on page 13-28 of this manual).

Standard appeal

The member, member’s designee or, in connection with retrospective adverse determinations, a member’s health care provider, can file a standard appeal in writing or by telephone (followed by a written signed appeal) of an adverse utilization review determination no more than ninety
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(90) days from the date the member/provider was informed of the adverse utilization review determination.

- All appeals are acknowledged in writing within fifteen (15) days of receipt of the appeal.
- VNSNY CHOICE will notify the member and provider of any additional information required to conduct the appeal within fifteen (15) days of receipt of the appeal. In the event only a portion of the necessary information is received, VNSNY CHOICE will request the missing information within five (5) days of receipt of the partial information.
- All medical necessity appeals are forwarded to the clinical peer reviewer to perform an independent review of the case. The clinical peer reviewer must be of the same specialty as the attending physician. The clinical peer reviewer may not be the Medical Director who made the initial adverse determination.

A final determination is completed as fast as the enrollee’s condition requires and no later than 30 days from receipt of the appeal. The member or member’s designee and, where appropriate, the member’s provider are notified within two (2) business days of the decision by VNSNY CHOICE.

- This timeframe may be extended for up to 14 days if:
  - The member, his/her designee or the provider requests an extension orally or in writing; or
  - VNSNY CHOICE can demonstrate that there is a need for additional information and the extension is in the member’s interest. VNSNY CHOICE will send notice of the extension to the member.

- If the original medical necessity determination is upheld on peer review, the provider, member or member’s designee may request an external review through the New York Department of Insurance. A letter will inform all parties of this next level of appeal. For further information, see the section entitled “Right to an External Appeal” on page 13-28 of this manual.
- Failure by VNSNY CHOICE to make a determination within the applicable time periods for making a determination on an appeal will be deemed to be a reversal of VNSNY CHOICE’s adverse determination.
- The member or designee may see their case file at any time before or during the appeal process and may present evidence to support their appeal in person or in writing.

A log is maintained by the Medical Management Department of all appeals to assure timely responses and to track outcomes.

Notice of Final Adverse Determination

A notice of final adverse determination of an expedited or standard appeal is sent to the member or member’s designee, and, as appropriate, the member’s provider. Each notice is in writing, is dated and includes the following:

- A clear statement describing the basis and clinical rationale for the denial as applicable to the member;
- Summary of appeal and date filed;
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- Date appeal process was complete;
- A clear statement that the notice constitutes the final adverse determination;
- VNSNY CHOICE’s contact person and his/her telephone number;
- The member’s coverage type;
- The name, address of VNSNY CHOICE and telephone number;
- A description of the health care service that was denied, including, as applicable and available, the name of the facility and/or physician proposed to provide the treatment and the development/manufacturer of the health care service;
- A statement that the member may be eligible for an external appeal and the time frame for requesting the appeal;
- A copy of the State issued standard description of the external appeal process including the form and instructions for requesting an external appeal
- The right of the member to request a fair hearing and the form to initiate the request.
- The right of the member to complain to the Department of Health with the telephone number (1-800-206-8125); and
- Statement that this information is available in other languages and formats by contacting VNSNY CHOICE.

A written notice of final adverse determination concerning an expedited appeal is transmitted to the member within 24 hours of rendering such determination. VNSNY CHOICE will make reasonable effort to provide oral notice to the member and provider at the time the determination is made. If a member and VNSNY CHOICE have jointly agreed to waive the internal appeal process, the information bulleted above is provided simultaneously to the member with the letter agreeing to such waiver. These documents are transmitted to the member within 24 hours of the agreement to waive VNSNY CHOICE’s internal appeal process.

Right to an External Appeal

A VNSNY CHOICE SelectHealth member, his/her designee or, in connection with retrospective or concurrent adverse determinations, the member’s health care provider, are eligible to request an external review under the following conditions:

- When the member has had coverage of a health care service, which would otherwise be a covered benefit denied on appeal, in whole or in part, on the grounds that such health service is not medically necessary, and
- VNSNY CHOICE has rendered a final adverse determination with respect to such health care service; or
- Both VNSNY CHOICE and the member have jointly agreed to waive any internal appeal

An external appeal may also be filed:

- When the member has had coverage of a health care service denied on the basis that such service is experimental or investigational, and
- The denial has been upheld on appeal or both VNSNY CHOICE and the member have jointly agreed to waive any internal appeal, and
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• The member’s attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard health service or procedure covered by VNSNY CHOICE, or (c) for which there exists a clinical trial, and

• The member’s attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member’s life threatening or disabling condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of experimental or investigational) that, based on two (2) documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. Any physician certification must include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

• The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for VNSNY CHOICE’s determination that the health service or procedure is experimental or investigational, clinical trial or rare disease treatment.

External appeals must be filed within forty-five (45) days of receipt of a final adverse determination or after VNSNY CHOICE and the member have jointly agreed to waive internal review procedures.

Provider External Appeal Rights

The fee requirements do not apply to providers who are acting as the member’s designee, in which case the cost of the external appeal is the responsibility of VNSNY CHOICE.

Providers can, however, request an external appeal in connection of concurrent adverse determinations. The health care provider filing the external appeal of a concurrent adverse determination is responsible for the full cost of the an appeal for a concurrent adverse determination upheld in favor of VNSNY CHOICE; VNSNY CHOICE is responsible for the full cost of an appeal that is overturned; and the provider and VNSNY CHOICE must evenly divide the cost of a concurrent adverse determination that is overturned in-part. At no time can the member be held responsible.

Fair Hearings

• Members may access the fair hearing process in accordance with applicable federal and state laws and regulations.

• Members may request a fair hearing concerning adverse local Department of Social Services determinations concerning enrollment, disenrollment and eligibility, and regarding the termination, suspension or reduction of a clinical treatment or other benefit package service by VNSNY CHOICE.

• For issues related to disputed services, members must have received an adverse determination from VNSNY CHOICE.

• A member may also seek a fair hearing for a failure by VNSNY CHOICE to comply
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- with the timeframes established for review of complaints, appeals and utilization management determinations.

**Care Coordination Program**

The purpose of VNSNY CHOICE’s Care Coordination Program is to provide a process in collaboration with the member, family, caregiver, physician(s) and other health care providers that focus on member education, advocacy and empowerment. The Care Coordination Program strives to enhance the member’s quality of life by creating continuity of care, facilitating provision of services in the appropriate setting, and managing resource allocation to promote high quality, cost-effective outcomes.

To achieve the goals of the Care Coordination Program, VNSNY CHOICE offers overall Care Coordination with includes but is not limited to Clinical Care Coordination and Psychosocial Care Coordination for its members.

**Medical/Clinical Care Coordination**

VNSNY CHOICE’s Clinical Care Coordination includes the coordination of the member’s services in conjunction with the PCP and the member’s case manager. The PCP and/or case manager receives support from VNSNY CHOICE’s Clinical Evaluation Managers (CEM). The CEM will participate in developing a clinical care plan that addresses identified member needs. The CEM then monitors service utilization towards meeting the problems, goals and interventions of the care plan. Clinical Care Coordination is implemented for any member who requires multiple health care providers, or who has catastrophic, terminal or complex, chronic and comorbid conditions requiring specialty care.

The objectives of VNSNY CHOICE’s Clinical Care Coordination Program are as follows:

- To plan, implement, monitor and evaluate services to meet an individual’s health needs in order to promote high quality, cost-effective outcomes.
- To identify members with complex health care needs who would benefit from medical care coordination intervention.
- To monitor and document the member’s on-going care needs.
- To coordinate member care in collaboration with physicians, the member, care providers and family.
- To identify and recommend alternative care options and prevent hospitalization when feasible.
- To develop and implement disease management for appropriate members in accordance with the standards of care of New York State Department of Health, the AIDS Institute, and other professional specialty groups.
- To evaluate clinical services through close contact with physicians, ancillary service providers, behavioral health specialist and members of the interdisciplinary team, engaging in continuous quality improvement.

**Clinical/Medical Care Coordination Process**

- All VNSNY CHOICE members, if new to a care site and/or provider, will be assessed
by a PCP within 30 days of the effective date of enrollment.

Specific criteria have been developed by VNSNY CHOICE for identifying members potentially suitable for referral to medical care coordination. This criteria includes but are not limited to the following:

- Hospitalizations that include ICU care and/or LOS >20 days
- Multiple hospitalizations in a calendar year
- One day stays
- Recurrent ER visits for primary care issues
- Pregnancy
- Newborns
- Advanced immuno suppression:
  - aCD4<200 and not on ART or on a failing regimen (AI criteria)
- Hospitalizations for Behavioral Health (Substance Abuse and Mental Health)
- Advanced liver disease
- Advanced cardiopulmonary disease.
- Advanced renal insufficiency or ESRD
- Active oncologic disorder
- Diabetes
- Active Tuberculosis
- Active STD
- Ongoing domestic violence
- Non-compliance with mental health referrals
- Home Care
- Antiretroviral noncompliance
- Lost to Follow-up
- Behavioral Health issues including but not limited to alcohol and substance abuse

The CEM monitors clinical services through close contact with physicians, ancillary service providers, community and faith based resources and members of the interdisciplinary team, as deemed appropriate, to help ensure the provision of high quality care. If the member is hospitalized, the VNSNY CHOICE CEM will remain in close contact with the member’s Case Manager, the hospital social worker, and UR department, as applicable, in order to facilitate an evaluation of the patient’s and family’s ability to comply with an agreed-upon treatment plan and facilitate an appropriate discharge plan.

If medically appropriate, the CEM discusses alternative care options with the member and his/her PCP. Alternative care providers include, but are not limited to:

- Home Health Services
- Rehabilitation Facilities
- Hospice (in or outpatient)
- Skilled Nursing Facilities
- Transitional Care Units
- Sub-Acute Facilities
- Long Term Care Facilities
- Referred Community Resources
- Behavioral Health Providers
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Medical Care Coordination is an important component of VNSNY CHOICE’s overall Quality Improvement Program. Specifically, the CEM helps set and monitor performance standards and measurable clinical outcomes.

Comprehensive Case Management addresses the total needs of the member (physical, psychological, cultural, financial, social, and environmental). Every member is assigned a CEM who is responsible for coordinating all aspects of the member’s care plan (unless the member opts out).

VNSNY CHOICE’s Comprehensive Case Management Program is comprised of Intensive (COBRA) Case Management and Non-Intensive HIV Comprehensive Case Management.

Intensive (COBRA) Case Management is defined as comprehensive family-centered case management with frequent contact by a team of case managers, case management technicians, and community follow-up workers. Intensive case management is designed for patients with multiple complex needs who require home visits, active community follow-up and frequent contacts. HIV COBRA intensive case management may be carried out only by an entity designated by the New York State Department of Health AIDS Institute.

Non-Intensive HIV Comprehensive Case Management is a process which provides members with the following services: care coordination, assessment of the need for non-intensive comprehensive and intensive case management, service plan development that addresses identified client needs, supportive counseling, crisis intervention, and referral to case management programs as appropriate.

VNSNY CHOICE has linkage agreements with various organizations, including community-based organizations, COBRA case management providers, hospital-based and Designated AIDS Center (DACS) outpatient programs, to provide hands-on case management services to the plan’s members. Case managers conduct comprehensive assessments of needs, coordinate and track referrals to participating psychosocial service providers, (e.g. housing, nutritional service agencies), communicate with the member’s PCP and the plan’s Medical Management Department.

The Plan’s Role in Psychosocial Case Management includes the following:
- Oversight of member assignment to a Case Manager
- Development of VNSNY CHOICE case management policies & procedures
- Network provider education & oversight of compliance with policies & procedures
- Oversight of direct case management services provided at network provider sites, through direct contact, site visits and/or annual chart reviews
- Report review and follow-up
- Identification of network gaps and subsequent network development
- Coordination of utilization management & quality improvement activities

The Hospital-Based Case Manager’s Role in Psychosocial Case Management includes the following:
- Intake/Assessment/Reassessment
- Multi-Disciplinary team care
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- Crisis intervention, counseling, service plan development
- Discharge planning
- Service plan development, implementation, monitoring & periodic reassessment
- Crisis intervention

The Community-Based Psychosocial Case Manager’s Role in Psychosocial Case Management includes the following:
- Intake
- Assessment
- Service plan development
- Service plan implementation
- Crisis intervention
- Monitoring and follow-up
- Reassessment
- Discharge
- Case conferencing
- Communication Between Psychosocial Case Management and the PCP

Communication between Psychosocial Case Management and the PCP

Regular communication between the member’s Case Manager and primary care provider is essential to assure coordination of care and to identify any gaps in or duplication of services.

Members receiving COBRA Case Management

The primary case management for members receiving both COBRA and other community-based case management services will be provided by the COBRA agency. Communication between the various agencies will consist of paper and telephonic referrals, case conferences and medical case management service plan update(s). It is the responsibility of the COBRA Case Manager to assure that case conferences are performed at the following intervals:
- Initial assessment and development of service plan (within 30 days of enrollment).
- Subsequent reassessments and service plan updates (every 180 days).
- Medical case management update (every 180 days). A copy of the completed status form will be maintained in the member’s file at both sites.
- Whenever there is a dramatic change in the member’s situation.

Members Receiving Non-Intensive HIV Psychosocial Case Management

If non-intensive case management is being provided by a site or CBO, the Case Manager is responsible for providing feedback to the member’s PCP using an appropriate format such as a “Case Management Update” form. If non-intensive case management is provided by the DAC, it is the responsibility of the Case Manager to follow-up with the individual psychosocial community-based organizations (e.g., housing, legal) and to chart all service referral(s) and outcome(s) in the member’s chart for review by and with the PCP.

The provision of psychosocial case management services is monitored through the Psychosocial Committee of VNSNY CHOICE’s Quality Improvement Program
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Care Management

A VNSNY CHOICE Care Manager is assigned to each member based on a member’s geographic location or care needs and is responsible for care across all settings, i.e. community, hospital, or nursing home. Upon enrollment and if there is a change, members are given the contact number for their Care Manager. Members may also call the VNSNY CHOICE toll free number which is listed in Section 1 of this provider manual.

The Care Manager assigned to the member is responsible for initial assessment, ongoing monitoring and reassessment, coordination and authorization of services. This will be done in collaboration with the member’s physician, team members and other disciplines within VNSNY CHOICE, its network, and the community. Care Managers are responsible for coordinating covered and non-covered services.

Care planning is further supported through VNSNY CHOICE’s cooperative agreement with VNSNY Home Care’s Clinical Triage Unit, which provides 24 hour/365 days nursing telephone consultation (live voice) and, when necessary, nursing or home health aide services in the home.

Care management is also supported by contracts with network providers specifying responsibility for timely initiation of services, adherence to VNSNY CHOICE standards of care and participation in joint planning and written and verbal communication.

The Care Manager also utilizes formal and informal linkages with community services in planning care. This includes community resources, reflecting programs and services available in the neighborhoods served by each team. In addition, Social Workers, participate in clinical conferences and interdisciplinary rounds. These meetings, focused on developing care management strategies may also include medical directors, clinical pharmacist, rehabilitation consultants, behavioral health specialists and nurse practitioners who are available to staff for consultation on members who present with multiple comorbid conditions and complex psychosocial problems.

The Care Manager, through ongoing assessment of members in hospitals and nursing homes, will regularly consult with facility staff to ensure an appropriate and effective inpatient plan of care that seeks to improve and stabilize the member’s health status and aid in the return of the client to the community, where possible.

Care management is an ongoing process. Through home visits, telephone contacts with members, caregivers, and communication with physicians, hospitals, disciplines and programs, the Care Manager is in touch with the member and their families about his/her condition and progress. As part of this process, the Care Manager is able to identify the need for further intervention, including the need for urgent or emergency services.

Role of VNSNY CHOICE MLTC in Nursing Homes

As a managed long term care plan, VNSNY CHOICE is responsible for nursing home care that is traditionally covered by Medicaid. As the payer, VNSNY CHOICE must play a significant role in the ongoing management of a member’s nursing home stay. These responsibilities are
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outlined below and described in more detail in Section 9 “Claims and Billing” and Section 12 “Quality Management”.

Regulatory Compliance

VNSNY CHOICE is bound by Medicaid and Medicare regulations. Consequently, the nursing home will be asked to provide the most recent State DOH, CMS and/or other regulatory/accreditation surveys on an annual basis. If there are ever any regulatory sanctions that prohibit Medicaid or Medicare admissions, VNSNY CHOICE must be notified at once.

Coordination of Care

VNSNY CHOICE Nurse Consultants and Social Workers are the Care Managers for their members across all settings. During the nursing home stay, the Care Managers continue to play a role in monitoring the member’s care and status. They will come and visit their patients and review the plan of care. They may request to speak to nursing home staff and attend the care planning meeting for their member. Regardless of whether the admission is from a hospital or directly from the community, the VNSNY CHOICE Care Manager plays a significant role in the admission process, and is the point person for ongoing communication regarding the member’s specific health needs.

Any Hospital Admission or Other Significant Change

VNSNY CHOICE must be contacted if there are any significant changes to a member’s status (hospital admission, discharge AMA, or death). Care Managers continue to monitor their patients if there is a hospital admission. The nursing home MUST contact the Care Manager or VNSNY CHOICE immediately so that they can be involved and make any decisions or authorizations needed such as bedhold for the member.

Services and Reimbursement

VNSNY CHOICE is contracted with the nursing home and pays for the same set of services that are required under Medicaid. The program acts as the payer in the place of Medicaid. VNSNY CHOICE generally follows Medicaid rules for payment. For example:

- Bedhold – same timeframes and notification processes apply but communication is with the VNSNY CHOICE Care Manager.
- Effective January 1, 2006, pharmacy services are no longer a covered benefit in the VNSNY CHOICE program.

NAMI and Medicaid Recertification

VNSNY CHOICE will continue to collect any Medicaid surplus for its members until the member’s placement becomes permanent, i.e. a custodial stay. VNSNY CHOICE will coordinate with the nursing home’s billing department regarding the timing and amount of the NAMI, and payments will be adjusted accordingly. Upon placement, the nursing home should follow
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through with the conversion packet for Institutional Medicaid with HRA. VNSNY CHOICE manages all Medicaid recertification activity with HRA and will coordinate with the nursing home for any necessary information.

Nursing Home Admission Procedures

It is the goal of VNSNY CHOICE to care for members in the home for as long as it is clinically appropriate to do so. However, we recognize that for some members, nursing home services are appropriate following a hospital stay or as a long term care placement. The following procedures have been developed to ensure that the nursing home has the information it needs to admit a VNSNY CHOICE member, and to facilitate a smooth transition for our members and their families during this stressful time.

If the member is being admitted directly from the hospital:

1. The VNSNY CHOICE Care Manager works with the hospital discharge planner to identify a nursing home in the VNSNY CHOICE Provider Network that is appropriate to meet the member's needs. The member and family must agree to the placement and the choice of facility.

2. The hospital's discharge planner will check with the nursing home to be sure that an appropriate bed is available for the member.

3. The hospital staff completes the PRI and forwards it to the nursing home.

4. The nursing home reviews the PRI and assigns the member to a floor and bed that is appropriate for his/her needs.

5. Upon hospital discharge, the hospital arranges transportation to the nursing home and informs the nursing home that the member is coming.

6. The nursing home follows its standard admission process. The member must be seen by a physician within 48 hours of admission to the nursing home.

7. The Care Manager will contact the nursing home within one week to ensure that the member is receiving appropriate care. During this call or visit, the Care Manager will talk with the nursing home’s staff and will establish a communication plan for ongoing care management.

8. The nursing home will convene a case conference within two weeks of the member’s admission. The VNSNY CHOICE Care Manager will attend this meeting.
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If the member is being admitted directly from the community:

1. The VNSNY CHOICE Care Manager works with the member and his/her family to identify a nursing home in the VNSNY CHOICE Provider Network that is appropriate to meet the member's needs. The member and family must agree to the placement and the choice of facility.

2. The Care Manager will check with the nursing home to be sure that an appropriate bed is available for the member.

3. A VNS nurse completes the PRI and forwards it to the nursing home.

4. The nursing home reviews the PRI and assigns the member to a floor and bed that is appropriate for his/her needs.

5. On the agreed upon admission date, VNSNY CHOICE arranges transportation to the nursing home and informs the nursing home that the member is coming.

6. The nursing home follows its standard admission process. The member must be seen by a physician within 48 hours of admission to the nursing home.

7. The Care Manager will contact the nursing home within one week to ensure that the member is receiving appropriate care. During this call or visit, the Care Manager will talk with the nursing home's nursing staff and will establish a communication plan for ongoing care management.

8. The nursing home will convene a case conference within two weeks of the member's admission. The VNSNY CHOICE Care Manager will attend this meeting.

Transportation Guidelines

A. Ordering Service
Transportation to medical appointments, social day and other health related services are covered by VNSNY CHOICE. The program arranges for car or ambulette services, based on the individual’s functional status and uses only transportation companies approved by VNSNY CHOICE to provide these services. The process for arranging transportation is outlined below:

1. Members are asked to call VNSNY CHOICE Regional Offices at least 48 hours in advance to arrange their transportation needs. Therefore, we will generally be able to give the provider 24 to 48 hours advance notice of scheduled trips. However, due to the changing health needs of our members, we may request service for the same day.

2. A Member Services Representative (MSR) will call/fax the transportation provider to order services. The MSR will specify the following information:
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- **a.** Type of vehicle
- **b.** Addresses and times for pick-up/drop-off
- **c.** Escort e.g. Home Health Aide/Caregiver (if applicable)
- **d.** Wheelchair (if applicable)
- **e.** 2-person assist (if needed)
- **f.** Special needs e.g. portable oxygen or hydraulic lift

3. The order will be transmitted to the transportation provider via the established internet portal or by fax.

4. The transportation provider then provides services, according to the specifications on the VNSNY CHOICE order form.

**B. Wait Time Authorization (Car Service)**

1. All wait times beyond the 15 minutes grace period must be approved by VNSNY CHOICE. The transportation provider should call the MSR 10 minutes into the 15 minutes grace period for authorization of the wait time.
2. The MSR is authorized to approve increments of 15 minutes of paid wait time not exceeding 30 minutes.
3. The MSR must obtain approval from management for wait time that exceed 30 minutes.
4. Provider should notify MSR prior to releasing the vehicle.
5. Upon request from the provider the MSR will fax a copy of the Order Processing Screen of the transportation order indicating authorized wait time.
6. All approved wait times are documented in the Order Processing System for claims adjudication.

**C. Cancellations**

The member should notify the MSR 24 hours prior to the scheduled pickup time. This will allow the MSR to give the provider 24 hours notice of cancellation. However, if 24-hour notice is not possible, a cancellation will be considered as follows:

1. **Car Service:** When the MSR or member notifies the car service provider 30 minutes (or less) prior to scheduled pick-up time.
2. **Ambulette:** Requires 24-hour notification prior to scheduled pick-up time.

Any cancellation after the pick up time will be considered a "no show".

Please refer to contract for when reimbursement for cancellation is applicable.

**D. "No Show"**

When a member of VNSNY CHOICE fail to notify a transportation provider of the cancellation of a trip and the provider has dispatched the car or ambulette.

Please refer to contract for reimbursement of “no show.”
E. Provider Late
A provider is considered late for a pickup when:

1. A car arrives 15 minutes after the scheduled pick up time
2. An ambulette arrives 30 minutes after the scheduled pick up time

The MSR will contact the provider 15 minutes after the scheduled pick up time to check the status of the pick up.

F. Tolls
Tolls will be reimbursed where applicable according to the terms of the contract (see Appendix A of your contract).

G. Stops
VNSNY CHOICE will not reimburse for any unauthorized stops.

H. Order Update
An update is any change to an existing order. Updates will be communicated to the provider as soon as they are available to the MSR.

I. Escorts
VNSNY CHOICE will only authorize one escort (Home Health Aide/Caregiver)

Emergency Procedures

An emergency medical condition is 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 behavioral condition, placing the health of the person or others in serious jeopardy; or (b) serious impairment to such person’s bodily functions; or (c) serious dysfunction or any bodily organ or part of such person; or (d) serious disfigurement of such person.

While emergency services are not provided through VNSNY CHOICE, member use of urgent and emergency services is monitored by VNSNY CHOICE to assure appropriate utilization of services and to ensure that the plan of care remains consistent with their changing needs.

The member and caregiver are provided with education about significant signs and symptoms that would require immediate hospitalization. The procedures for obtaining emergency care are reviewed. Members are instructed to call 911 in an emergency or urgent care situation and do not need any prior approval from VNSNY CHOICE.

For example, in the event that a member’s condition continues to worsen or a sudden, unanticipated change occurs requiring emergency care, and the care manager is in the home or contacted by the member/family, arrangements are made for the member to receive care. One of two options are pursued: (1) If the member’s condition allows, arrangements are made to
transport the member to the hospital emergency department; or, (2) 911 is called and the member is transported to the emergency department by EMS.

Once the emergency is over and the member’s condition has stabilized, members are requested to notify their physicians and VNSNY CHOICE.

**24-Hour Coverage**

VNSNY CHOICE provides 24-hour/365 day nursing telephone consultation (live voice) and allows for timely referral to emergency services (911). Additionally, a VNSNY CHOICE Care Manager is on-call at all times to cover for the member’s assigned Care Manager. If a member calls the VNSNY CHOICE regional office after business hours, the call is automatically routed to VNSNY Home Care’s Clinical Triage Unit.

**Prior Authorizations** (for a new service or a new authorization period):

For those services that are VNSNY CHOICE covered benefits, VNSNY CHOICE will help members obtain these services from network providers, including making appointments and arranging transportation. Providers will receive orders indicating the service, frequency, and duration from VNSNY CHOICE either verbally and/or on paper via fax.

When VNSNY CHOICE orders services on behalf of a member, the order is documented in VNSNY’s care management and/or order processing system (OPS). In cases where a member may self-refer, the following process should occur:

- **Annual routine eye exam**: Provider should contact the Membership Coordinator at the appropriate region (see telephone numbers in Section 1 of this provider manual) to verify eligibility.
- **Dental Services**: Provider should contact VNSNY CHOICE’s designated agent, Healthplex, Inc., at the telephone number listed in Section 1 of this provider manual to verify eligibility and coverage. Healthplex providers should follow Healthplex guidelines and predetermination procedures.

Members and providers will be notified both by telephone and in writing within 3 business days of receipt of necessary information. Providers will receive a copy of the form that is sent to VNSNY CHOICE members which explains the health plan’s decision and indicates appeal rights.

Please see Section 14 for a list of VNSNY CHOICE MLTC services that require Prior Authorization or you can check our website at www.vnsnychoice.org.

**Concurrent Authorizations** (for a change in service level within an authorization period):

Members and providers will be notified both by telephone and in writing within 1 business day of receipt of necessary information. Providers will receive a copy of the form that is sent to
VNSNY CHOICE members which explains the health plan’s decision and indicates appeal rights.

**Retrospective Authorizations**

Members and providers will be notified in writing within 30 days of receipt of necessary information.

When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one (1) business day of receipt of the request in writing and shall be conducted by the member’s health care provider and the clinical peer reviewer making the initial determination.

If you need to contact our Medical Management Department, please see the contact information in Section 1 of this provider manual.
Section 14: Services the Require Prior Authorization

The following list of services requires prior authorization by VNSNY CHOICE Medicare Advantage Plan providers. The list includes but is not limited to the following services:

Prior authorization is required for all elective admissions, outpatient surgery, and outpatient treatment and testing if the services are being provided in a facility that is not participating (out-of-network provider) with VNSNY CHOICE Medicare Advantage plans.

The following procedures require prior authorization including but not limited to:

- Elective non-participating hospital admissions, including mental health admissions
- All Skilled Nursing Facility (SNF) admissions
- All procedures considered experimental /investigational that are required by Medicare to be covered services
- All transplants and all transplant evaluations
- All Referrals to non-participating providers
- The following surgeries:
  - Bariatric surgery
  - Breast Cancer surgery
  - Hysterectomy
  - Surgery which may be considered Cosmetic
  - Experimental/Investigational procedures
  - Clinical Trials
- Speech, occupational and physical therapies after the initial 8 visits per discipline per calendar year. No authorization is required for in-network providers for the first 8 visits.
- Home health and visiting nurse services
- Select Radiology including MRIs, MRAs, and PET Scans
- Select Durable medical equipment as well as prosthetics and orthotics
- Ambulance transportation in non-emergency situations

A complete Prior Authorization list is available on the VNSNY CHOICE website – www.vnsnychoice.org.
Section 14: Services the Require Prior Authorization

The following list of services requires prior authorization by VNSNY CHOICE SelectHealth providers. The list includes but is not limited to the following services:

- Allergen Desensitization Treatments
  - Physicians (PCPs) can request authorization for out of network services.

- Ambulance/Ambulette and Livery Care Services (non-emergency)
  - Outpatient (non-emergency) requires prior authorization.
  - All requests are referred to Member Services. Requires approval from MD and the approval cannot exceed more than one (1) year.

- Ambulatory Surgery
  - Physicians (PCPs) can request authorization for out of network services.

- Bariatric Surgery
  - Requires prior authorization for medical necessity and to assure that the place of service is designated by the Centers for Medicare and Medicaid Services as a certified center for bariatric surgery or that a hospital has been designated by the SDOH as a “Bariatric Specialty Center”.

- Birthing Centers
  - Physicians (PCPs) can request authorization for out of network services.

- Breast Cancer Center
  - Requires prior authorization to assure that members are not receiving care at a facility considered to be “low volume” by the NYS Department of Health. Only the place of service requires approval.

- Cardiac Rehabilitation (Outpatient)
  - Prior Authorization is not required for the initial 36 visits. Visits exceeding 36 require prior authorization.
  - Physicians (PCPs) can request authorization for out of network services.

- Chemotherapy (Outpatient)
  - Physicians (PCPs) can request authorization for out of network services.

- Chemotherapy (Inpatient)
  - Prior Authorization is required for non-participating facilities.

- Continuity of Care - Provider Left the Network
- Continuity of Care - New Member with a Non-Participating Provider

- Cosmetic Surgery

- CT Scan and Interpretation
  - Physicians (PCPs) can request authorization for out of network services.

- Dental
  - Requires Prior Authorization for elective inpatient admissions and ambulatory surgery.

- Diabetic Equipment and Supplies:
  - DME that costs more than $250 requires Prior Authorization.

- Dialysis (Outpatient)
  - Physicians (PCPs) can request authorization for out of network services.

- Durable Medical Equipment
  - All rentals require Prior Authorization.

- Experimental Procedures/Services
- Freestanding Surgical Centers
  - Members or physicians (PCPs) can request authorization for out of network services.

- Hearing Testing
  - Physicians (PCPs) can request authorization for out of network services.
Section 14: Services the Require Prior Authorization

- Hearing Aids
- Hearing Implants
- Home Health Care
  - Requires Prior Authorization. However, all initial evaluation visits do not require an authorization following an inpatient hospitalization.
- Home Health Care Post Partum
  - Physicians (PCPs) can request authorization for out of network services.
- Hospital Admissions – Elective Scheduled
  - Elective admissions to a non-par hospital require prior authorization. An elective admission to a non-par hospital requires prior authorization five (5) days prior to admission. However, the plan will review notification that is received later than the five (5) day period.
  - Admission authorizations cover all inpatient services.
- Hospital – Outpatient Services
  - Prior Authorization is required for non-par outpatient services
- Hysterectomy (elective)
- Impacted Wisdom Teeth
  - Requires prior authorization if done in an inpatient or ambulatory surgical setting.
- In-Office Procedures
  - Prior Authorization is necessary for non-par providers.
  - Prior authorization is needed for experimental/investigational procedures in a physician’s office.
- Insulin Pump
- Investigational Procedures/Services
- IV Infusion Therapy
  - Physicians (PCPs) can request authorization for out of network services.
- Laboratory – Diagnostic or Clinical
  - Members or PCPs can request authorization for out of network services.
- Mammography – Screening
  - Members or PCPs can request authorization for out of network services.
- Mammography – Diagnostic
  - Members or PCPs can request authorization for out of network services.
- Medical Supplies
  - All medical supplies the cost more than $250 require authorization.
- MRI
  - Physicians (PCPs) can request authorization for out of network services.
- Multiple Surgeries
  - Non-emergent multiple surgeries are authorized, if medically necessary.
- Non-Participating Providers (Elective)
- Nursing Home (SNF Level of Care)
- Observation Beds
  - Prior Authorization is required for non-par physicians.
- Occupation Therapy (Change in Coverage Effective 10/1/11)
Section 14: Services the Require Prior Authorization

- Outpatient occupational is limited to 20 visits per calendar year. For members under the age of 21 or developmentally disabled, additional visits can be approved if medically necessary.
- Physicians (PCPs) can request authorization for out of network services.
  - Out of State Care (Elective)
    - Case must be referred to Medical Director.
  - Oral Surgery
    - Requires prior authorization for elective inpatient admissions and ambulatory surgery.
  - Orthotics
    - Requires prior authorization if item costs more than $250. Coverage limitations are based on the MDM DME manual.
    - Prior Authorization is necessary for non-par providers, regardless of the cost.
  - Personal Care Services (Coverage effective 8/1/11)
    - Requires Prior Authorization. Services are limited to 8 hours per week for members receiving only housekeeping (Level 1). Other services include total assistance with personal hygiene, dressing and feeding, and assisting in preparing meals. (MD order is required and services must be medically necessary).
  - Physical Therapy (Outpatient) (Changed in coverage effective 10/1/11)
    - Outpatient physical therapy is limited to 20 visits per calendar year. For members under the age of 21 or developmentally disabled, additional visits can be approved if medically necessary.
    - Prior authorization required for non-par providers.
  - Podiatry
    - Prior Authorization is required for non-par providers.
  - Pre-Op Day
    - Prior Authorization is required for non-par providers.
  - Pre-Surgical (Admission) Testing
    - Physicians (PCPs) can request authorization for out of network services.
  - Prosthetic Devices
    - Requires Prior Authorization if the item costs more than $250.
    - Physicians (PCPs) can request authorization for out of network services.
  - Private Duty Nursing (Inpatient or Home Care)
    - Prior authorization required after initial assessment completed.
  - Radiation Therapy
    - Prior authorization not required if performed at par facility.
    - Physicians (PCPs) can request authorization for out of network services.
  - Radiology – Diagnostic
    - Physicians (PCPs) can request authorization for out of network services.
  - Rare Disease Treatment
    - Referrals to Out of Network (OON) Specialists and Other Providers (Elective)
    - Requires Prior Authorization.
    - Elective referrals to OON providers require approval from the Plan.
  - Referrals to Network “ Specialty Care Centers”
  - Referrals to Out of Network “Specialty Care Centers”
  - Rehabilitation, Physical (Inpatient – Hospital)
  - Rehabilitation, Physical (Inpatient – Other Facility)
Section 14: Services the Require Prior Authorization

- Second Opinions
  - Physicians (PCPs) can request authorization for out of network services.
- Sex Change
- Shoe Inserts
  - Requires Prior Authorization only if the cost is more than $250 and if the request exceeds more than one (1) per foot per year.
  - Non-Par providers require authorization
- Sleep Apnea Study
- Skilled Nursing Facility – Short Term Rehab
- Skilled Nursing Facility – Short Term Skilled Needs
- Specialist as PCPs – In Network Provider
- Specialist as PCP – Out of Network Provider
- Speech Therapy (Change in coverage effective 10/1/11)
  - Outpatient speech therapy is limited to 20 visits per calendar year. For members under the age of 21 or developmentally disabled, additional visits can be approved if medically necessary.
  - Physicians (PCPs) can request authorization for out of network services.
- Standing Referrals to Out of Network Specialists
- Sterilization Reversal
- TENS Unit
  - Requires Prior Authorization if the cost is greater than $250.
  - Physicians (PCPs) can request authorization for out of network services.
- Transplants
- Transportation (Out-Patient), Non-Emergency (Car Service, MetroCards, Ambulette/Ambulance), Inpatient (Car Service, Ambulette/Ambulance)
  - Outpatient (OP) (non-emergency) – Requires approval from MD not to exceed one (1) year
  - In-patient (non-emergency) – Does not require authorization

A complete Prior Authorization list is available on the VNSNY CHOICE website – www.vnsnychoice.org.
Section 14: Services the Require Prior Authorization

The following list of services requires prior authorization by VNSNY CHOICE Managed Long Term Care providers. The list includes but is not limited to the following services:

- Adult Day Services
- Audiology Services
- Chore or Housekeeping Services
- Home Care Services, including nursing care, social work services, rehabilitation therapies, nutritional counseling, and home health aide services
- Home Delivered Meals
- Home Safety Modifications
- Medical and Surgical Supplies
- Medical Equipment
- Nursing Home Care
- Nutritional Supplements
- Outpatient Rehabilitation Therapy
- Personal Emergency Response System (PERS)
- Podiatry (required if the services are not covered by Medicare)
- Respiratory Therapy and Oxygen
- Transportation

A complete Prior Authorization list is available on the VNSNY CHOICE website – www.vnsnychoice.org.
Appendix A: VNSNY CHOICE Medicare Advantage Plan Forms

List of documents included in this section:

1. Medical Coverage Determination Form
2. Part-D Prescription Drug Coverage Determination Form
3. Medicare Part-D Coverage Exception Form
4. Transitional Coverage Request Form – Request for Continuity of Care for Medical Benefits
5. Provider Dispute Resolution Form
6. Sample CMS-1500 Professional Claim Form
7. Sample CMS-1450/UB-04 Institutional Claim Form
8. An Important Message from Medicare About Your Rights
Medical Coverage Determination Form

FAX AUTHORIZATION REQUEST FORM FOR COVERAGE DETERMINATIONS

Please utilize this form as an alternative to calling in request(s) or services. This form should be faxed to VNSNY CHOICE Utilization Management Department at 1-866-791-2214. Should you have any questions please call 1-866-793-0222. Thank you for your cooperation.

♦ PATIENT & INSURANCE INFORMATION (PLEASE FILL-IN AVAILABLE) ♦

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Patient Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID #</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Patient's Home Telephone</td>
<td>Alternate Telephone</td>
</tr>
<tr>
<td>Other insurance</td>
<td>Effective Date</td>
</tr>
</tbody>
</table>

Is this service related to:  □ Motor vehicle accident  □ Worker's Compensation  □ Other

♦ AUTHORIZATION INFORMATION ♦

<table>
<thead>
<tr>
<th>Date of Request</th>
<th>Service Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of onset of service/hospital admission</td>
<td>Requested length of stay/service</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ICD9 Code(s)</td>
</tr>
<tr>
<td>Procedure</td>
<td>CPT Code(s)</td>
</tr>
</tbody>
</table>

In order to expedite your request in a timely manner, please submit copies of all pertinent medical information.

♦ PHYSICIAN INFORMATION ♦

<table>
<thead>
<tr>
<th>Ordering/Attending Physician Name</th>
<th>Tax ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City/State</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>Fax Number</td>
</tr>
<tr>
<td>Facility</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>Submitted by</td>
<td>Physician Signature</td>
</tr>
</tbody>
</table>

♦ FOR INTERNAL USE ONLY ♦

Authorization Status: □ Approved Authorization #: ___________________________

LOS/# Visits: ___________________________ Dates of Service: ___________________________

□ Denied □ Pended

Additional Information ___________________________ Medical Review ___________________________

CONFIDENTIALITY NOTICE: This fax transmission contains information to the sender, which may include proprietary information of VNSNY CHOICE. The information is intended only for the use of the individual identified above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this faxed information is strictly prohibited. If you have received this fax in error, please notify us by telephone immediately to arrange for return or destruction of the documents.

Service Request form 11/2010
# PART-D PRESCRIPTION DRUG COVERAGE DETERMINATION FORM

## REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

### Enrollee's/Requestor's Information

<table>
<thead>
<tr>
<th>Enrollee's Name</th>
<th>Enrollee's Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee's Medicare Number</td>
<td>Enrollee's Part D Plan ID Number</td>
</tr>
<tr>
<td>Requestor's Name (if not enrollee)</td>
<td></td>
</tr>
<tr>
<td>Requestor's relationship to Enrollee (attach documentation that shows authority to represent enrollee, if other than prescribing physician)</td>
<td></td>
</tr>
</tbody>
</table>

### Enrollee/Requestor's Address

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

### Phone

Phone

### Name of prescription drug you are requesting (if known, include strength, quantity and quantity requested per month):

### Prescribing Physician's Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Medical Specialty</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
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<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Work Phone</th>
<th>Fax</th>
<th>Office Contact Person</th>
</tr>
</thead>
</table>

### Type of Coverage Determination Request

- □ I need a drug that is not on the plan's list of covered drugs (formulary exception).*
- □ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*
☐ I request an exception to the requirement that I try another drug before I get the drug my doctor prescribed (formulary exception).*

☐ I request prior authorization for the drug my doctor has prescribed.

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

*NOTE: If you are asking for a formulary or tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request. You cannot ask for a tiering exception for a drug in the plan's Specialty Tier. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs.

Additional information we should consider (attach any supporting documents):

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

☐ I need an expedited coverage determination (attach physician’s supporting statement, if applicable)

Beneficiary/Requestor's Signature ___________________________ Date _____________

Send this request to your Medicare drug plan. Note that your Medicare drug plan may require additional information. See your plan benefit materials for more information.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.
Part-D Prescription Drug Coverage Exception Form

<table>
<thead>
<tr>
<th>Plan Name</th>
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<tbody>
<tr>
<td>Phone #</td>
<td></td>
</tr>
<tr>
<td>Fax #</td>
<td></td>
</tr>
</tbody>
</table>

**Medicare Part D Coverage Determination Request Form**

This form cannot be used to request:
- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- Biotech or other specialty drugs for which drug-specific forms are required. [See Part D plan website.] OR [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCovGenInl04_Formulary.asp]

<table>
<thead>
<tr>
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<th>Prescriber Information</th>
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<tbody>
<tr>
<td>Patient Name:</td>
<td>Prescriber Name:</td>
</tr>
<tr>
<td>Member ID#:</td>
<td>NPI# (if available):</td>
</tr>
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<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
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<td>Office Fax #:</td>
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<td>Sex (circle):</td>
<td>DOB:</td>
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<td>Contact Person:</td>
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**Diagnosis and Medical Information**

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Strength and Route of Administration:</th>
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<tbody>
<tr>
<td>Qty:</td>
<td>Frequency:</td>
</tr>
<tr>
<td>New Prescription</td>
<td>Expected Length of Therapy:</td>
</tr>
<tr>
<td>Date Therapy Initiated:</td>
<td>Agreed upon:</td>
</tr>
<tr>
<td>Height/Weight:</td>
<td>Drug Allergies:</td>
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<tr>
<td>Diagnosis:</td>
<td></td>
</tr>
<tr>
<td>Prescriber’s Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

**Rationale for Exception Request or Prior Authorization**

**FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION**

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)
  - Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s).
- Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s), high risk of significant adverse clinical outcome with medication change
  - Specify below: Anticipated significant adverse clinical outcome
- Medical need for different dosage form and/or higher dosage
  - Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason
- Request for formulary tier exception
  - Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome
- Other: Explain below

**REQUIRED EXPLANATION:**

**Request for Expedited Review**

- REQUEST FOR EXPEDITED REVIEW [24 HOURS]
  - BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.
Transitional Coverage Request Form

Subscriber's Name: ____________________________ Subscriber ID No.: ____________________________
Address: ____________________________________
City: ___________________ State: ___________ Zip: __________________
Daytime Tel: _______________ Home Tel: _______________
Policy Effective Date: ____________________

Other Insurance:  [ ] Yes*  [ ] No

*If yes, Name of Insurance: ____________________________ Effective Date: ____________________

This request applies only to members that are currently in treatment for an unstable, severe or life-threatening condition that requires continuation of care with their current provider or for those who have entered their second trimester of pregnancy on or before their VNSNY CHOICE effective date. **Please have your Provider complete the following:**

| Form Completed By: ____________________________ | Title: ____________________________ |
| Name of Treating Provider: ____________________________ | Hospital/Affiliation: ____________________________ |
| Primary Diagnosis: ____________________________ | Complications: ____________________________ |

If pregnant, give estimated Due Date: ____________________________

Date started 2nd trimester: ____________________ Date of Most Recent Visit: ____________________

Frequency of Visits: ____________________________

Date of Most Recent Hospitalization (if applicable): ____________________________

Name of Hospital:

For the latest Hospitalization please provide:

- [ ] Primary Diagnosis
- [ ] Copy of discharge summary
- [ ] Copy of operative report
- [ ] Copy of pathology report

Current Therapy: ____________________________

Proposed Treatment Plan: ____________________________

Duration Treatment: ____________________________

I agree to accept VNSNY CHOICE reimbursement as payment in full. I also agree to comply with all of VNSNY CHOICE UM/QI policies and procedures.

Physician Signature: ____________________________ Date: ____________________

I understand that requests for continuity of care transition benefits are approved at the sole discretion of VNSNY CHOICE and the term of any such transition period will terminate when VNSNY CHOICE determines that care can be safely transferred to a network participating provider. I further understand that once the transition period has expired or my request is denied, the benefit for out-of-network services as stated in my subscriber contract will apply. I understand that any claim by me may be denied and/or coverage cancelled without written notice if I have provided materially false information in my request. My signature below authorizes the provider indicated to release medical records to VNSNY CHOICE Utilization Management Department in order to review this request. I have reviewed the information supplied on this form and attest to its accuracy to the best of my knowledge.

Member's Signature: ____________________________ Date: ____________________

To expedite this process, please FAX form to: 1-866-791-2214 OR mail form to:
VNSNY CHOICE Medicare
Attn: UM Department
1250 Broadway
New York, NY 10001

<table>
<thead>
<tr>
<th>For Office Use Only:</th>
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<tr>
<td>[ ] Approved Date:</td>
</tr>
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</table>
| [ ] Denied Signature:

Transitional Coverage Request Form 11/2010
**PROVIDER DISPUTE RESOLUTION REQUEST**
for Medicare or Medicaid Advantage claims only

**INSTRUCTIONS**
- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Please include a copy of the original claim(s) as well as a copy of the remittance.
- Mail or fax the completed form to:

  **VNSNY CHOICE**
  Attn: Grievance and Appeals Department, 3rd Floor
  1250 Broadway
  New York, NY 10001
  Fax: 866-791-2213

<table>
<thead>
<tr>
<th>*Provider Name:</th>
<th>*Provider NPI:</th>
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</table>

**Provider Address**

**Provider Type:**
- **MD**
- **SNF**
- **Ambulance**
- **Hospital**
- **DME/Supplies**
- **Home**
- **ASC**
- **Rehab**
- **Other (please specify)**

**Claim Information**
- Single
- Multiple “LIKE” Claims (see additional form)
- Number of Claims: ___

<table>
<thead>
<tr>
<th>*Patient Name</th>
<th>Date of Birth:</th>
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<table>
<thead>
<tr>
<th>*Health Plan ID Number</th>
<th>Patient Account Number</th>
<th>Original Claim Number: (If multiple claims, use attached form)</th>
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<table>
<thead>
<tr>
<th>Service “From/To” Date</th>
<th>Original Claim Amount Billed:</th>
<th>Original Claim Amount Paid:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**DISPUTE TYPE**
- **Claim Payment Dispute**
- **Contract Dispute**
  - Dispute of Medical Necessity / Utilization Management Decision
  - Other (please specify)

**DESCRIPTION OF DISPUTE**

**EXPECTED OUTCOME**

<table>
<thead>
<tr>
<th>Contact Name:</th>
<th>Title:</th>
<th>Phone:</th>
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<table>
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Sample CMS-1450/UB-04 Institutional Claim Form

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**PAGE OF** 1  **CREATION DATE** 11/15/95  **TOTALS**

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**Remarks**

- LAST
- Previous
- Other
- Date

**Page 1 of** A-9
An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

- Be involved in any decisions about your hospital stay, and know who will pay for it.

- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

  Name of QIO

  Telephone Number of QIO

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.

- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.

  - If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.

  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.

- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call ____________________________.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative

Date/Time

Form CMS-R-193 (approved 07/10)
Steps To Appeal Your Discharge

- **Step 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  
  - Here is the contact information for the QIO:
    
    | Name of QIO (in bold) |
    |------------------------|
    | Telephone Number of QIO |
    |
  
  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  
  - Ask the hospital if you need help contacting the QIO.
  
  - The name of this hospital is:
    
    | Hospital Name | Provider ID Number |
    |---------------|--------------------|
    |               |                    |

- **Step 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

- **Step 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.

- **Step 4:** The QIO will review your medical records and other important information about your case.

- **Step 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
  
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  
  - If you have Original Medicare: Call the QIO listed above.
  
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.

- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1859.
Notice Instructions: The Important Message From Medicare

Completing The Notice

Page 1 of the Important Message from Medicare

A. Header

Hospitals must display “Department of Health & Human Services, Centers for Medicare & Medicaid Services” and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: Fill in the patient’s full name.

Patient ID number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.

Physician: Fill in the name of the patient’s physician.

B. Body of the Notice

Bullet number 3 – Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here ————————————————————.

Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

Page 2 of the Important Message from Medicare

First sub-bullet – Insert name and telephone number of QIO in bold: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials, date, and time to document delivery of the follow-up copy of the IM, or documentation of refusals.
Appendix B: VNSNY CHOICE SelectHealth

List of documents included in this section:

1. Tips About Partner Notification
2. STD Screening for HIV Positives
3. MetroCard Sample Letter and Provider Request Form
4. HIV Related Confidentiality
5. Authorization for Release Health Information and Confidential HIV-Related Information (DOH-2537) and Information Concerning Submission of the Form
6. Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information (DOH –5032) and Technical Specifications
7. Provider Referral for Consultative Subspecialist (Private Office and Clinic)
8. Provider Directory Listing Update Form
9. Patient Health Questionnaire (PHQ)
10. Compendium of Clinical Guidelines Relevant to the Care of People Living With HIV/AIDS (PLWHA) and their Dependent Children
Tip Sheet for Partner Notification: What Providers Need to Know

What are health care provider responsibilities for reporting cases of HIV infection, HIV-related illness and AIDS?

Since June 1, 2000, the New York State Department of Health has established an integrated HIV/AIDS surveillance system to monitor cases of HIV infection, HIV-related illness and AIDS. Under the new regulations, health care providers will report newly diagnosed cases of HIV infection, HIV-related illness and AIDS.

**Reporting of HIV infection:** Physicians, nurse practitioners (NPs), physician assistants (PAs) and nurse midwives will be responsible for reporting to the Health Department all persons they newly diagnose with HIV infection. Providers should report cases of HIV infection by completing the Medical Provider HIV/AIDS and Partner/Contact Form within 21 days of the diagnosis. In New York City, health care providers will call the New York City DOH Office of AIDS Surveillance at the phone number listed on the form and arrange for pick-up of the reports.

**Reporting of HIV-related illness:** Health care providers may complete a report form for new diagnosis of HIV-related illness; this will also be tracked through laboratory reporting of all positive viral load tests, CD4 counts less than 500 and CD4/CD8 ratios below 29%. The Health Department will follow-up with the provider to confirm the case, gather epidemiological information and to offer partner notification assistance services.

**Reporting of AIDS:** Providers should continue to report all new diagnoses of AIDS to the Department of Health using the new reporting form.

**Delegating reporting responsibilities:** Physicians, NPs, PAs and nurse midwives may delegate specific tasks associated with reporting to other supervised members of the care team. However, it is the responsibility of the diagnosing physician, NP, PA or nurse midwife to be sure that reporting of new cases of HIV infection and AIDS takes place and that all reporting forms are appropriately signed.

What are health care provider responsibilities regarding HIV partner/spousal notification?

The new program requires providers to:

- Report to the Health Department the names of all known sexual and needle-sharing partners, including spouses, as well as the names of any partners the patient wishes to have notified.
- Report information about partner notification plans and the results of screening for domestic violence of each reported partner on the Medical Provider HIV/AIDS and Partner/Contact Form.
- The law states that there is no penalty if the patient chooses not to name partners or engage in partner notification assistance activities. Public health staff may follow-up with providers on the status of their patient's HIV partner notification.
following a case report.

The responsible local public health officer will determine which cases merit partner notification by public health staff. Upon initial diagnosis of IIIV infection, providers must discuss in post-test counseling the importance of partner/spousal notification and work with the patient to develop a plan for notifying exposed partners.

**Providers should explain the three (3) options for partner notification:**

1. Notification of the partner by the NYSDOH Partner Assistance Program (PNAP) or the NYCDOH Contact Notification Assistance Program (CNAP);
2. Assisted notification of the partner in which the patient notifies the partner with the assistance of a willing provider or a public health counselor from PNAP/CNAP;
3. Self-notification in which the patient notifies the partner him/herself. When self-notification is chosen for a known or named partner, a continuation plan will be worked out between PNAP/CNAP staff and the provider. If PNAP/CNAP cannot sufficiently verify the self-notification, PNAP/CNAP staff may also follow-up with the patient and/or the known partner to confirm the self-notification.

Self-notification is particularly an option if the patient does not wish to disclose the partner's name to the provider. PNAP/CNAP counselors never reveal the name or any information about the HIV positive patient (index case) to the partner(s) during partner notification. Since HIV infection is life-long, providers should routinely discuss with patients the importance of partner notification. These discussions should focus on the importance of avoiding transmission to new partners and may include referring the patient for primary and secondary prevention services at a community-based organization that provides such services.

**How will the state's partner notification assistance programs (PNAP & CNAP) assist providers and patients?**

PNAP and CNAP are public health programs that have many years of experience working with the partners of HIV positive clients. PNAP/CNAP staff can assist health care providers in the following areas:

- Working collaboratively to address the partner notification needs of patients.
- Providing consultation to health care providers who are coaching patients through self-notification.
- Reviewing good practices for conducting a provider-assisted notification.
- Clarifying questions about HIV confidentiality and partner notification.
- Providing information about accessing HIV counseling and testing services.
- Providing information about the specific conditions under which a physician, PA or NP may notify a partner of exposure to HIV without the patient’s consent.
PNAP/CNAP counselors can meet with HIV positive clients to assist with the following services:

- Providing assistance with partner notification.
- Conducting assisted notification of partners, where the PNAP/CNAP counselor meets with the client and partner.
- Conducting notification of partners without revealing the client's name or any identifying information.
- Preparing clients for self-notification of partners
- Assisting patients with arranging for notification of partners who are out of the state.

Information about these programs is available at the following numbers:

PNAP (Statewide, outside NYC) 800-541-2437 (available 9 am-5 pm weekdays)
CNAP (New York City) 212-693-1419 (available 9 am-5 pm weekdays)

Where can I obtain training about these regulations and how can I obtain DOH patient education materials?

The Department of Health has many training and informational resources available for health care providers and the general public. To view a number of these resources visit the DOH web site at www.health.state.ny.us. For more information about training programs or to order a catalog of materials for providers or the general public, call the Health Department at 518-474-9866.
STD Screening for HIV Positives

STD screening and treatment is an essential component of HIV care for several reasons including the observation that control of STDs may reduce the transmission of HIV to uninfected partners. Federal, state and specialty society guidelines suggest the following strategies:

For all HIV Positive Patients:

- Syphilis screening should be done at baseline and at least annually with a non-treponemal test (eg: RPR or VDRL). Repeat screening is advised every 3 months for patients with continued high-risk behavior.
- Gonorrhea and Chlamydia screening should be done at baseline and at least annually for the following patients:
  1. Sexually active women <25 years old.
  2. Women older than 25 with a risk factor such as: recent STI, having multiple sexual partners, having had a new sexual partner, or having a sexual partner with symptoms of an STI.
  3. All HIV-infected men with ongoing risk behavior.

Recommendations for specific subgroups of HIV Patients

1. Pregnant women should have testing for syphilis, hepatitis B surface antigen, and chlamydia at their first prenatal visit.

2. Men Who Have Sex With Men:

   Among MSM, yearly testing for syphilis serology should be performed.

   - For MSMs who have had insertive intercourse within the past year, a yearly urethral Chlamydia and Gonorrhea test (preferably NAAT testing) should be sent.
   - For MSMs who have had receptive anal intercourse within the past year, a yearly rectal Chlamydia and Gonorrhea test (preferably NAAT testing) should be sent.
   - For MSMs who have had had receptive oral intercourse within the past year, a yearly pharyngeal Gonorrhea test (preferably NAAT testing) should be sent.
   - MSMs should be tested for HBsAg to detect early Hepatitis B. Baseline Hepatitis C screening should be done for MSM.

More comprehensive recommendations regarding STD screening and treatment can be found under the CDC STD Treatment Guidelines: http://www.cdc.gov/std/treatment/2010/

June 1, 2012

Provider Staff Name
Provider Name
Provider Address
Provider City, State Zip

Dear Provider Staff Name,

Six (6) MetroCards are enclosed for distribution to VNSNY CHOICE SelectHealth’s Members. Kindly sign the bottom of this letter and fax it back to me at 646-459-7725 to confirm receipt of your MetroCards.

Please do not hesitate to contact me at 212-630-5271 if you have any questions regarding your MetroCards.

Sincerely,

VNSNY CHOICE Plan Employee Name

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HIV RELATED CONFIDENTIALITY

New York State's HIV Confidentiality Law was enacted in 1989 to encourage people to learn their HIV status voluntarily, seek appropriate treatment, and get the education and resources they might need to change behavior that increases the risk of HIV transmission. The law also sought to limit the risk of discrimination, invasion of privacy and other harm caused by unnecessary disclosure of HIV related information.

The HIV Confidentiality Law is Article 27-f of the New York Public Health Law, §§2780-2787 and New York Codes, Rules and Regulations, 10 NYCRR Parts 63, 69-1 and 69-6.

Who and What is Protected?

"Confidential HIV related information" is any information that is obtained by a person who provides health or a social service regarding the HIV status (negative or positive) of an individual, or that is revealed to another person pursuant to a written release. It includes information that:

- Reveals whether a person has been tested for HIV, or has HIV infection, HIV related illness or AIDS;
- Might reasonably identify someone as having been tested for HIV, or having HIV infection, HIV related illness or AIDS; or
- Might reasonably identify the "contacts" of someone who has been tested for HIV, or has HIV infection, HIV related illness or AIDS.
- Contacts include spouses, sexual partners and people with whom syringes have been shared.

Confidential HIV Related Information

The Confidentiality Law protects anyone who has taken an HIV test or has been diagnosed as being HIV+ or having AIDS. A person covered by the law is protected from the release of any HIV related information that might identify him or her as a person who has been tested for HIV or who might be HIV+.

Those Who Must Follow the Law

The only people who have to follow the Confidentiality Law are those who discover confidential HIV related information in the course of providing health or social services, or who obtain information pursuant to a release of confidential HIV related information.

Health and social service providers must obtain an individual's written consent before revealing confidential HIV related information about him or her. In emergencies, a provider may obtain an oral consent: but that must be followed up by written consent within ten days. Other exceptions also apply.
Those Exempt From the Law

The law does not prohibit everyone who learns about confidential HIV related information from disclosing it. In fact, most people are exempt from the law altogether. For instance, the law does not prohibit an HIV+ person, or a person who has taken an HIV test, from revealing that information.

Releasing Information Without Consent

Certain disclosures can be made even without an HIV+ person’s written consent. Thus, a person mandated to protect HIV related information may legally release that information without your consent in the following situations.

- To the protected individual or a person authorized by law to consent to health care for that individual;
- To assist health care providers and facilities provide medical services to the protected individual, including as part of internal communication within a particular treatment/service unit or facility;
- For HIV/AIDS case reporting and contact notification;
- In limited circumstances, to parents or legal guardians, if the protected individual is a minor;
- Pursuant to certain court orders or some federal or state laws;
- For administrative case review and monitoring;
- To foster care and adoption agencies, for limited purposes;
- To third-party payers;
- To insurance institutions, pursuant to a release;
- To health authorities and others regarding newborn testing;
- To corrections, probation, parole and other criminal justice officials and when the person is a sex offender;
- In medical emergencies; and
- For other limited purposes.

Every disclosure of HIV related information should be accompanied by the following warning:

**CONFIDENTIAL**

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization is NOT sufficient for further disclosure.

*NYS Public Health Law, Article 27-F § 2782(5) (a)*
**Content of the Consent**

Unless the information is being disclosed as an exception to the law, HIV related information may not be disclosed unless a written authorization, signed by the protected individual or the person authorized by law to consent on the protected individual's behalf, is obtained.

The authorization must include:

- A statement specifically authorizing the disclosure of HIV related information;
- The name of the protected individual;
- The name of the provider;
- The name of the recipient;
- The reason or purpose for the disclosure;
- The time period for which the consent is effective;
- The signature of the protected individual or the person authorized by law to consent on the protected individual's behalf signature; and
- The date.

**Penalties for Violating the Law**

If a health or social service provider or a recipient pursuant to a release of confidential HIV related information discloses confidential HIV related information without the protected individual's written consent, the person who discloses the information faces:

- Civil fines up to $5,000 for each violation (the fines are pursued by the New York Commissioner of Health, and are payable to the State, not to the protected individual);
- Criminal penalties for willful violations; and
- Compensatory and punitive damages through a civil lawsuit (these are pursued by, and payable to, the protected individual).

**CASE REPORTING AND CONTACT NOTIFICATION**

The case reporting and contact notification rules are designed to assist the government in keeping accurate records regarding HIV and to locate people who may be HIV+ for treatment and to prevent the spread of HIV. If you test positive, health care providers and the Department of Health are supposed to share the role of counseling and notifying your "contacts," according to specific guidelines set out in the law, and with your input.

The Department of Health and local public health officials are required to keep all reports and information obtained in connection with case reporting and contact notification confidential, except to the extent that it is used to further the protection of the public health.

**Legal Definition of a "Contact"**

The Law defines a Contact as: "an identified spouse or sex partner of the protected individual, a person identified as having shared hypodermic needles or syringes with the protected
individual or a person who the protected individual may have exposed to HIV under circumstances that present a risk of transmission of HIV, as determined by the Health Commissioner."

**Case Reporting**

As of June 1, 2000, case reporting to the State Department of Health must be made in all cases of HIV infection, HIV related illness and AIDS upon a health care or diagnostic provider’s initial diagnosis according to the following rules:

- All reports must include the name and address of the person who is diagnosed (the protected individual), and the names of contacts known to the reporting healthcare provider.
- The healthcare provider must also inquire regarding contacts, and include any information provided by the protected individual. The report should include a statement regarding the status of contact information.
- The healthcare provider must report no later than twenty-one days after receiving a confirmed positive laboratory test result or after diagnosis, whichever event occurs first.

Laboratories, medical examiners, pathologists, coroners, blood and tissue banks, organ procurement organizations and other similar service providers that perform tests for HIV must also report positive results. Such reports will contain identifying information, including the subject’s name.

Results of the following tests must be reported:

- Positive HIV tests;
- Diagnoses of HIV related illnesses;
- Tests showing t-cell counts under 500; and
- Diagnoses of AIDS.

**Process of Contact Notification**

The healthcare provider works with the individual to determine who the contacts are and how the individual wants them to be notified. The individual’s release of names of contacts are not mandatory and there is no penalty for withholding this information. If names are released notification must be made to spouses and known contacts. If names are not released by the individual three options exist for notification: A public health official can notify any contacts; the individual can notify contacts together with his/her health care provider; or the individual can notify contacts him/herself.

**Domestic Violence Screening**

Health care providers can play an integral role in identifying and helping victims of domestic violence. Screening for domestic violence may present the opportunity for the health care provider to enable the member through counseling, making safety plans or referring members to advocate resources. Screening and counseling for domestic violence should be done in a manner that does not put the individual in jeopardy. If there are children involved, domestic
violence information can trigger an investigation by child protective authorities.

**Those Exempted From Reporting HIV Status**

- Any diagnostic provider who did not make the initial diagnosis;
- Diagnostic providers who have already reported the initial diagnosis;
- Providers of other health or social services (dentists, therapists, etc.);
- Government entities that provide or monitor services to individuals; and
- Anyone not providing health care to the protected individual.
- Anonymous testing sites.
Authorization for the Release of Health Information and Confidential HIV-Related Information: DOH-2557 (2/11)

GENERAL QUESTIONS

Why was the release form revised?
This revised form has been streamlined. It may be used for disclosures to single parties as well as to multiple parties. It may be used to allow multiple parties to exchange information between and among themselves or to disclose information to each listed party separately. Form #DOH-2557 (2/11) replaces all previous versions of release forms. This and other forms can be downloaded from the DOH web site: health.ny.gov/diseases/aids/forms/.

Can providers continue to use old release forms?
Release forms completed before June 2011 may be used until the specified end date. All new authorizations must be made using Form #DOH-2557 (2/11).

How and when should this form be used?
Form #DOH-2557 permits individuals to use a single form for the release of general health and/or HIV-related information to single or multiple providers. Providers do not need an HIV release to receive information, only to disclose it.

Should clients have to sign more than one release form if they are seeing more than one provider?
Yes, in some situations. It may not always be possible or practical to list all providers on a single form. As additional providers become involved in a client’s care over time, new forms will be needed to include them. Some providers may only have limited participation in a client’s care and may not need to case conference with others, so a release form could be completed solely for their involvement.

Can photocopies/faxes of release forms be accepted?
Yes, unless there is some reason to suspect that the copy or fax of a release is false or inaccurate, a provider, acting in good faith, may release HIV information based upon a photocopy or a fax of an executed release.

How should this form be printed?
It is suggested that when possible the form should be printed “2-sided” (i.e. front & back). If extra pages (3, 4, 5) are used to include additional providers, they should also be printed “2-sided” and stapled together to prevent separation.

How does one ensure the client understands the form?
If a provider suspects a client has a low literacy level and/or does not understand the language used on the form, it should be reviewed with the client and/or translated. Providers should explain the purpose of the form and ask if the client has any questions. Additionally, a Spanish version of this form is available at: www.health.state.ny.us/diseases/aids/forms/.

Can information released using this form be re-disclosed?
No. State law prohibits re-disclosure without specific written consent. Unauthorized re-disclosure may result in a fine, jail sentence or both. HIV-related information provided pursuant to a release must be accompanied by the appropriate re-disclosure language from Public Health Law Article 27-F-§2782 6.(a) citing limitations and penalties. The recipient of HIV-related information becomes bound by and is required to comply with confidentiality requirements of Article 27-F in handling or re-disclosing that information to anyone else.
Sample re-disclosure language could include:

“This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient for further disclosure.”

COMPLETING THE FORM - Page 1:

Allows the client to specify the following:

I consent to disclosure of:

a. My HIV-related information,
b. My non-HIV medical information
c. Both (non-HIV medical and HIV-related medical information)

There may be circumstances in which an individual or provider only wants to release non-HIV medical information (choice “b” above). Rather than using this HIV-specific form, another approved HIPAA-compliant general medical release form may be used.

Name and address of facility/person disclosing HIV-related information:
This refers to the facility/person that is going to be releasing information about the client, which is likely to be the facility/person completing the form. It is best practice to name a specific individual or position within the facility.

Name of person whose information will be released:
This is usually the client, but may be a collateral (partner or other family member) or child, depending on the circumstances.

Name and address of person signing this form, if other than above; Relationship to person whose information will be released:
When a client is unable to complete the form, this section should include a legal guardian, parent, health care proxy or other caregiver designated to provide consent on the client’s behalf in accordance with State Law.

Describe information to be released:
The description should be as specific as possible. For example, case managers may wish to release assessments, treatment plans, progress notes and other related information.

Reason for release of information:
The reason should be as specific as possible. For example, case managers may need to release information for coordination of case management services.

Time period during which release of information is authorized:
Time frames should be specific and limited, and must be included for the form to be considered complete and valid. Best practice is to use a one-year expiration from the date the form is created and signed by the client (e.g. 10/15/10 - 10/15/11), but could also include a specified period or condition for non-repeating tasks or time-limited situations (e.g. “Until my son/daughter reaches the age of...” or “Until housing benefits are attained”).
Exceptions to the right to revoke consent, if any:
This explains a client’s right to revoke authorization. If no other exceptions to the right to revoke consent exist, “None” or “No Exceptions” could be written here.

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):
This section is intended to provide notice to the individual that refusal to sign the authorization may have an impact upon the provision of care. This is important when failure to release information limits access to services, payment, eligibility for housing or other entitlements, enrollment in clinical trials or research protocols, etc. Examples of responses could include: “No consequences,” “Not applicable,” “Information is required to access housing benefits,” “Information is required for the coordination of care and services,” or “Information is required to participate in clinical trials and access free medications.”

Please sign below only if you wish to authorize all facilities/persons listed on pages 1, 2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services:
If communication among providers is intended, the client must sign and date this section. This allows for case conferencing between multiple providers.

COMPLETING THE FORM – Page 2 (3, 4, 5):
Allows the client to specify the individual(s) or organization(s) to whom the information is being released.

Name and address of facility/person to be given general health and/or HIV-related information:
The form can be used to list as many providers as the client wishes, attaching additional pages (3, 4, 5) as necessary. Best practice is to name a specific individual or position within the facility, rather than granting the entire facility full access to a client’s personal information. Unused sections should be ‘X’ed out.

Additional providers should never be included after the release form has been signed and dated by the client. New forms should be created and reviewed with the client when additional providers are identified.

Reason for release, if other than stated on Page 1:
This section should only be completed if different from the reason stated on Page 1.

If information to be disclosed to this facility/person is limited, please specify:
This may only pertain in instances regarding time frames, such as a single event with no future communication planned.

Signature and Date:
This form is incomplete until the client has signed and dated it here, authorizing that he or she has reviewed and understood the form. If additional pages (3, 4, 5) are used, the client must sign and date the bottom of each page. The date should be consistent on all pages. Once it has been signed and dated, the form should not be changed in any way.

Client/Patient Number:
This field may be used for reference, to attach an ID number used in a particular setting.
This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state laws. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):
- My HIV-related information
- My non-HIV health information
- Both (non-HIV health and HIV-related information)

<table>
<thead>
<tr>
<th>Name and address of facility/person disclosing HIV-related information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person whose information will be released: --------------</td>
</tr>
<tr>
<td>Name and address of person signing this form (if other than above):</td>
</tr>
<tr>
<td>Relationship to person whose information will be released:</td>
</tr>
<tr>
<td>Describe information to be released:</td>
</tr>
<tr>
<td>Reason for release of information: ---------------------------------</td>
</tr>
<tr>
<td>Time Period During Which Release of Information is Authorized From: To:</td>
</tr>
<tr>
<td>Exceptions to the right to revoke consent, if any*</td>
</tr>
</tbody>
</table>

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):

Please sign below **only** if you wish to authorize all facilities/persons listed on pages 1, 2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature ___________________________________________ Date

*This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.
Authorization for Release of Health Information and Confidential HIV-Related Information*

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _________________________________________________________________________  Date ____________

(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: __________________________________________

Print Name _________________________________________________________________________

Client/Patient Number ______________________________________________________________

*This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.
Authorization for Release of Health Information and Confidential HIV-Related Information*

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature ____________________________________________________________ Date __________________________

(Subject of Information or Legally Authorized Representative)

Client/Patient Number ________________________________________________

*This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.
Technical Assistance Bulletin:

Authorization for Release of Health Information
(Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information
(DOH-5032)

General Questions

Why was a “combined” release form created?
The “Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information” (DOH-5032) was created to facilitate sharing of substance use, mental health and HIV/AIDS information. This form is somewhat like the “Authorization for Release of Medical Information and Confidential HIV Related Information” (DOH-2557), but would fulfill a need to share information within facilities in which different teams handle substance use, mental health and HIV/AIDS-related issues. In addition, the DOH-5032 form would fulfill a need to share information between facilities and providers that care for the same patient. Like the DOH-2557 form, the DOH-5032 form is intended to encourage multiple providers to discuss a single individual’s care among and between themselves to facilitate coordinated and comprehensive treatment.

Does the new form replace other release forms?
No. Although the new form may be used in place of DOH-2557, it is not intended to replace any forms currently available.

How does the provider ensure that the patient understands the form?
If a provider suspects that a patient has a low literacy level and/or does not understand the language used on the form, it should be reviewed with the patient and/or translated. Providers should explain the purpose of the form and ask if the patient has any questions. Additionally, a Spanish version of this form is available (DOH-5032es).

Can information released using this form be re-disclosed?
When records are disclosed, the person or entity receiving the information cannot re-disclose it unless permitted under the law that applies to those records. In some cases, a specific re-disclosure prohibition notice must be included whenever records are disclosed.

For alcohol and substance abuse re-disclosure, as per 42 CFR Section 2.32, each disclosure made with the patient’s written consent must be accompanied by the following written
statement: This information has been disclosed to you from records protected by Federal
confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further
disclosure of this information unless further disclosure is expressly permitted by the written
consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general
authorization for the release of medical or other information is NOT sufficient for this purpose.
The Federal rules restrict any use of the information to criminally investigate or prosecute any
alcohol or drug abuse patient.

For confidential HIV-related information re-disclosure, as per Public Health Law Section
2782(5), each disclosure made pursuant to a release of confidential HIV-related information
must be accompanied by the following written statement: This information has been disclosed
to you from confidential records which are protected by state law. State law prohibits you from
making any further disclosure of this information without the specific written consent of the
person to whom it pertains, or as otherwise permitted by law. Any unauthorized further
disclosure in violation of state law may result in a fine or jail sentence or both. A general
authorization for the release of medical or other information is NOT sufficient authorization for
further disclosure.

Completing the Form
Patient Name, Date of Birth, Patient Identification Number and Patient Address:
This refers to the patient’s name, date of birth and current place of residence. The patient
identification number is used for reference by the provider or facility.

#5. Name and Address of Provider or Entity to Release this Information:
This refers to the provider or entity that will release the information regarding the patient,
which is likely to be the provider completing the form. It is best practice to name a specific
individual and their facility address.

#6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
This refers to the name of the provider(s) who the patient or authorized representative wishes
to receive the information. It is best practice to name specific individual(s) rather than granting
access to the entire facility. If there are multiple names and addresses, a sheet may be
attached with the names and addresses of those providers. Additional individuals should never
be included after the release form has been signed and dated by the patient or authorized
representative. As additional providers are identified, additional forms should be completed
and signed by the patient or authorized representative.

#7. Purpose for Release of Information:
The purpose for the release of information should be as specific as possible. For example, case
managers may wish to release information for coordination of case management services.

#8. Unless previously revoked by me, the specific information below may be disclosed from
(insert start date) until (insert expiration date or event):
This refers to the time period during which the release of information is authorized. Time
frames should be specific to the month, day and year, and must be included for the form to be
considered complete and valid. Best practice is to use a one-year expiration from the date the
form is created and signed by the patient or authorized representative (e.g., 10/15/11 until
10/15/12), but could also include a specified event for its expiration (e.g., “until my son/daughter reaches the age of...” or “until housing benefits are attained”).

If there are exceptions to releasing “all health information (written and oral)”, the first box under #8 should be checked and the exceptions should be specified. If there are no exceptions, this box should be checked and “not applicable” or “none” should be written.

For the following to be included, indicate the specific information to be disclosed and initial below:
The authorization may include disclosure of information relating to alcohol and drug treatment, mental health treatment and confidential HIV/AIDS-related information only if the patient or authorized representative specifies the information to be disclosed and places their initials on the appropriate line for “records from alcohol/drug treatment programs”, “clinical records from mental health programs” and/or “HIV/AIDS-related information”. Information from mental health clinical records may be released pursuant to the authorization to the person(s) identified on the form who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

#9. If not the patient, name of person signing form:
This refers to the name of the patient’s authorized representative, which must be specified if the form is not signed by the patient.

#10. Authority to sign on behalf of patient:
This refers to the patient representative’s authority to sign the form (e.g., legal guardian, parent, health care agent under a health care proxy for a patient who lacks decision-making capacity or caregiver designated to provide consent on the patient’s behalf in accordance with New York State law).

Signature of Patient or Representative Authorized by Law and Date:
This form is incomplete until the patient or the patient’s representative authorized by law has signed and dated the form, authorizing that he or she has reviewed the form and understands it. Once the form has been signed and dated, the form must not be changed in any way.

Witness Statement/Signature:
This form is also incomplete until the provider or other staff person from the facility has signed and dated the form, acknowledging that he or she has witnessed the execution of the authorization and states that a copy of the signed authorization was provided to the patient and/or the patient’s authorized representative.
Authorization for Release of Health Information (Including Alcohol/Drug Treatment
and Mental Health Information) and Confidential HIV/AIDS-related Information

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Patient Identification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in item 8, I specifically authorize release of such information to the person(s) indicated in item 6.

2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _______ until _______.

<table>
<thead>
<tr>
<th>INSERT START DATE</th>
<th>INSERT EXPIRATION DATE OR EVENT</th>
</tr>
</thead>
</table>

   □ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.

<table>
<thead>
<tr>
<th>Information to be Disclosed</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Records from alcohol/drug treatment programs</td>
<td></td>
</tr>
<tr>
<td>□ Clinical records from mental health programs*</td>
<td></td>
</tr>
<tr>
<td>□ HIV/AIDS-related Information</td>
<td></td>
</tr>
</tbody>
</table>

9. If not the patient, name of person signing form:

10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

**Signature of Patient or Representative Authorized by Law**

**Date**

**Witness Statement/Signature:** I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient’s authorized representative.

**Staff Person's Name and Title**

**Signature**

**Date**

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.*

DOH-5032 (4/11)
VNSNY CHOICE SelectHealth
www.vnsnychoice.org

Provider Referral for Consultative Subspecialist (Private Office and Clinic)

Today’s Date: ____________  
PCP: _________________________  Telephone: _________________________  
Fax: _________________________  

Member Information

Name: _________________________  ID #: _________________________  
Home Telephone: _________________________  Alt Phone: _________________________

Subspecialty Information:

Type of Subspecialist Service: _________________________  
Is this a standing referral (member needs to see specialist on a regular basis?)  ☐ Yes  ☐ No  
Should your patient be referred to a ☐ clinic or  ☐ private office?  
If it is a Select Health private office-based provider and you know the name of the specialist, please indicate:  
___________________________  Is another specialist okay, if not available?  ☐ Yes  ☐ No  
Reason for Referral: _________________________

(Attach additional info if necessary and supporting documentation)

Referral is:  
Emergent  Urgent  Routine  
(3 days)  (7 days)  (2 – 3 weeks)  

Do you want copies of consult reports sent to your attention?  ☐ Yes  ☐ No

For VNSNY CHOICE SelectHealth Use Only

Appointment Date: _________________________  
Provider Name: _________________________  
Member Notified: ☐ Yes  ☐ No  _________________________
Dear NYPSSH Provider:

In order to ensure accuracy in our provider records, we are requesting that you complete this form and refax to the Provider Relations department at (212) 404-4894. Please attach additional sheets, if necessary. Thanks.

PROVIDER NAME: ----------------------------------------------------- M.D. D.O. Other ---------------
SPECIALTY: ---------------------------------- ____ SUBSPECIALTY: --------------------------------------

Female    Male    Age Range of Patients Served: ---- to ---------

SITE NAME (if applicable): ------------------
SITE ADDRESS: -------------------------
OFFICE MANAGER: -----------------------------------------
PHONE NUMBER: ----------------------------- FAX NUMBER: ----------------------------------------

OFFICE HOURS
Monday ------------- Tuesday ------ _ ------ Wednesday ------------- Thursday -------------- Friday .........

Wheelchair Accessible: YES NO Languages Spoken: ------------------------

List Nurse Practitioners, Physician Assistants and Certified Nurse Midwives (if applicable):

Hospital Privileges: ------------------------------------------

BILLING INFORMATION

Tax Identification Number: ------------------------------------------
Make Check Payable To: ------------------------------------------
Billing Contact Person: ------------------------------------------
Billing Phone Number: ----------------------------- Billing Fax Number: ----------------------------------------

Covering Physician Name: ------------------------------------------ NYPSSH Provider ID: ---------------
Physician Address: ------------------------------------------ Phone Number: ------------------------------------------

PROVIDER SIGNATURE: -------------------------------- DATE: -------------------

24 hour/7 day week coverage is REQUIRED for Primary Care Providers. Please mark your mode of coverage.

Answering Service Answering Machine Other

NYPSSH Provider ID:

New Location: YES NO

PROVIDER UPDATE FORM
Research Quick Guide to
Patient Health Questionnaire (PHQ) and Brief PHQ

Purpose. The Patient Health Questionnaire (PHQ) is designed to facilitate the recognition and diagnosis of the most common mental disorders in primary care patients: somatoform, depressive, anxiety, eating and alcohol disorders. The Brief PHQ only covers depressive disorders and panic disorder. Both instruments includes questions about functional impairment, recent psychosocial stressors, and for women, questions about menstruation, pregnancy and childbirth. For patients with depressive symptoms a Total Depression Score can be calculated and repeated over time to monitor change.

Who Should Take the PHQ or Brief PHQ. Ideally, either questionnaire should be used with all new patients, all patients who have not completed the questionnaire in the last year, and all patients suspected of having a mental disorder.

Making a Diagnosis. Since the questionnaire relies on patient self-report, definitive diagnoses must be verified by the clinician, taking into account how well the patient understood the questions in the questionnaire, as well as other relevant information from the patient, his or her family or other sources. In addition, the diagnoses of Major Depressive Disorder (rather than Syndrome) and Other Depressive Disorder requires ruling out normal bereavement (mild symptoms, duration less than 2 months), a history of a manic episode (Bipolar Disorder) and a physical disorder, medication or other drug as the biological cause of the depressive symptoms. Similarly, the diagnoses of Panic Disorder and Other Anxiety Disorder require ruling out a physical disorder, medication or other drug as the biological cause of the anxiety symptoms.

Interpreting the PHQ or BPHQ. At the bottom of pages that begin with “FOR OFFICE CODING” (in small type) are criteria for judgments about diagnoses assessed on that page. The names of the categories are abbreviated, e.g., Major Depressive Syndrome is Maj Dep Syn.

Additional Clinical Considerations. After making a provisional diagnosis with the PHQ or Brief PHQ, there are additional clinical considerations that may affect decisions about management and treatment.

- Have current symptoms been triggered by psychosocial stressor(s)?
- What is the duration of the current disturbance and has the patient received any treatment for it? To what extent are the patient’s symptoms impairing his or her usual work and activities?
- Is there a history of similar episodes, and were they treated?
- Is there a family history of similar conditions?

Customizing the PHQ or Brief PHQ by Omitting Pages

<table>
<thead>
<tr>
<th>Option</th>
<th>Questionnaire Ingredients</th>
<th>No of pages</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>PHQ</td>
<td>4</td>
<td>Mental disorders (somatoform, mood, anxiety, eating, alcohol) Functional impairment Stressors Menstruation, pregnancy, childbirth</td>
</tr>
<tr>
<td>B</td>
<td>First 3 pages of the PHQ</td>
<td>3</td>
<td>Mental disorders Functional impairment</td>
</tr>
<tr>
<td>C</td>
<td>Brief PHQ</td>
<td>2</td>
<td>Depressive disorders and Panic disorder Functional impairment Stressors Menstruation, pregnancy, childbirth</td>
</tr>
<tr>
<td>D</td>
<td>First page of Brief PHQ</td>
<td>1</td>
<td>Depressive disorders and Panic disorder</td>
</tr>
</tbody>
</table>
Example of Diagnosing Major Depressive Disorder and Calculating Total Depression Score

**Patient:** A 43-year-old woman who looks sad and complains of fatigue for the past month.

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following:</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>b. Feeling down, depressed, or hopeless?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>c. Trouble falling or staying asleep, or sleeping too much?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>d. Feeling tired or having little energy?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>e. Poor appetite or overeating?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or watching television?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>h. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself in some way?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

FOR OFFICE CODING: Maj Dep Syn if #2a or b and five or more of #2a-i are at least “More than half the days” (count #2i if present at all). Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least “More than half the days” (count #2i if present at all).

**Major Depressive Disorder Diagnosis.** The criteria for Major Depressive Syndrome are met since she checked #2a “Nearly every day” and five of items #2a to i were checked “More than half the days” or “Nearly every day”. Note that #2i, suicidal ideation, is counted whenever it is present.

In this case, the diagnosis of Major Depressive Disorder (not Syndrome) was made since questioning by the physician indicated no history of a manic episode; no evidence that a physical disorder, medication, or other drug caused the depression; and no indication that the depressive symptoms were normal bereavement. Questioning about the suicidal ideation indicated no significant suicidal potential.

**Total Depression Score.** This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of “Not at all,” “Several days,” “More than half the days,” and “Nearly every day,” respectively. The Total Depression Score is the sum of the scores for the nine items, and ranges from 0 to 27. In the above case, the score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3).

In a study of 3000 primary care patients, the mean Total Depression Score was 5.0. The standard deviation was 5.8. The mean score for patients with Major Depressive Disorder (N=290) was 18.6; for patients with any mood disorder (N=473) the mean score was 15.1.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr. Spitzer at rls8@columbia.edu. The names PRIME-MD® and PRIME-MD TODAY® are trademarks of Pfizer Inc.
This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name______________________   Age_____      Sex:  ☐ Female  ☐ Male      Today’s Date________

1. During the last 4 weeks, how much have you been bothered by any of the following problems?
   a. Stomach pain..................................………………….
   b. Back pain...............................................………………….
   c. Pain in your arms, legs, or joints (knees, hips, etc.)...
   d. Menstrual cramps or other problems with your periods..............................................
   e. Pain or problems during sexual intercourse............
   f. Headaches..............................................………………….
   g. Chest pain..............................................………………….
   h. Dizziness..................................................………………….
   i. Fainting spells..............................................………………….
   j. Feeling your heart pound or race...........................………………….
   k. Shortness of breath..............................................………………….
   l. Constipation, loose bowels, or diarrhea..............………………….
   m. Nausea, gas, or indigestion..............................................………………….

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?
   a. Little interest or pleasure in doing things...............………………….
   b. Feeling down, depressed, or hopeless....................………………….
   c. Trouble falling or staying asleep, or sleeping too much..............………………….
   d. Feeling tired or having little energy..........................………………….
   e. Poor appetite or overeating..............................................………………….
   f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down..........................………………….
   g. Trouble concentrating on things, such as reading the newspaper or watching television..............………………….
   h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual..........................………………….
   i. Thoughts that you would be better off dead or of hurting yourself in some way..........................………………….

FOR OFFICE CODING: Som Dis  if at least three of #1a-m are “a lot” and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least “More than half the days” (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least “More than half the days” (count #2i if present at all).
3. Questions about anxiety.

   a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?………………………………..

If you checked “NO”, go to question #5.

   a. Has this ever happened before?………………………………..
   b. Do some of these attacks come suddenly out of the blue — that is, in situations where you don’t expect to be nervous or uncomfortable?…………………………………………………
   c. Do these attacks bother you a lot or are you worried about having another attack?……………………………………….….

4. Think about your last bad anxiety attack.

   a. Were you short of breath?……………………………………
   b. Did your heart race, pound, or skip?……………………
   c. Did you have chest pain or pressure?……………………
   d. Did you sweat?…………………………………………………
   e. Did you feel as if you were choking?……………………
   f. Did you have hot flashes or chills?……………………
   g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?……………………
   h. Did you feel dizzy, unsteady, or faint?……………………
   i. Did you have tingling or numbness in parts of your body?…
   j. Did you tremble or shake?………………………………….…
   k. Were you afraid you were dying?…………………………….

5. Over the last 4 weeks, how often have you been bothered by any of the following problems?

   a. Feeling nervous, anxious, on edge, or worrying a lot about different things………………………………………..

If you checked “Not at all”, go to question #6.

   b. Feeling restless so that it is hard to sit still………………
   c. Getting tired very easily……………………………………..
   d. Muscle tension, aches, or soreness……………………
   e. Trouble falling asleep or staying asleep…………………..
   f. Trouble concentrating on things, such as reading a book or watching TV………………………………………
   g. Becoming easily annoyed or irritable…………………..

FOR OFFICE CODING: Pan Syn if all of #3a -d  are ‘YES’ and four or more of #4a-k are ‘YES’.
Other Anx Syn if #5a and answers to three or more of #5b-g are “More than half the days”.
6. Questions about eating.
   a. Do you often feel that you can't control what or how much you eat? ………………………………………………….. NO YES □ □
   b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food? ………………………………………………….. □ □

If you checked ‘NO’ to either #a or #b, go to question #9.
   c. Has this been as often, on average, as twice a week for the last 3 months? ………………………………………………….. □ □

7. In the last 3 months have you often done any of the following in order to avoid gaining weight? NO YES □ □
   a. Made yourself vomit? ……………………………………………………… a YES □ □
   b. Took more than twice the recommended dose of laxatives? □ □
   c. Fasted — not eaten anything at all for at least 24 hours?…… □ □
   d. Exercised for more than an hour specifically to avoid gaining weight after binge eating? ………………………………………………….. □ □

8. If you checked ‘YES’ to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?…………… NO YES □ □

9. Do you ever drink alcohol (including beer or wine)? …………………… NO YES □ □

If you checked “NO” go to question #11.

10. Have any of the following happened to you more than once in the last 6 months? NO YES □ □
    a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.…….. □ □
    b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities…………………………………… □ □
    c. You missed or were late for work, school, or other activities because you were drinking or hung over………………. □ □
    d. You had a problem getting along with other people while you were drinking……………………………………………….. □ □
    e. You drove a car after having several drinks or after drinking too much…………………………………………………… □ □

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all ‘YES’; Bin Eat Dis the same but #8 either ‘NO’ or left blank. Alc Abu if any of #10a-c is ‘YES’.
12. In the last 4 weeks, how much have you been bothered by any of the following problems?
   Not bothered  Bothered a little  Bothered a lot
   a. Worrying about your health………………………….……..
   b. Your weight or how you look………………………..………
   c. Little or no sexual desire or pleasure during sex…………
   d. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend………………………………….……….
   e. The stress of taking care of children, parents, or other family members…………………………………………
   f. Stress at work outside of the home or at school…………
   g. Financial problems or worries…………………………..
   h. Having no one to turn to when you have a problem…….
   i. Something bad that happened recently………………
   j. Thinking or dreaming about something terrible that happened to you in the past - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act……………………

13. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?  NO  YES
14. What is the most stressful thing in your life right now? __________________________________________

15. Are you taking any medicine for anxiety, depression or stress?  NO  YES
16. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.
   a. Which best describes your menstrual periods?
      No periods because pregnant or recently gave birth  No periods for at least a year
      Periods are unchanged  No periods because
      Periods have become pregnant or recently gave birth  No periods for
      irregular or changed in frequency, duration or amount at least a year
      Having periods because taking hormone replacement (estrogen)
      therapy or oral contraceptive
      b. During the week before your period starts, do you have a serious problem with your mood - like depression, anxiety, irritability, anger or mood swings?………………………
      NO (or does not apply)  YES
      c. If YES: Do these problems go away by the end of your period?
      d. Have you given birth within the last 6 months?
      e. Have you had a miscarriage within the last 6 months?
      f. Are you having difficulty getting pregnant?

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr. Spitzer at rls8@columbia.edu. The names PRIME-MD® and PRIME-MD TODAY® are trademarks of Pfizer Inc. © 1999, Pfizer Inc.
**Brief Patient Health Questionnaire**

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have.

Name______________________   Age_____      Sex: □ Female □ Male      Today’s Date________

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Feeling tired or having little energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Poor appetite or overeating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a log more than usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Questions about anxiety.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Has this ever happened before?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Do these attacks bother you a lot or are you worried about having another attack?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. **If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>

FOR OFFICE CODING: Maj Dep Syn if answers to #1a or b and five or more of #1a-i are at least “More than half the days” (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #1a-i are at least “More than half the days” (count #1i if present at all). Pan Syn if all of #2a-e are “YES.”
4. In the last 4 weeks, how much have you been bothered by any of the following problems? Not bothered Bothered a little Bothered a lot
a. Worrying about your health........................................

b. Your weight or how you look....................................

c. Little or no sexual desire or pleasure during sex...........

d. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend...................................................

e. The stress of taking care of children, parents, or other family members..................................................

f. Stress at work outside of the home or at school...........

g. Financial problems or worries....................................

h. Having no one to turn to when you have a problem......

i. Something bad that happened recently.......................  

j. Thinking or dreaming about something terrible that happened to you in the past - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act........................................

5. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? NO YES

6. What is the most stressful thing in your life right now?____________________________________

7. Are you taking any medicine for anxiety, depression or stress? NO YES

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.
   b. Which best describes your menstrual periods?

<table>
<thead>
<tr>
<th>Periods are unchanged</th>
<th>No periods because pregnant or recently gave birth</th>
<th>Periods have become irregular or changed in frequency, duration or amount</th>
<th>No periods for at least a year</th>
<th>Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   a. During the week before your period starts, do you have a serious problem with your mood - like depression, anxiety, irritability, anger or mood swings?........................................

   b. If YES: Do these problems go away by the end of your period?  

   c. Have you given birth within the last 6 months?  

   d. Have you had a miscarriage within the last 6 months?  

   e. Are you having difficulty getting pregnant?

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr. Spitzer at rls8@columbia.edu. The names PRIME-MD® and PRIME-MD TODAY® are trademarks of Pfizer Inc. © 1999, Pfizer Inc
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Compendium of Clinical Guidelines Relevant to the Care of People Living With HIV/AIDS (PLWHA) and their Dependent Children:

The following guidelines can be accessed by following the links or by visiting VNSNY CHOICE SelectHealth’s website at www.nyp.org/selecthealth. Guidelines by relevant federal, state, city, or professional societies are reviewed quarterly by VNSNY CHOICE SelectHealth’s Medical Management Department for updates or changes thought likely to have an impact on clinical care. Guidelines that have been updated within the previous calendar year will be noted to alert readers that new information within a particular topic exists.

**Treating opportunistic infections among HIV-infected adults and adolescents.**
Additional link: http://www.journals.uchicago.edu/CID/journal/issues/v40nS3/35615/35615.html

**Treating opportunistic infections among HIV-exposed and infected children:**


Food and Drug Administration (U.S.) - Federal Government Agency [U.S.]
Health Resources and Services Administration - Federal Government Agency [U.S.]

**Updated U.S. Public Health Service guidelines for the management of occupational exposures to HIV and recommendations for postexposure prophylaxis.** Centers for Disease Control and Prevention - Federal Government Agency [U.S.]
Food and Drug Administration (U.S.) - Federal Government Agency [U.S.]
Health Resources and Services Administration - Federal Government Agency [U.S.]
NYSDOH AIDS Institute guidelines can be accessed at: www.hivguidelines.org

Recently Updated Guidelines
- Antiretroviral Therapy
  Updated July 2007
- Hepatitis A Virus
  Updated July 2007
- Prevention of Secondary Disease: Lipid Screening and Cardiovascular Risk
  Updated June 2007
- Long-Term Complications Of Antiretroviral Therapy
  Updated May 2007
- Prevention of Secondary Disease: Diabetes
  Updated May 2007
- Primary Care Approach To The HIV-Infected Patient
  Updated March 2007
- HIV Drug-Drug Interactions
  Updated February 2007
- Neoplastic Complications Of HIV Infection
  Updated February 2007
- Suicidality and Violence in Patients With HIV/AIDS
  Updated January 2007
- Prevention of Secondary Disease: Immunizations
  Updated December 2006


One of the most important efforts by NYC DOHMH in recent years is the Take Care New York (TCNY) initiative. Health care providers are important partners for the Take Care New York program. They can play a vital role by promoting prevention and early detection at every clinical encounter. The material found on the following website provide guidelines for key preventive services related to the 10 areas of Take Care New York. Additional resources and information are available by clicking on the embedded links. Please take a moment to review this worthwhile effort and consider becoming a TCNY partner.
Appendix C: VNSNY CHOICE Managed Long Term Care Plan Forms

List of documents included in this section:

1. NAMI Deduction Letter
Dear [FAC_CONTACT],

Please accept this letter as confirmation that the above Member is in your facility as a long-term placement.

Accordingly, VNSNY CHOICE has calculated the Net Available Monthly Income (NAMI). This amount was calculated using the current Social Security Award and pension document(s). This amount is already net of the Member’s $50.00 Personal Needs Allowance.

If you have not already done so, please begin the process of redirecting any funds that are payable to the Member (i.e. Social Security payments or pensions).

If you are aware of a NAMI amount already in effect, you must inform us and appropriately adjust your billing. If it is determined that NAMI was collected and not deducted we will adjust future claim payment(s).

Deduction Effective Date:  [SBSA_EFF_DT]
NAMI Amount:  [SBSA_SAL_AMT]

Regards,

Carleen D. Taylor
Director Membership and Eligibility, VNSNY CHOICE
Appendix D: Disease and Reporting Forms
For Use By All Plans

List of documents included in this section:

1. Reporting Requirements
2. Reporting Requirements for Tuberculosis
3. Diseases and Conditions That Must Be Report to the New York City Office of Health and Mental Hygiene
4. Universal Reporting Form
Section 1 Reporting Requirements

Why, What and How to Report to the New York City Department of Health and Mental Hygiene

Why report?

Physicians are required by Article 11 of the New York City Health Code to report certain diseases, conditions and events to the New York City Department of Health and Mental Hygiene (NYC DOHMH). Even though laboratories report findings associated with these diseases and conditions, only physicians can provide the valuable clinical and demographic data that the Department needs to identify and prevent outbreaks and monitor disease trends.

As emphasized in the “Dear Colleague” letter sent by NYC DOHMH Commissioner, Dr. Thomas R. Frieden, in May 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not affect the legal requirements in the New York City Health Code for reporting of notifiable diseases and providing access to medical records, when needed as part of a public health investigation. The NYC DOHMH protects the confidentiality of information reported by providers.

What to report?

This Appendix includes the current Universal Reporting Form (URF) and instructions for using this form. It is expected that by summer of 2009, the revised list of reportable conditions will be posted at http://www.nyc.gov/html/doh/downloads/pdf/hcp/hcp-reporting.pdf, revised to accord with changes to the NYC Health Code that became effective in February 2009. Section 11.03 of the New York City Health Code requires the immediate reporting by telephone of a suspected outbreak among three or more persons of any disease or condition (whether or not it is listed among reportable conditions), and of any unusual manifestation of disease in an individual: therefore, in spring 2003, physicians were also mandated to report suspected cases of Severe Acute Respiratory Syndrome (SARS). As of January 2003, the New York State Sanitary Code also mandated the reporting of suspected and confirmed adverse events associated with smallpox vaccination, including transmission of vaccinia to contacts, autoinoculation, generalized vaccinia, eczema vaccinatum, progressive vaccinia, fetal vaccinia and post-vaccination central nervous system disease.

Health care providers should be aware that the New York City Health Code has been amended, effective February 1, 2009. Several new diseases or conditions, including Lymphocytic choriomeningitis virus, drownings and Ricin poisoning, have been added to the list of reportable conditions in New York City. In addition, the disease formerly identified as Ehrlichiosis has been reclassified into two new diseases, Human Granulocytic Anaplasmosis and Human Monocytic Ehrlichiosis. The scope of persons required to report to the Department has been broadened, to allow the Department to obtain more comprehensive monitoring of diseases and conditions.

Except for nosocomial outbreaks, physicians need report these conditions only to the NYC DOHMH, not to the New York State Department of Health. The NYC DOHMH is responsible for reporting diseases and conditions for the city to the State Department of Health; the city is an independent reporting jurisdiction, and therefore reports directly to the Centers for Disease Control and
Prevention, as well as to the State. Any nosocomial outbreak or increased incidence of hospital-associated infection must be reported to both the NYC DOHMH and the NYS DOH as stated in the Universal Reporting Form Instructions.

It is important that physicians remain aware of new reporting requirements or instructions that may be developed to assist public health authorities in monitoring an emerging condition or assessing and responding to an emergency, even before these conditions are defined in the Health Code. These instructions are conveyed to physicians through Health Alerts and advisories that are sent to hospitals and posted on the NYC DOHMH website. As an example, the 2009 Health Alert #11, “Swine Influenza Update”, is the first of those on swine influenza in NYC and is an example of one which would advise health care providers of a disease outbreak and provide information on reporting requirements, testing of clinical specimens, and management of suspected and confirmed cases and contacts. This alert was followed by several updates on Influenza H1N1 (Swine Origin). Physicians should check the NYC DOHMH website to remain informed of reporting instructions and requirements and of updates to documents included in this Compendium.

How to report?

Reporting of Communicable Diseases Conditions and Events

During normal working hours, health care providers can rapidly report all conditions by calling the Provider Access Line (1-866-NYC-DOH1/1-866-692-3641). If a provider needs to report a condition outside of normal working hours, he or she should call the Poison Control Center (212-POISONS/212-764-7667). Health care providers can also call the Provider Access Line to have forms mailed or faxed to their offices; consult with expert medical staff; access the immunization registry and other NYC DOHMH registries; and obtain information or publications. The Universal Reporting Form may be downloaded from http://www.nyc.gov/html/doh/html/hct/hct-urf.shtml. Reporting to the Provider Access Line or to a Department program, however, is not a substitute for reporting diseases and conditions in writing or online.

The Universal Reporting Form (URF) can be used to notify the Department of almost all communicable conditions for which reporting is mandated, including tuberculosis and sexually transmitted diseases, as well as various types of poisonings. Certain conditions, as designated on this form, should be reported immediately by telephone; if immediate reporting is not required, cases should be reported within 24 hours or on the next working day. Even when telephone reporting occurs, however, the form should be completed online or mailed or faxed to the Department: mailing address and fax numbers are included on the form. The URF is now available for on-line reporting. Instructions for completing the paper URF and for submitting it electronically are included in this Appendix; as mentioned above, a revised list of reportable conditions should be posted at http://www.nyc.gov/html/doh/downloads/pdf/hcp/hcp-reporting.pdf by summer 2009.

The Universal Reporting Form (URF) can be used to report almost all mandated conditions and instructs providers in how to report three mandated conditions for which the URF cannot itself be used:
HIV/AIDS and known contacts of persons with HIV/AIDS: New York State Public Health Law Article 21, Title III, requires named reporting of diagnoses of HIV and AIDS and all known partners and contacts. Detailed instructions on how to report a case can be obtained by accessing the NYCDOHMH HIV Epidemiology Program's web site at http://www.nyc.gov/html/doh/html/dires/hivepi.shtml or by calling the program's HIV provider call line (212-442-3388). Copies of the “Medical Provider HIV/AIDS and Partner/Contact Report Form” (PRF) must be used to report HIV/AIDS diagnoses and partner information. The forms can be ordered from the New York State Department of Health Bureau of HIV/AIDS Epidemiology (518-474-4284). For assistance on how to report a case, use the PRF, or to arrange for pickup of a completed PRF by a NYCDOHMH Public Health Advisor, call the NYCDOHMH HIV Epidemiology Program at 212-442-3388. Forms may not be mailed, Faxed or emailed.

Window Falls: Falls must be reported by phone to the Window Fall Prevention Program at 212-676-2903/2158 during the business hours of 9:00am – 5:00pm Monday to Friday. All reports occurring outside of business hours must be reported by phone to the Poison Control Center at 1-800-222-1222.

For First Responders - NYPD, FDNY, Hospitals and Physicians:

After reporting by phone – the “Child Window Fall Report” card must be completed and mailed. A copy of the fall report may be faxed to 212-442-2629.

Note: The color of the “Child Window Fall Report” card has been changed from “blue” to “yellow”. You may request a supply by contacting the Window Fall Prevention Program.

Animal Bites: Health Care providers must report animal bites immediately by using the Universal Reporting Form or the Form VPHS-55, for providers who still have the form in stock. Also, animal bites can be reported online at: http://www.nyc.gov/html/doh/html/vet/vetegp.shtml. For consultation on rabies prophylaxis, health care providers should call the Provider Access Line (1-866-NYC-DOH1 or 1-866-692-3641) or, after normal working hours, the Poison Control Center (212-POISONS/212-764-7667).

Reporting of Immunizations

The New York City Health Code (section 11.04 and subsection [d] of 11.07) mandates that health care providers who order the administration of immunizations to children and adolescents from birth through age 18 years in New York City must report the immunizations to the Citywide Immunization Registry (CIR) within 14 days of administration. Immunizations administered to individuals aged 19 years or older may be reported to the CIR, with the patient’s written consent. Consent may be obtained by having the patient sign the consent form. As of January 1, 2009, New York City health care providers are required to report immunizations electronically from their own system or to report on-line. It should be noted that providers must report to the CIR in order to receive vaccines through the Vaccines for Children Program. For more information, or to set up online access to the CIR for reporting immunizations and/or for obtaining patient or plan member immunization and lead test histories, call 212-676-2323.
Health care providers should be aware that New York State Public Health Law 2168 (posted at http://www.health.state.ny.us/prevention/immunization/information_systems/laws_and_regulations/public_health) mandates reporting statewide. Under this State Law, New York City providers continue to report to the CIR, even if the patient lives outside of New York City. The CIR and NYS Immunization Information System will exchange data regularly on shared patients.

Federal law requires that Vaccine Information Statements be handed out to the patient or authorized individual before any vaccine is administered. Included in Attachment 8 are the instructions for use of Vaccine Information Statements and for reporting of Vaccine Adverse Events.

**Reporting of Lead Test Results**

The New York City health code requires that health care providers report all blood lead levels (BLLs) >10 μg/dL within 24 hours of receiving results. This prompt notification allows the Lead Poisoning Prevention Program to quickly initiate services. Providers using an office-based portable analyzer are required to report BLLs < 10 μg/dL as well.

Reports of BLLs >10 μg/dL in children should be faxed to 212-676-6326 and reports of BLLs >10 μg/dL in pregnant women should be faxed to 212-676-6188.

**Termination of Pregnancy**

All terminations of pregnancy in New York City, whether they are spontaneous or surgically or medically induced, must be reported to the New York City Department of Health and Mental Hygiene. Questions on legal requirements for filing termination of pregnancy certificates as well as birth and death certificates should be directed to 212-788-4585.

**School Health Forms**

Healthcare providers who see school age children can facilitate their entry into school and improve the continuity of care they receive by timely completion of the following two forms. A downloadable, pre-completed Child and Adolescent Health Examination Form (211S) with immunization and lead test results already entered can be created by the Citywide Immunization Registry (CIR). Go to http://www.nyc.gov/health/cir. A downloadable, blank form can be found at http://home2.nyc.gov/html/doh/downloads/pdf/scah/scah-211s.pdf.

- Child and Adolescent Health Examination Form

Parents should receive two copies of completed forms downloaded from the Internet or they may request a duplicate form by contacting the local school.
Diagnosis: Reporting Requirements for Tuberculosis

Reporting suspected and confirmed tuberculosis

Medical providers and infection control practitioners are required by the New York City Health Code Article 11, in particular, Sections 11.03, 11.05 and 11.47(a), to report all patients suspected and confirmed with tuberculosis (TB) to the New York City Department of Health and Mental Hygiene (DOHMH), Bureau of Tuberculosis Control, within 24 hours of diagnosis or clinical suspicion. Medical providers must report these patients even though microbiologists and pathologists are also required to report findings consistent with TB. Note that the reports must be received by the DOHMH within 24 hours, whether by express or overnight mail, fax, telephone, or electronically.

It is mandatory to report patients who meet any of the following criteria:

- Smear (from any anatomic site) positive for acid-fast bacilli (AFB)
- Nucleic acid amplification (NAA) test (e.g., Roche's AMPLICOR®) or Genprobe's MTD™ result positive for Mycobacterium tuberculosis complex
- Culture positive for M. tuberculosis complex including: M. tuberculosis, M. africanum, M. bovis-BCG, M. caprae, M. canetti, M. microti, M. pinnipedii, M. bovis
- Biopsy, pathology, or autopsy findings consistent with active TB, including but not limited to caseating and necrotizing granulomas in biopsy of lung, lymph nodes, or other specimens
- Treatment with two or more anti-TB medications for suspected or confirmed active TB
- Clinical suspicion of pulmonary or extrapulmonary TB such that the physician or other health care provider has initiated or intends to initiate isolation or treatment for TB
- Continuation, discontinuation, completion, or other outcomes of treatment for active TB
- Any child younger than five years old (up to the day of the fifth birthday) who has a positive tuberculin skin test (TST) or a positive U.S. Food and Drug Administration (FDA) approved blood-based test for TB infection such as QuantIFERON®-TB Gold (QFT-G)
- In addition, Section 47.21 requires that Day Care staff report those with latent TB infection (LTBI) to the Bureau of Day Care

When an individual has an AFB-positive smear or has started treatment for TB, reporting should never be delayed pending identification of M. tuberculosis with a NAA test. Patients should be reported whenever TB is suspected, even if bacteriologic evidence of disease is lacking or treatment has not been initiated. Additionally, when requested by the DOHMH, a physician shall report the results of any examination of a contact.

Microbiology and Pathology Laboratories

The New York City Health Code also requires laboratories to report as per Articles 11 and 13, Sections 11.03, 11.05, and 13.03, all of the following within 24 hours of identification to the Bureau of Tuberculosis Control:

- AFB-positive smears (regardless of anatomic site)
- Cultures positive for M. tuberculosis complex
- NAA test results that identify M. tuberculosis complex (e.g. AMPLICOR®, MTD™)
- Results of susceptibility tests performed on M. tuberculosis complex cultures
- Biopsy, pathology, or autopsy findings consistent with active TB, including but not limited to presence of AFB on smear and caseating and/or necrotizing granulomas that are consistent with TB in the lung, lymph nodes, or other specimens
- Any culture or NAA result associated with an AFB-positive smear (even if negative for M. tuberculosis complex)
Reporting by telephone and on the URF

Suspected and confirmed TB patients may be reported by telephone to the TB Hotline, 212-788-4162, but a completed Universal Reporting Form (URF) must follow within 48 hours. The URF should be faxed to the Bureau of Tuberculosis Control at 212-788-4179 and the original mailed to the Bureau of Tuberculosis Control, DOHMH at 253 Broadway, Room 602, CN-72, NY, NY 10007. The URF can also be completed online, by first creating an account on NYC-MED at http://www.nyc.gov/health/nycmed. Assistance is available by calling 1-888-NYC-MED9 or 212-442-3384.

Information reported on the URF should be as complete as possible. The following essential information must be included when the report is submitted to the New York City DOHMH:

- Information needed to identify and locate the individual (i.e., name, telephone, address, and date of birth)
- Provider information (i.e., physician’s name and telephone number, reporting facility)
- Results of smear for AFB (including date specimen obtained and accession number, if available)
- Results of chest radiographs
- Any treatment information

Laboratories are required to report via the Electronic Clinical Laboratory Reporting System (ECLRS) as of July 1, 2006. Assistance with ECLRS is available by calling 212-313-5137. In addition, within 24 hours of observing growth of M. tuberculosis complex in a culture from any specimen, the New York City Health Code Section 13.05(a) requires that a portion of the initial culture be sent for DNA analysis to the NYC DOHMH Public Health Laboratory (455 First Avenue, Room 236, NY, NY 10016). Laboratories outside of New York City should submit isolates directly to the Wadsworth Center Mycobacteriology Laboratory in Albany, NY for genotyping.

Patient follow-up

The treating physician should also report whether the patient completed treatment and the outcome of the patient (cured, failed, relapsed, lost, moved) or whether treatment was discontinued if the patient was found not to have TB. Physicians must assist the DOHMH in its efforts to evaluate persons suspected of having TB and in patient follow-up. Case managers will be in contact with the treating physicians to request updates and ensure that appropriate treatment and monitoring is being conducted. A Report of Patient Services Form (TB 65) may need to be completed.

Reporting TB-related evaluation and treatment of contacts

Medical providers are required, under Section 11.47(b) of the New York City Health Code, to report to the DOHMH, when requested, all information on the evaluation, testing, and treatment of individuals who have been in contact with a person with active TB disease.

Inquiries and forms


Notes:

1. Pedact names are provided for identification purposes only; their use does not imply endorsement by the NYC DOHMH.
2. To report a positive test for TB infection in a child less than 5 years old, use the Universal Reporting Form. For guidelines for interpreting skin test results, see City Health Information: Testing and Treating for Latent TB Infection, April 2006. www.nyc.gov/html/doh/downloads/pdf/chih/2006/1-30-03.pdf

This TB Fact Sheet is one of a series that addresses important topics in tuberculosis treatment and control.
For more information about TB call 311 or visit our website nyc.gov/health/ht
Diseases and Conditions that Must Be Reported to the NYC Department of Health and Mental Hygiene

Report suspected confirmed cases immediately by calling 1-888-NYC-DIVH (1-888-692-3454) during business hours or 212-986-7647 after hours.

**HIV/AIDS**
- Diagnosis of HIV infection
- Diagnoses of HIV illness in a previously unreported individual (i.e., HIV illness not meeting AIDS case definitions)
- Diagnosis of AIDS defining conditions

For assistance in reporting a case of HIV/AIDS, to receive the required NYS Provider Report Forms (PRF), or to obtain more information, please call 212-442-3386.

NYC law requires that PRFs contain names of sexual or needle-sharing partners of the infected person known to medical providers or those whom the infected person has notified of their possible exposures. Providers can utilize and/or refer HIV-infected persons to the NYC DOHMH’s Contact Notification Assistance Program (CNAP) at 212-689-1419 for assistance in carrying out partner notification.

For more information about reporting a case of HIV or AIDS to the NYC DOHMH, visit:

**Sexually Transmitted Diseases**

- Chancroid
- Chlamydia
- Gonorrhea
- Granuloma inguinale (Donovanosis)
- Herpes, genital
- Hepatitis B: simple virus infection in infants age 60 days or less with or without lab confirmation
- Syphilis, including congenital syphilis
- **Tuberculosis**

  - Active TB
  - Positive TB smear
  - Positive acid-fast bacillus test for Mtb complex
  - Positive culture for Mtb complex
  - Continuation, discontinuation, completion, or other outcomes of treatment for active TB
  - Susceptibility test on Mtb cultures
  - Pathology findings consistent with TB
  - Patients suspected of having TB
  - Patients notified of TB

**Vaccines - Preventable Diseases**

- Diphtheria
- Measles
- Mumps
- Pertussis
- Poliomyelitis
- Rubella, including congenital rubella syndrome
- Tetanus
- Varicella zoster virus (chickenpox)

**Other Reportable Communicable Diseases and Conditions**

- Alcoholism (11, 12)
- Arthropod-borne infections, acute
- Babesiosis
- Brucellosis
- Campylobacteriosis (1, 2)
- Chickenpox
- Chlamydial infections, acute
- Cryptosporidiosis (1, 2)
- Cytomegalovirus
- Dengue
- Endemic (1)
- Encephalitis (1)
- Escherichia coli (E. coli)
- Hepatitis (1)
- Human immunodeficiency virus (HIV) infection
- Influenza
- Klebsiella pneumoniae
- Legionnaires’ disease
- Listeriosis
- Lyme disease
- Lymphoh ypocytic lymphoma
- Meningitis
- Meningococcal disease
- Mumps
- Neisseria meningitidis
- Ophthalmia neonatorum
- Pneumonia, bacterial
- Pneumococcal disease
- Pneumonia, atypical (1)
- Pneumonia, bacterial
- Pneumonia, viral
- Pneumonia, pneumonia
- Pseudomonas aeruginosa
- Pseudotuberculosis
- Ricketsia
- Rocky Mountain spotted fever
- Salmonellosis
- SARS (Severe Acute Respiratory Syndrome)
- Shigellosis
- Smallpox
- Spinal cord injury
- Syphilis
- Tuberculosis
- Typhoid fever
- Varicella zoster virus (chickenpox)

**Injuries**

- Animal Bites, FAX 212-768-5463
  - Reports are received via fax of Animal Report Form (HVM-55) to the Animal Control Enforcement Section, 212-768-5543
  - Exposure to rabid or rabid-at-risk animal, or any rabies vector species

- Drawings, FAX 212-768-1517
  - Reports are received via fax of Accident/Injury Form (HMF-61) to the Risk Management Services Section, 212-768-4296
  - Exposure to tobacco smoke or any hazardous substance
  - Falls, FAX 212-442-2629
  - Falls from windows of buildings with 3 or more stories

**Poisonings**

- Phone: 212-768-7667
  - Fax: 212-447-8223
  - Poisoning by drugs or other toxic agents including but not limited to pesticides and herbicides

**Stabilizations**

- Permanent stabilization procedures performed on both male and female patients must be reported to the Department for information on how to report, call 212-442-1740.

**Vital Events Certificates**

- All births, deaths, and spontaneous and induced terminations of pregnancy must be reported to the Department using appropriate NYC certificates. To obtain a blank certificate form, call 212-768-4296. To report on the NYC’s Electronic Death Registration System, email DRS@health.nyc.gov.

**Notes**

- 1. Report immediately by telephone a suspected case in a child, a young person, a child in a childcare setting, or a child in a hospital, nursing home, convalescent home, or other institutional setting.
- 2. Report immediately by telephone a suspected case in a food handler, child care worker, health care worker, or person with a possible exposure to the virus.

**Outbreaks**

- Reports are received via fax of Animal Report Form (HVM-55) to the Animal Control Enforcement Section, 212-768-5543
- Exposure to rabid or rabid-at-risk animal, or any rabies vector species

- Reports are received via fax of Accident/Injury Form (HMF-61) to the Risk Management Services Section, 212-768-4296
- Exposure to tobacco smoke or any hazardous substance
- D-8
### NYCDHM Universal Reporting Form

**To order more copies of this form call the Provider Access Line: 1-866-NYC-DOH1**

**Matt completed form to: NYC Dept. of Health & Mental Hygiene, 125 Worth Street, Room 315, CH-6, New York, NY 10013  ●  Or complete online: www.nyc.gov/nycdhm**

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**Patient Information**

- **Patient Last Name**
- **First Name**
- **Middle Name**
- **Date of Birth**
- **Age**
- **Country of Birth**
- **Sex**
- **Race**

- **If patient is a child, Guardian Last Name**
- **Guardian First Name**
- **Date of Report**

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**ARTFACT INFORMATION**

- **Home Telephone Number**
- **Other Telephone Number**
- **Medical Record Number**

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**Reporting Information**

- **Facility of Person Reporting Disease**
- **Name of Person Reporting Disease**
- **Address**
- **City**
- **State**
- **Zip Code**
- **Phone**

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**Date of Admission**

- **Admitted to Hospital?**
- **Admission Date**
- **Discharge Date**

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**Date of Diagnosis**

- **Risk Groups for Disease Exposure**
- **Date of Oldest Onset**

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**Doctor**

- **Address**
- **City**
- **State**
- **Zip Code**

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Call DOHMH if there is an outbreak or suspected outbreak of any disease or condition, of known or unknown etiology, which may be a danger to public health, occurring in three or more persons or any unusual manifestation of a disease in an individual. Call Provider Access Line: 1-866-NYC-DOH1; after hours, call Poison Control Center: 1-212-POISON (764-7647).
<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>First Name</th>
<th>Medical Record Number</th>
</tr>
</thead>
</table>

**SYMPTOMS**

- Intestinal: [ ]
- Neurologic: [ ]
- Respiratory: [ ]
- Gastrointestinal: [ ]
- Dermatologic: [ ]
- Other: [ ]

**SYMPTOM ASSESSMENT** (Check all that apply)

- None: [ ]
- Nausea/vomiting: [ ]
- Diarrhea: [ ]
- Other: [ ]

**TREATMENT PROVIDED**

- Anti-biotics: [ ]
- Anti-fungal: [ ]
- Other: [ ]

**SEXUALLY TRANSMITTED DISEASES**

**SPECIMEN SOURCE**

- Male: [ ]
- Female: [ ]
- Other: [ ]

**DATE OF EXPOSURE**

- Date collected: [ ]
- Date analyzed: [ ]

**SEROLOGY**

- Serum: [ ]
- Urine: [ ]
- Other: [ ]

**TREATMENT**

- Treatment: [ ]
- Unknown: [ ]
- Other: [ ]
List of documents included in this section:

1. New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts (Revised 3/2011)
Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. Definitions For Purposes Of This Appendix

"Managed Care Organization " or "MCO " shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

"Independent Practice Association " or "IPA " shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider " shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

B. General Terms And Conditions

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least thirty (30) days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to
enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

4. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the Provider at least thirty (30) days in advance of implementation, including but not limited to:
   - quality improvement/management
   - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data
   - member grievances; and
   - provider credentialing

5. The Provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. If the Provider is a primary care practitioner, the Provider agrees to provide for twenty-four (24) hour coverage and back up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.

7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.


9. To the extent the MCO enrolls individuals covered by the Medical Assistance, and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO
and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:

a. The MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;

b. The Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA's performance; and

c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.

d. The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.

e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

f. The Provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

g. The Provider or IPA agrees, pursuant to 31 U.S.C.§1352 and CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The Provider or IPA agrees to complete and submit the "Certification Regarding Lobbying", Appendix ____ attached hereto and incorporated herein, if this Agreement exceeds $100,000. If any funds other than Federally appropriated funds have been paid or will be paid to any person for the
purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

h. The Provider agrees to disclose to MCO on an ongoing basis, any managing employee that has been convicted of a misdemeanor or felony related to the person's involvement in any program under Medicare, Medicaid or a Title XX services program (Block grant programs).

i. The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals posted by the OMIG on its Website.

j. The Provider agrees to disclose to MCO complete ownership, control, and relationship information.

k. Provider agrees to obtain for MCO ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12 month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to MCO within 35 days of such request.

10. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

11. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA’s providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act; the HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law§33.13.

C. Payment; Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between
the MCO and the New York State Department of Health. In the case of Family Health Plus, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR § 422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under
this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

5. The parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member's inpatient hospital discharge, consistent with Public Health Law §4903.

D. Records; Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

2. When such records pertain to Medicaid or Family Health Plus reimbursable services the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA.
or to third parties. If the Agreement is between an MCO and an IPA, or between
an IPA and an IPA, the IPA agrees to require the providers with which it
contracts to agree as provided above. If the Agreement is between an IPA and a
provider, the Provider agrees to obtain consent from the enrollee if the enrollee
has not previously signed consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non-renewal of an agreement between an MCO and an IPA,
institutional network provider, or medical group Provider that serves five
percent or more of the enrolled population in a county, or the termination or
non-renewal of an agreement between an IPA and an institutional Provider or
medical group Provider that serves five percent or more of the enrolled
population in a county, requires notice to the Commissioner of Health. Unless
otherwise provided by statute or regulation, the effective date of termination
shall not be less than 45 days after receipt of notice by either party, provided,
however, that termination, by the MCO may be effected on less than 45 days
notice provided the MCO demonstrates to DOH's satisfaction prior to
termination that circumstances exist which threaten imminent harm to enrollees
or which result in Provider being legally unable to deliver the covered services
and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO
shall provide to such health care professional a written explanation of the
reasons for the proposed contract termination, other than non-renewal, and an
opportunity for a review as required by state law. The MCO shall provide the
health care professional 60 days notice of its decision to not renew this
Agreement.

3. If this Agreement is between an MCO and an IPA, and the Agreement does not
provide for automatic assignment of the IPA's Provider contracts to the MCO
upon termination of the MCO/IPA contract, in the event either party gives notice
of termination of the Agreement, the parties agree, and the IPA's providers
agree, that the IPA providers shall continue to provide care to the MCO's
enrollees pursuant to the terms of this Agreement for 180 days following the
effective date of termination, or until such time as the MCO makes other
arrangements, whichever first occurs. This provision shall survive termination of
this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA
insolvency or termination of this contract for any reason, the Provider shall
continue, until medically appropriate discharge or transfer, or completion of a
course of treatment, whichever occurs first, to provide services pursuant to the
subscriber contract, Medicaid Managed Care contract, or Family Health Plus
contract, to an enrollee confined in an inpatient facility, provided the
confine ment or course of treatment was commenced during the paid premium
period. For purposes of this clause, the term "provider" shall include the IPA
and the IPA's contracted providers if this Agreement is between the MCO and
an IPA. This provision shall survive termination of this Agreement.
5. Notwithstanding any other provision herein, to the extent that the Provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

F. Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

G. IPA-Specific Provisions

1. Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA’s analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL “Disclosure Form to Reporting Lobby,” in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: ______________________

TITLE: ____________________________________________

ORGANIZATION: ______________________________________

NAME: (Please Print) ______________________________________

SIGNATURE: _______________________________________

*(this form is submitted along with all signed contracts)*