

EPO/PPO

Care Management

Now that's HIP
HEALTH PLAN OF NEW YORK

Care Management

Introduction

Health care today is complicated. Sometimes it is difficult to understand all the treatment options available in every case. Sometimes it is difficult to be certain exactly what is covered and what is not – even though HIP provides detailed information to assure full disclosure and to facilitate understanding. And many members tell us they want even more information, so they can be empowered to take a more active role in making decisions about their health and their health care.

For these reasons, HIP has developed a series of special information, support and review programs, which are described in this section of your handbook. We have described them in detail, because we want you to understand how we work to help you receive the most appropriate care in the most appropriate settings and understand what benefits are available to you. We also want you to know how we fulfill our obligation to deliver coverage consistent with the terms of your Evidence of Coverage.

We believe these programs support sound medical choices and help to improve health outcomes. It is up to you and your physician to make the final decisions about which health care choices are best for you. HIP, however, reserves the right to determine if the medical services provided are medically necessary and/or covered under your Evidence of Coverage.

Care Management Program (CMP)

HIP's Care Management Program (CMP) gives you important resources to help with the medical care decisions you and your physician must make. The CMP team comprises physicians, nurses, social workers, epidemiologists, biostatisticians and highly trained supporting associates.

CMP consists of these key utilization review components:

- Anticipated and Continuing Care Services Program

- Concurrent Care Program
- Case Management Program
- Post-Service Review Program
- Technology Evaluation Program

In carrying out their responsibilities, team members consult extensive clinical databases, Medical Guidelines and Clinical Review Criteria and HIP participating physicians and Centers of Excellence.

Anticipated and Continuing Care Services Program

The CMP Anticipated and Continuing Care Services Program (ACCSP) assists in making decisions about care or diagnostic services that members and their physicians anticipate they will need to receive in the near future. Its goal, like yours and your physician's, is to support best outcomes through services that are provided for the right reasons, at the right place, by the right provider and at the right time. To achieve that goal, HIP requires members (or their physicians on their behalf) to contact ACCSP to assure coverage of certain services. The services requiring ACCSP contact and prior approval have been identified through careful research and are on the ACCSP list for one or more of the following reasons:

- The service is associated with a high degree of risk to the member.
- The service will require follow-up during or after the service is rendered, requiring continuity of care and coordination of services.
- The service may be associated with benefit limitations or exclusions.
- There may be alternative methods of treatment that you may wish to explore.
- The service might be provided at a Center of Excellence, improving the probability of the best possible outcome for you.
- The service is to be provided by a non-credentialed and non-participating provider.
- The service could be provided only for the convenience of the physician or member.
- A different sequencing or timing of the service(s) might lead to a better outcome for you.

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Services that meet these criteria and require prior ACCSP approval for coverage are:

- Inpatient non-emergency admissions that provide acute, rehabilitation and skilled nursing care.
- All outpatient surgery, procedures and/or treatment in a facility or doctor's office.
- Inpatient treatment of mental illness and chemical abuse and dependence, detoxification treatment of chemical abuse and dependence, and rehabilitation treatment of chemical abuse and dependence.
- Service provided by non-participating providers or in non-participating facilities, except in the case of an emergency. (Applies to EPO members only.)
- Non-emergent transportation.
- Home health care.
- Hospice care.
- Pre-transplant evaluation and transplant services.
- Outpatient cardiac and pulmonary rehabilitation.
- Outpatient diagnostic radiology services.

Generally, when you anticipate receiving these services, your participating physician will know to contact ACCSP for you. Always check with the doctor's office, however, to make sure that ACCSP has been contacted.

The ACCSP will make all determinations that require prior approval for coverage and provide notice of the determination to you or your designee and your participating physician. Notification will be made by telephone and in writing within two business days from receipt of necessary information. The maximum time HIP will take to make a determination is 15 days from the date HIP receives your request.

To be sure that services have been approved, you may contact your physician's office staff before you're scheduled to receive the above services.

PPO members only

- If you choose to receive out-of-network services, you are responsible for notifying ACCSP for any service requiring prior ACCSP approval (see left hand column).
- If you do not provide prior notification for these services, HIP may pay only 50 percent of out-of-network benefits otherwise payable.
- If HIP does not grant prior approval of coverage in these cases, HIP may not provide any benefits for these services.

When receiving care from a non-participating provider, you are responsible for notifying the plan and requesting prior approval for the above services.

On occasion, the requested service does not meet the standards referenced by ACCSP representatives. This may occur for one or more of the following reasons:

- The service is not a covered benefit under your Evidence of Coverage.
- The ACCSP has determined that the request is not medically necessary or is investigational or experimental.
- The service has a benefit limitation under your Evidence of Coverage.
- ACCSP has recommended that a different service and/or place of service may be in the best interest of the member.

These circumstances may result in no approval being given and, instead, lead to the issuance of a denial, or adverse determination. (See *Care Management: Adverse determinations*.) Prior to an adverse determination being issued, a physician from HIP will attempt to resolve any outstanding issues with your physician.

Be assured that a HIP physician may issue an adverse determination only after careful consideration of all of the available information.

Contacting ACCSP

Should you need to contact ACCSP, just call **1-888-447-2884**. Representatives are available Monday through Friday from 9 am to 5 pm. If you call after those hours and your call concerns an urgent or emergency admission, you will be prompted to leave a message and ACCSP will call you or your doctor back if necessary. If ACCSP receives sufficient information, that case will be routed to the appropriate Concurrent Reviewer. If your call concerns an elective admission, you will be advised to call back the next business day when representatives are available. Please refer to your HIP member ID card for the number to call.

Experimental/Investigational Treatment

HIP will not provide coverage for any procedure or service, which in HIP's sole judgment, is experimental or investigational, unless required by an external appeals agent.

(continued)

Determinations for non-urgent care. You or your designee and your health care provider will be advised (by telephone and in writing) of a non-urgent care determination that requires prior approval within two business days of receiving all necessary information. The maximum time HIP will take to make a determination is 15 days from the date CMP receives your request.

Important. If the Care Management Program (CMP) does not make a determination within 3 business days of receiving all necessary information, your request will be deemed adversely determined and subject to internal appeal. This designation provides you with the ability to pursue a prompt appeal through the appeals process .

Concurrent Care Program

The Concurrent Care Program (CCP) facilitates the coordination and continuity of services rendered to a member when in a hospital or other facility. You are automatically entered into the program at the time you are admitted to the hospital.

Inpatient care is one of the most complex services provided to any member. The CCP team supports you during this difficult period. The team includes physicians, nurses, social workers and discharge planners. They have access to protocols, clinical practice guidelines and specialists to assist them in helping you during and after the hospitalization. Some inpatient care requires minimal involvement, while others require more extensive assistance.

Concurrent Care Program support begins within 24 hours of your admission to the facility. It's important for the program to start early in the facility, since typically as much as 80% of all hospital services are provided within the first 48 hours. When your admission is arranged through the Anticipated and Continuing Care Services Program, the team knows

Our commitment to you for timely Anticipated and Continuing Care Services Program determinations and notifications

Determinations for urgent care. You or your designee and your health care provider will be notified (by telephone) of an urgent care determination of coverage that requires prior approval as soon as possible considering your medical condition, but no later than 72 hours after the Care Management Program (CMP) receives your request. Written notification will follow in three calendar days after the decision is made.

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in advance that you are being admitted to a facility. When your admission is an emergency, the hospital will usually contact the CCP within 24 hours for you.

The Concurrent Care Program for facility services works as follows:

- A CCP nurse is assigned to your case and reviews the case with the facility utilization management team, facility discharge planners and your attending physician.
- Throughout your hospital stay the CCP team will make coverage determinations to facilitate the care plan for your particular situation and help ensure that the facility and other resources are necessary and most appropriate.
- The CCP team will assist in discharge planning with your physician and other caregivers early in the admission and facilitate post discharge arrangements that meet medical necessity, setting, level and type of care.

Initial approvals for acute inpatient care, acute rehabilitation or skilled nursing admissions, may be extended concurrently by having the utilization management team and/or your provider contact the CCP for medically necessary additional care.

Adverse Determinations

On occasion, the Concurrent Care Program may find that the care rendered in the facility or outpatient setting does not meet nationally recognized medical criteria. This may occur because the care is not medically necessary (see definition of medical necessity under **Care Management: Adverse determinations**). In addition, an adverse determination may be issued for lack of benefit or delay in service and care delivery.

When this situation occurs, and after discussion with your physician by one of the CCP physicians, an adverse determination of coverage may be made. (See **Care Management: Adverse determinations** for more information.)

Our commitment to you for timely Concurrent Care Program determinations and notifications

Concurrent care determinations involving coverage for continued or extended health care services, or additional services when you are undergoing a course of continued treatment prescribed by a health care provider, will be made and notice of such determination will be provided to you or your designee or health care provider.

Notification will be made (by telephone and/or fax) within the shorter of one day or sufficiently in advance so that you can appeal a denial before it goes into effect. All adverse determinations have appropriate appeal rights.

Any request to extend the course of treatment beyond the period of time or number of treatments that involve urgent care shall be decided as soon as possible taking into account your medical circumstances. HIP will notify you or your designee and your health care provider of the decision within twenty-four (24) hours of the receipt of this request, provided that any such request is received at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Case Management Program

The Case Management Program assists members who have complex or serious diseases or conditions. HIP constantly screens the member population looking for possible candidates: patients with conditions that are known to benefit from Case Management Program coordination. Possible candidates are assigned to a case management nurse. The nurse contacts each candidate and enrolls them in the program if appropriate. The assigned nurse is then supported by the entire team, consisting of specially trained case management nurses, physicians, social workers and numerous supporting associates that provide information for the program. They consult up-to-date medical literature, specialists, databases, Clinical Practice Guidelines and computerized tools

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in coordinating the services needed by this special group of patients. A highly specialized disease management unit is also available for support where appropriate.

Members may be in the program from weeks, to months, to years, and Case Management Program contact may be daily, weekly or monthly – it all depends on the individual condition and the circumstances. All contacts and services have one main purpose: the most optimal health care outcome for you.

Post-Service Review Program

The Post-Service Review Program reviews medical and hospital records after services have been provided to determine if such services were medically necessary and/or qualified as covered services. For example, a post-service review may be triggered by a history of an unusually high number of tests ordered by the physician for the particular service provided.

Under such circumstances, HIP has a responsibility to review the claim and assure that the medical services you received are covered in accordance with the terms of your HIP Evidence of Coverage. In this way, HIP is able to assure that coverage contracts are administered consistently for all members and that premium rates remain as reasonable as possible for HIP's comprehensive benefits and coverage.

Such reviews may result in a post-service denial if, for example, the services you received:

- Were not approved prior to your receiving them.
- Were not a medical emergency as defined in the *Emergency and Out-of-Area Care* section of the member handbook.
- Were not medically necessary (see definition of medical necessity under *Care Management: Adverse determinations*) or are otherwise excluded from coverage as provided in your Evidence of Coverage.

Please remember: HIP is obligated to administer coverage to ensure that all contract provisions are honored. That means providing all benefits to which members are entitled. It also means not providing benefits that are excluded from coverage. For example, HIP EPO/PPO members are not covered for experimental/investigational treatment. Please refer to your Evidence of Coverage for more details.

Our commitment to you for timely Post-Service Review determinations and notifications

Determination and notification involving post-service benefit reviews shall be made no later than 30 days after receipt of the request.

Important. If the Care Management Program (CMP) does not make a post-service review determination within 30 days of receiving all necessary information, your request will be deemed adversely determined. This designation provides you with the ability to pursue a prompt appeal through the appeals process.

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Our commitment to stand by our decisions

HIP may reverse a prior approval treatment, service or procedure on retrospective review only when:

- The relevant medical information presented to HIP or utilization review agent is, upon retrospective review, materially different from the information that was presented during the prior approval review.
- The relevant medical treatment information presented to HIP or utilization review agent, upon retrospective review, existed at the time of the prior approval but was withheld from or not made available to HIP or utilization agent.
- HIP or utilization review agent was not aware of the existence of the information at the time of prior approval review.
- If HIP or utilization review agent had been aware of the information, the treatment, service, or procedure being requested would not have been authorized. This determination is to be made using the same specific standards, criteria or procedures as used during the prior approval review.

Technology Evaluation Program

Our members deserve the most current, safe, appropriate and effective medical care consistent with the professional standard of care available in our service area. In keeping with this commitment, HIP generally excludes coverage for treatments of an experimental or investigational nature.

Benefits are not available for services, supplies, procedures and items considered to be investigational or experimental. A drug, device, procedure or treatment may be determined to be experimental if any of the following applies:

- There are insufficient outcome data available from controlled clinical trials published in the

peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.

- The FDA has not granted the required approval for general use.
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.
- The written protocols or informed consent used by the treating facility, or the protocols or informed consent of any other facility studying substantially the same drug, device, procedure or treatment, state it is experimental, investigational or for research purposes.

Also, your coverage does not include any technology or any hospitalization in connection with such technology if, in HIP's sole judgment, such technology is obsolete or ineffective. Governmental approval of a technology is not necessarily sufficient to render it of proven benefit, appropriate or effective for a diagnosis or treatment of a particular condition.

HIP believes that our ongoing evaluation of medical technology helps to improve health outcomes for our members. We provide you with the opportunity to further pursue your request for coverage of a specific treatment if we have initially denied you benefits.

HIP's Technology and Bioethics Committee meets a minimum of four times a year to decide when certain technologies previously considered experimental have come to satisfy the general medical standards in effect in our service area at the time of their evaluation.

Also, in making a coverage determination in an individual patient case, HIP's professional staff will consult with physicians involved in the care of a member.

Adverse determinations

In some instances, it may be determined through the Care Management Program, that a particular service is, or in the case of a post-service review, was not medically necessary.

What Does Medically Necessary Mean?

Medically necessary health care services or supplies are those that are required to prevent, diagnose, correct or cure conditions in the member that cause acute suffering, endanger life, result in illness or infirmity, interfere substantially with the member's capacity for normal activity or threaten some significant disability. Services or supplies that are not provided in the most appropriate setting or level of care are not medically necessary.

All determinations are conducted by qualified personnel as follows:

- Licensed health care professionals who are trained in the principles and procedures of intake screening and data collection. Administrative personnel are used only to perform intake screening, data collection and nonclinical review functions. They are supervised by licensed health care professionals.
- A health care professional who is appropriately trained in the principles, procedures and standards of utilization management.
- A clinical peer reviewer when the review involves an adverse determination.

A clinical peer reviewer is a physician who possesses a current and valid nonrestricted license to practice medicine. A clinical peer reviewer may also be a health care professional other than a licensed physician who, where applicable, possesses a current and valid nonrestricted license, certification or registration.

Where no provision for a license, certificate or registration exists, a clinical peer reviewer for a health care professional other than a physician must be credentialed by the national accrediting body appropriate to the profession and in the same profession/specialty as the health care provider who typically manages the medical condition. In some instances, an adverse determination is made without providing an opportunity for a discussion with the health care provider who specifically recommended the health care service, procedure or treatment under review. In such a case, the health care provider will have the opportunity to request a reconsideration.

Points to remember about reconsideration include:

- Except in cases of post-service review, such reconsideration will occur within one business day of notice of adverse determination.
- The reconsideration will be conducted by your health care provider and the original clinical peer reviewer who made the initial determination or a designated clinical peer reviewer, if the original clinical peer reviewer is not available.

If the adverse determination is upheld after reconsideration, you will be notified as described above.