

5 PRIMARY CARE SERVICES

5.1 OVERVIEW

The Primary Care Provider or hospital/center is reimbursed a monthly capitation fee for each member who selects the provider as his/her PCP. The capitation payment covers all services provided by the PCP including, but not limited to:

- Office visits for the diagnosis and treatment of disease, illness or injury
- Preventive healthcare (i.e., routine physicals, periodic Pap smears, etc.)
- Routine diagnostic services (including but not limited to routine laboratory and radiology services, EKGs)
- Immunizations & Biologicals (PCPs who treat children are required to participate in the Vaccines for Children Program)
- Injections
- Hospital visits
- Home visits
- Venipuncture
- Minor office surgery routinely provided by PCP
- Removal of sutures
- Determining the need for specialist referrals
- Counseling as needed for weight control, health maintenance, control of chronic medical conditions such as asthma, hypertension, diabetes, etc.
- All supplies and reports associated with the provision of primary care services.

Each time the PCP provides services to a Plan member, the PCP must submit a claim encounter to the Plan. Providers should report services using the CMS1500 universal claim form (or UB04). The claim form must include CPT-4 codes (including preventive care CPT codes where appropriate), place of service codes, appropriate ICD-9-CM codes for each service (i.e. well visit service codes should have well visit diagnosis codes), the PCP name, and the correct Plan provider ID number. Submit claims/encounter forms **electronically using submitting ID# 11325** or send **paper claims/encounters** to:

**Neighborhood Health Providers
PO Box 6008
Hauppauge, NY 11788-9007**

If you do not know your Plan provider number, call Provider Services. The data submitted to the Plan is used to produce utilization reports, including HEDIS/QARR Reporting as required by State and City agencies, and enables the Plan to provide feedback to providers.

PCPs are monitored for compliance with 24-hour coverage, appointment scheduling, encounter data submission, medical records and care standards. Failure to comply with these standards may result in sanctions.

Cost Sharing

Plan Providers are prohibited from collecting payments, billing Plan members or imposing any other cost sharing requirements on members for delivery of services included in the prepaid benefit package except for any applicable deductibles, co-payments or coinsurance as allowed under the specific benefit program.

5.2 SELECTION/CHANGE OF PRIMARY CARE PROVIDER

At the time of enrollment, members are required to select a Primary Care Provider (PCP) from the Plan Provider Directory. Plan PCPs may include Internists, Family Practitioners, Pediatricians, and Nurse Practitioners but not residents or Physician Assistants. The selection of the PCP is entirely the member's choice and the Plan does not in any way attempt to influence the member. Members enrolled through auto selection in the Mandatory program are assigned a PCP. The member always has the option of changing PCPs once enrolled. PCP assignments will be made to providers in or near the zip code where the member resides. More than one PCP may serve a single family, but each member can only have one PCP.

Members have the freedom to change a PCP for whatever reason, providing of course that they choose another Plan participating PCP. The Plan does not limit the number of change requests that its members can make in a twelve (12) month period.

For ease of administration and provider payment, the Plan makes PCP changes effective on the first day of the following month. The member is then sent a new Identification Card within 14 calendar days of the PCP change.

The Plan will perform an urgent PCP change any time that the member feels it is necessary. Urgent changes are made effective on the date that the change is requested. However, PCP changes made before the 15th of the current month, the capitation payment is made to the new PCP. In the case where changes become effective on the 16th day of the month or later, the new PCP will have to agree to forego capitation for the current month. If the new PCP does not agree, the PCP change will become effective on the 1st day of the next month

To change PCPs:

Plan members must call the Member Services Department. If the member is in your office and needs to change their PCP you can call Provider Services.

If a PCP finds that he/she is unable to effectively provide services to a member, or if the PCP has reached a capacity that may affect the delivery of patient care, the PCP can request that a member be transferred or the panel be closed.

The request should be in writing and should be directed to the *Provider Relations Department at 521 Fifth Avenue – 3rd Floor, New York, NY 10175* or email us at Providers@royalhc.com. The Plan also may initiate a PCP transfer when the member requires specialized care with the approval of the Chief Medical Officer.

To request a member transfer, the PCP must show good cause, for example, if the member is continually rude or abusive to office staff or if the member acts fraudulently.

A PCP MAY NOT REQUEST A CHANGE BECAUSE OF THE PATIENT'S PHYSICAL CONDITION, DEGREE OF ILLNESS, OR AMOUNT OF SERVICES REQUIRED.

5.3 ROLE OF THE PRIMARY CARE PROVIDER (PCP)

Within the context of the Plan health care delivery system, a PCP is a participating provider (Physician or a Nurse Practitioner, **not a Resident or Physician Assistant**, specializing in Family Practice, Internal Medicine, or Pediatrics) who has agreed to provide and deliver primary care services to Plan members. Effective PCP involvement in all phases of patient care will help to assure:

- Coordination of care among various specialists, providers and settings
- Continuity of primary care
- Improved health care outcomes
- Efficient use of health care resources, and
- Increased member satisfaction.

Participating PCPs are responsible for supervising and coordinating all medically necessary health care, including having coverage available 24 hours per day, 7 days per week, for their members. Residents are restricted to acting under the supervision of the member's PCP. A PCP may supervise no more than four (4) Residents. Members always have the right to request an appointment with their assigned PCP.

As **care manager**, Plan PCPs:

1. Efficiently provide preventive health services and quality medical care that meets patient needs.
2. Check member rosters monthly and contact new members who have not been in for an appointment within three months of their initial date of enrollment.
3. Make referrals for specialty care and other medically necessary services. This includes assisting the member in selecting a specialist. Providers do not have to fill a referral voucher to refer a member to a specialist visit, but are encouraged to communicate the reason(s) in writing for the referral to the specialist.

4. Encourage members to take advantage of classes to promote wellness and prevent illness. Refer to www.getnhp.com or www.suffolkhealthplan.com for classes available.
5. Coordinate managed care covered health care services for members including the identification of medical problems that require a consultation with a specialist within the Plan network when such services are medically necessary. If the medical service is only available outside of the network the PCP will work with the Plan's Care Coordination Department to obtain an authorization for referral to the non participating provider. The PCP will also coordinate services not covered through Medicaid Managed Care through the Medicaid Fee-For-Service program.
6. NHP expects Primary Care Providers (PCPs) to play an active or supportive role whenever possible and appropriate in inpatient management and discharge planning. PCPs can coordinate inpatient services as follows:
 - If the PCP is directly admitting the patient under his/her name, then the PCP will be the attending of record for that admission.
 - Whenever NHP is notified of an emergency inpatient admission, a letter is sent to the PCP informing him/her of the date of admission, the admitting diagnosis and the name of the hospital (1009-PCP Admit Notification, template attached). In this situation it is expected that the PCP will make use of one or more of the following options to support and coordinate inpatient management:
 - If the member was admitted to a hospital where the PCP has admitting privileges, then the PCP can become the attending of record. (In some of these cases the PCP might have sent the member to the Emergency Room, or the ER might notify the PCP of the admission).
 - If the member was admitted to a hospital where the PCP has admitting privileges, but inpatients are routinely cared for by hospitalists or teams of house staff and teaching attendings, then the PCP can communicate with the responsible physicians and transmit vital health care information. The PCP might have access to the hospital's electronic health record so that clinical data from the admission can be easily transferred into the outpatient record.
 - If the member was admitted to a hospital where the PCP does not have admitting privileges, then the PCP can reach out to the attending of record to give information from the outpatient record and coordinate discharge planning.
 - If the member was admitted to a service such as surgery, urology, intensive care, etc., then the PCP can reach out to the specialist attending of record to give information from the outpatient record and coordinate discharge planning.

- If the PCP referred the member to a participating specialist, it is expected that the specialist will send back a consultation report to the PCP. If the PCP does not receive this information, he/she should contact the specialist. In so far as the treatment recommendation includes any procedures or other services by the specialist that will take place in the inpatient setting, the PCP may be asked to provide preoperative clearance and will be responsible for staying informed of the admission and outcome.
 - When a member is enrolled in Care Coordination (case management), the care coordination representative (CCR) routinely reaches out to the PCP and to solicit the PCP's involvement in care planning. This outreach is initially by telephone, with a follow-up faxed letter if the provider does not respond to telephone outreach. For every new case a care plan is mailed to the PCP. The CCR will stay in contact with the PCP to give updates on the member's progress, and will indicate when the member has been hospitalized. If the member is admitted to an inpatient facility the CCR will assist the PCP in identifying and reaching out to the attending physician, will work with the PCP on the discharge plan, and will update the care plan to address any new issues or changes in treatment that resulted from the hospitalization.
7. The PCP will review the findings and recommendations from specialists and diagnostic testing, and help to coordinate the member's ongoing evaluation and treatment as needed.
 8. Coordinate prevention and treatment of reportable communicable diseases through the local public health department.
 9. New York City Providers must report communicable diseases to the New York City Department of Health and Mental Hygiene in compliance with the New York State Sanitary Code and New York City Health Code. Suffolk County Providers must report communicable diseases to the New York State Department of Health in compliance with the New York State Sanitary Code.
The diseases and conditions that must be reported include: AIDS, Parasitic Diseases, Sexually Transmitted Diseases, Tuberculosis, Vaccine Preventable Diseases, Other reportable diseases such as Poisonings (drugs, lead or other toxic agents), Injuries (animal bites and falls), and Outbreaks. For assistance, call the New York City Department of Health and Mental Hygiene Communicable Disease Program at 347-396-2600 or the New York State Department of Health Communicable Disease Program at 518-473-4439 or 866-881-2809 after hours. Or on their web site at:
<http://health.ny.gov/professionals/diseases/reporting/communicable/>
for the current reportable disease list.
 10. Submit encounter data on a CMS1500 or UB04 form for all services provided. Form must include diagnosis codes related to each service, dates of service, service codes and the Plan provider number. All services provided including well visits and immunizations must be reported. Charge fields should be completed with the PCPs usual fee.

11. Maintain a **legible** medical record for each member with dated and signed entries that completely describe all encounters and **clearly demonstrates that the PCP is coordinating and managing all medical care for the member**. The medical record for *adult* members should indicate that the PCP has discussed the preparation of an Advanced Health Care Directive. It must be clearly indicated if the discussion occurred and that the member does or does not have an Advanced Health Directive. All medical records must be retained in readily accessible form, for a period of at least six (6) years from the last date of service, six (6) years from the termination of your Agreement with the Plan, or six (6) years after the Enrollee's age of majority, whichever is longer, or such other longer period as may be required by law. In addition, the Plan requires that all medical records be accessible to the Plan for Utilization Review and Quality Assurance purposes as well as to the New York State Department of Health and for Medicaid members to the New York City Department of Health and Mental Hygiene. **Detailed Medical Record Guidelines are available in Appendix Tab # 9.**
12. Provide patient education which includes:
 - information regarding the proper use of Plan services;
 - information regarding the patient's medical condition(s) which is understandable to the patient and/or family members;
 - health promotion and illness prevention information;
 - Member rights and responsibilities. (Refer to Section 21)
13. Make members aware of self-referral services such as family planning, HIV pre- and post-test counseling, OB/GYN visits, and services provided through the Plan's vision care and behavioral health program. (Refer to Section 10)
14. Educate pregnant women and families with members under age 21 about the Child/Teen Health Program (C/THP). (See section 5.3.7 of this manual for full details on the Child/Teen Health Program.)
15. Conduct outreach (e.g., mail and telephone) to ensure children are kept current with respect to their Child/Teen Health Plan (C/THP) periodicity schedules.
16. Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals, and conduct follow-up visits with children and adolescents who miss or cancel appointments.
17. Be available to see patients at least 16 hours per week at each site of practice.
18. Comply with the Plan's 1 hour maximum waiting time standard for members with scheduled appointments in provider offices/centers; if waiting time will be longer; you must provide an explanation and offer the member the opportunity to reschedule the appointment.

19. Follow New York State Department of Health appointment scheduling standards:

- emergency care immediately upon presentation at a service delivery site,
- urgent medical or behavioral problems within 24 hours,
- non-urgent "sick visits" within 48 to 72 hours, as clinically indicated,
- routine, non-urgent or preventive care visits within 4 weeks,
- specialist referrals (not urgent) within four (4) to six (6) weeks of request'
- adult baseline and routine physicals within 12 weeks of enrollment (adults older than 21),
- well child care within four (4) weeks of request,
- initial prenatal visits within 3 weeks during the first trimester, 2 weeks during the second trimester and 1 week during the third trimester,
- initial visit for newborns to their PCP within 2 weeks of hospital discharge,
- initial family planning visits within 2 weeks of request,
- mental health or substance abuse follow-up visits pursuant to an emergency or hospital discharge with a Participating Provider within 7 days, or as clinically indicated,
- non-urgent mental health or substance abuse visits within 2 weeks of request, and
- Visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a member's ability to perform work when requested by LDSS within ten (10) days of request by the Medicaid Managed Care enrollee.

20. Deliver medically necessary primary care services as per the standards of the Plan and the State Department of Health Office of Managed Care. This includes, but is not limited to, behavioral health screening and Child /Teen Health Program (C/THP) screening services for all Plan members. The tools used in identifying members with behavioral health care needs, i.e. the CAGE test, TWEAK test, "Mini-Mental State" and the PHQ-9 can be found in the Appendix section (Tabs 11 – 14) of this manual. In addition, the PCP provides services to members requiring ongoing mental health care:

- identify members who require such services, and encourage early entry into treatment,
- participate in case management activities to ensure all required services--including emergency services--are furnished on a timely basis,
- Participate in the coordination of service delivery between physical health, substance abuse, and mental health providers.

21. Oversee services to members requiring substance abuse services:
 - identify members who require such services, and encourage early entry into treatment,
 - refer pregnant women to Beacon Health Strategies for appropriate services beyond Plan's benefit package,
 - refer members in need to the Plan Case Management Program and ask to speak to a Prenatal Case Manager
 - Participate in the coordination of service delivery between physical health, substance abuse, and mental health providers.
22. Educate members on what to do to obtain services after business hours and on weekends.
23. Notify the Plan and their members thirty (30) days in advance of the effective date of a change in office address, office hours or telephone number.
24. Have a coverage system in place for twenty-four (24) hours a day, seven (7) days a week access that meets New York State Department of Health requirements and instructs members on what to do to obtain services after office/center operating hours. **If the after hours call system is an answering machine it must direct the member to a live voice. Your answering machine may not direct members to the ER.**
25. Have Plan participating providers as covering providers; Plan PCPs cannot "sign-out" to non-participating providers.
26. Provide requested information to public health clinics and to the Citywide Immunization Registry on immunization records of members.
27. Participate in the Vaccines for Children program (Pediatric PCPs or Family Practice PCPs who treat children).
28. Screen, diagnose and treat children with elevated blood lead levels, and coordinate care with the local health department in accordance with existing State and local laws and regulations.
29. Supply MetroCards to Medicaid Managed Care members and Family Health Plus members (New York City residents only) age 19 to 20 who are receiving Child/Teen Health Program services and, if applicable, to their parent or guardian, for public transportation if the member resides more than ten (10) blocks from the provider's office.
30. Coordinate and track non-emergent transportation for Medicaid Managed Care members, and Family Health Plus members age 19 to 20 who are receiving Child/Teen Health Program services, as medically required. **NON-EMERGENT TRANSPORTATION VIA AMBULETTE, LIVERY OR TAXI MUST BE PRE-AUTHORIZED. PLEASE CONTACT CARE COORDINATION TO OBTAIN APPROVAL AND TO COORDINATE NON-EMERGENT**

TRANSPORTATION. REQUESTS SHOULD BE MADE 72 HOURS IN ADVANCE TO ALLOW TIME TO APPROPRIATELY SCHEDULE THE REQUIRED TRANSPORTATION. Non-emergent transportation is covered for all Medicaid members for all medically necessary covered benefits even if they are not part of the Plan Medicaid Benefit Package. **Non-emergent transportation is not a covered benefit for Child Health Plus and Family Health Plus members.** Failure to obtain prior authorization of the transportation will result in claim denial.

31. Treat adult members with chronic illnesses and physical or developmental disabilities:
 - comply with the Americans with Disabilities Act,
 - identify members who are at risk of, or having, chronic diseases and disabilities, and determine their specific needs,
 - participate in case management activities,
 - participate in systems for coordinating service delivery with out-of-network providers and ongoing service providers for all members, and
 - oversee existing relationships with out-of-network providers, when considered to be in the best medical interest of the member.
32. Treat children with special health care needs, i.e., serious or chronic physical, developmental, behavioral, or emotional conditions which may require services beyond that required by children generally:
 - interact with school districts, child protective service agencies, early intervention officials, behavioral health, and developmental disabilities service organizations to coordinate the proper service delivery, and
 - assure that children with serious, chronic, and rare disorders receive appropriate diagnostic work-ups on a timely basis.
33. Oversee services to developmentally disabled individuals.
34. Provide services to the HIV affected population as per AIDS Institute guidelines and protocols, as well as address the HIV prevention needs of uninfected members and
 - provide patients with HIV related education and risk reduction information;
 - promote early identification and prevention of HIV to members;
 - Inform members being asked to consent to HIV testing about the seven points of information as required by the September 2010 changes to the New York HIV Testing Law (please refer to Section 22, HIV/AIDS);
 - inform members of the availability of both in-plan HIV counseling and testing services, as well as those services available from New York State and New York City-operated Anonymous Counseling and Testing Programs;
 - assure timely and accurate required reporting;

- use AIDS Institute protocols and procedures for patient evaluation (please refer to section 22); encourage early entry into treatment, paying special attention to HIV+ women who are pregnant; and,
 - participate in case management activities to ensure that all necessary services are furnished on a timely basis.
35. Use the New York City Department of Health and Mental Hygiene ***Asthma Action Plan*** (Appendix tab # 25) for members with asthma, as appropriate.
36. Provide new admission examinations for school age children.
37. Provide age-appropriate anticipatory guidance, using TIPP (The Injury Prevention Program) and/or other materials recommended by the U.S. Preventive Services Task Force.
38. Assess Members' needs to identify if he/she requires:
- A referral to an Out of Network Provider.
 - A Standing Referral to a Specialist.
 - Use of Specialists as PCPs.
 - Referral to Specialty Care Centers.

These requests may be made by contacting the Plan's Care Coordination Department, and require the approval of the Chief Medical Officer.

Please refer to section 5.5 of this manual for a detailed explanation of these special referral types and how to identify those members that require any of these types of referral.

39. Providers may not bill Plan Medicaid, CHP or Family Health Plus members for any services covered by the Plan. Our payment is payment in full for all services with the exception of any applicable co-insurance or co-payments. When providing services not covered by the Plan, the provider must advise the member prior to initiating the service that the service is not covered by the Plan, the specific cost of the service and that the service will be the financial responsibility of the member; and obtain the written consent of the member authorizing the provider to render the non-covered service. The Plan will bear no financial responsibility for services not covered by the Plan.
40. The Plan protects the rights of its members, and expects all Providers to protect the rights of their patients, to:
- a. Receive information about the Plan and managed care;
 - b. Be treated with respect and due consideration for his or her dignity and privacy;

- c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand, or if the member is not able to understand this information provide it to their designee on the member's behalf.
 - d. Participate in decisions regarding his or her health care, including the right to refuse treatment;
 - e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in Federal regulations on the use of restraints and seclusion; and
 - f. If the privacy rule, as set forth in 45CFR Parts 160 and 164, subparts A and E, applies, request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.
41. Give the Plan sixty (60) days prior written notice if you want to terminate participation in the Plan Provider network.

5.3.1 Transition of Care - Provider Left Network

Consider a Member's request for Continuation of Care should you leave the Plan network. A transition period begins on the date the provider's contractual obligation to provide services with the Plan terminates and ends no later than ninety (90) days thereafter, or for pregnant members, a transitional period to include postpartum care directly related to the delivery if the Member has entered the second trimester of pregnancy.

This request is conditional on whether you agree to continue to adhere to Plan's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the Plan, adhere to Plan's Quality Assurance requirements, to accept Plan's reimbursement as payment in full (which reimbursement will be no more than the level of reimbursement applicable to similar participating providers), and if your termination from the network is not the result of the suspension or revocation of your license to practice medicine in the State of New York. The request for Continuation of Care should come from the Member.

5.3.2 Transition of Care - New Member

If a member is being treated by a non-participating provider for a life threatening disease or condition or disease or a degenerative or disabling disease or condition, the Plan will allow the member to continue treatment with the non-participating provider for a transition period of up to sixty (60) days.

If the member has entered the second trimester of pregnancy prior to the effective date of enrollment, the Plan will allow the continued use of the non-participating provider for a transitional period which shall include the provision of postpartum care directly related to the delivery.

In both situations noted above the non-participating provider must adhere to Plan policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the Plan, adhere to Plan's quality assurance requirements, agree to provide Plan with the necessary medical information related to such care and accept Plan reimbursement rates (which reimbursement will be no more than the level of reimbursement applicable to similar participating providers) .

5.3.3 Member Roster

Providers are responsible for verifying an Enrollee's eligibility for Covered Services and may rely on the most recent Enrollee membership roster provided by the Plan for the month during which the requested services would be provided. **However, it is recommended that you or your staff verify member eligibility prior to providing any services by using our online eligibility search on www.getnhp.com or www.suffolkhealthplan.com for the most accurate eligibility information. You may also call Provider Services.**

These services are available 24 hours per day, 7 days per week. Failure to verify a member's eligibility may result in the denial of payment.

5.3.4 Welfare Reform – Applies to Medicaid Managed Care (MMC) Program Only

The Local Department of Social Services (LDSS) is responsible for determining whether each public assistance or combined public assistance/Medicaid applicant is incapacitated or can participate in work activities. As part of this work determination process, the LDSS may require medical documentation and/or an initial mental and/or physical examination to determine whether an individual has a mental or physical impairment that limits his/her ability to engage in work.

The LDSS may not require the Plan to provide the initial district mandated or requested medical examination necessary for an Enrollee to meet welfare reform work participation requirements.

The Plan requires that the Participating Providers in its Medicaid Managed Care (MMC) product, upon MMC Enrollee consent, provide medical documentation and health, mental health and chemical dependence assessments as follows:

- Within ten (10) days of a request of an MMC Enrollee or a former MMC Enrollee, currently receiving public assistance or who is applying for public assistance, the MMC Enrollee's or former MMC Enrollee's PCP or specialist provider, as appropriate, shall provide medical documentation concerning the MMC Enrollee or former MMC Enrollee's health or mental health status to the LDSS or to the LDSS' designee. Medical documentation includes but is not limited to drug prescriptions and reports from the MMC Enrollee's PCP or specialist provider. The Plan shall include the foregoing as a responsibility of the PCP and

- Within ten (10) days of a request of an MMC Enrollee, who has already undergone, or is scheduled to undergo, an initial LDSS required mental and/or physical examination, the MMC Enrollee's PCP shall provide a health, or mental health and/or chemical dependence assessment, examination or other services as appropriate to identify or quantify an MMC Enrollee's level of incapacitation. Such assessment must contain a specific diagnosis resulting from any medically appropriate tests and specify any work limitations. The LDSS, may, upon written notice to the Plan, specify the format and instructions for such an assessment.

5.3.5 Family Planning and Reproductive Health Service

The Plan includes Family Planning and Reproductive Health services in its Benefit Package. Family Planning and Reproductive Health services mean the offering, arranging and furnishing of those health services which enable members, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies.

All Plan members of reproductive age, including minors who may be sexually active at the time of Enrollment, may self-refer to family planning and reproductive health services.

Medicaid Managed Care (MMC) Members may receive such services from any qualified Medicaid provider, regardless of whether the provider is a Plan Participating or Non-Participating Provider, without referral from the member's PCP and without approval from the Plan.

Family Health Plus (FHP) Members may receive such services from **any Plan Participating Provider** without referral from the member's PCP and without approval from the Plan.

Child Health Plus members may receive such services from **any Plan Participating Provider** without referral from the member's PCP and without approval from the Plan.

Plan Members should be informed that they have the right to:

- Obtain Family Planning and Reproductive Health services and supplies without referral or approval.
- Obtain full range of Family Planning and Reproductive Health services, including HIV counseling and testing when performed as part of a Family Planning and Reproductive Health encounter, from the Plan's Participating Provider without referral, approval or notification.

Family Planning and Reproductive Health services include the following medically-necessary services, related drugs and supplies which are furnished or administered under the supervision of a physician, licensed midwife or certified nurse practitioner during the course of a Family Planning and Reproductive Health visit for the purpose of:

- Contraception, including all FDA-approved birth control methods, devices such as insertion/removal of an intrauterine device (IUD) or insertion/removal of contraceptive implants, and injection procedures involving Pharmaceuticals such as Depo-Provera;
- Emergency contraception and follow up;
- Sterilization;
- Screening, related diagnosis, and referral to a Participating Provider for pregnancy;
- Medically-necessary induced abortions, which are procedures, either medical or surgical, that result in the termination of pregnancy. The determination of medical necessity shall include positive evidence of pregnancy, with an estimate of its duration.

Family Planning and Reproductive Health services include those education and counseling services necessary to render the services effective.

When clinically indicated, the following services may be provided as a part of a Family Planning and Reproductive Health visit:

- A) Screening, related diagnosis, ambulatory treatment and referral as needed for dysmenorrhea, cervical cancer, or other pelvic abnormality/pathology.
- B) Screening, related diagnosis and referral for anemia, cervical cancer, glycosuria, proteinuria, hypertension and breast disease.
- C) Screening and treatment for sexually transmissible disease.
- D) HIV testing and pre- and post-test counseling.

The cost of the member's Family Planning and Reproductive care will be fully covered. If the patient to whom you provide Family Planning and Reproductive care is a Plan member, remember to bill the Plan for these services. **Plan Participating Providers should never bill the Medicaid Fee for Service Program directly for these services when provided to Plan members.**

5.3.6 Child/Teen Health Program (C/THP)

Child/Teen Health Program (C/THP) is a package of early and periodic screening, including inter-periodic screens and, diagnostic and treatment services that New York State offers all Medicaid eligible children under twenty-one (21) years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health (see Appendix 15 for the periodicity schedule and guidelines).

The Plan and our Participating Providers are required to provide the Child Teen Health Program (C/THP) services and be compliant with the Early Periodic Screening and Diagnostic Testing (EPSDT) requirements for providing early and periodic screening and diagnosis of eligible Medicaid recipients under age 21 to ascertain physical and mental defects, and provide treatment to correct or ameliorate defects and chronic conditions found.

The care includes necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The package of services includes administrative services designed to assist families obtain services for children including outreach, education, appointment scheduling, administrative case management and transportation assistance.

The Plan is required to educate participating providers about the program and their responsibilities under it.

The Plan and Plan Participating Providers must provide C/THP services to Enrollees under twenty-one (21) years of age when:

1. The care or services are essential to prevent, diagnose, prevent the worsening of, alleviate or ameliorate the effects of an illness, injury, disability, disorder or condition.
2. The care or services are essential to the overall physical, cognitive and mental growth and developmental needs of the Enrollee.
3. The care or service will assist the Enrollee to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Enrollee and those functional capacities that are appropriate for individuals of the same age as the Enrollee.
4. The Plan shall base its determination on medical and other relevant information provided by the member's PCP, other health care providers, school, local social services, and/or local public health officials that have evaluated the member.

Providers are required to do at least the following with respect to all Enrollees under age 21:

1. Educate Enrollees who are pregnant women or are parents of Enrollees under age 21 about the program and its importance to a child's or adolescent's health.
2. Conduct outreach, including by mail, telephone, and through home visits (where appropriate), to ensure children are kept current with respect to their periodicity schedules.
3. Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals, and conduct follow-up with children and adolescents who miss or cancel appointments.

4. Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a C/THP screen.
5. Achieve and maintain an acceptable compliance rate for screening schedules during the contract period.
6. In addition to C/THP requirements, the Plan requires that Participating Providers comply with the American Medical Association's Guidelines for Adolescent Preventive Services (questionnaires available in Appendix 16) which require annual well adolescent preventive visits which focus on health guidance, immunizations, and screening for physical, emotional, and behavioral conditions.

5.3.7 Native Americans

If a Plan member is a Native American and s/he chooses to access primary care services through his/her tribal health center, the member's Plan PCP must develop a relationship with the member's PCP at the tribal health center to coordinate services for said Native American member.

5.3.8 Human Immunodeficiency Virus (HIV)

Primary care clinicians should be capable of evaluating HIV-infected patients at all stages of HIV infection. Primary care clinicians should consult with an HIV Specialist when initiating or changing treatment.

Plan has an obligation to inform MMC members newly diagnosed with HIV infection or AIDS, and are known to the Plan, of their enrollment options including the ability to return to the Medicaid fee-for-service program or to disenroll from the Plan's MMC product and to enroll into HIV Special Needs Plans (SNP), if such plan is available.

5.4 SECOND OPINIONS

Plan allows its members to obtain a second surgical opinion for major surgical procedures within the Plan's network of providers. Major surgical procedures are defined as all surgical procedures performed on an inpatient basis and any surgical procedure performed on an outpatient basis, requiring the services of an anesthesiologist. The Plan also allows members to obtain a second medical opinion. The member's PCP may assist the member to obtain a second opinion by helping the member select a relevant physician from the Plan network of participating providers.

5.5 SPECIAL REFERRALS

Special referrals are authorized and dispensed when certain cases arise.

5.5.1 Referrals to Non-participating Providers

If the Plan determines that it does not have a health care provider with appropriate training and experience in its network to meet the particular health care needs of an enrollee, the Plan shall make a referral to an appropriate provider outside of its network, pursuant to a treatment plan approved in consultation with the primary care provider, the non-participating provider and the enrollee or enrollee's designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

5.5.2 Standing Referral

An enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist, as long as the following conditions are met:

- Plan Medical Director or the primary care provider in consultation with the Plan Medical Director and specialist, if any, determines that such a standing referral is appropriate.
- The treatment plan is approved by the Plan Medical Director in consultation with the primary care provider, the specialist, and the enrollee or the enrollee's designee. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

The Plan is not required nor our members permitted to elect a non-participating specialist, unless the member requires a provider with a specialty that we do not have in our network.

5.5.3 Specialist as a PCP

The Plan has a procedure by which a new enrollee upon enrollment, or an enrollee upon diagnosis, with;

- a life-threatening condition or disease or
- a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time,

may receive a approval to see a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the enrollee's primary and specialty care. If the

Plan, or primary care provider in consultation with the Plan medical director and a specialist, if any, determines that the enrollee's care would most appropriately be coordinated by such a specialist, the Plan shall approve the enrollee to be assigned to such specialist.

In no event shall the Plan permit an enrollee to elect to have a non-participating specialist as a PCP. Such assignment shall be pursuant to a treatment plan approved by the Plan, in consultation with the primary care provider if appropriate, the specialist, and the enrollee or the enrollee's designee.

The Plan expects that specialists who are functioning in the capacity of a PCP adhere to all of the responsibilities identified in this section of the Provider Manual and as such shall be permitted to treat the enrollee and refer the member for specialty care, procedures, tests and other medical services as the enrollee's primary care provider would otherwise be permitted to provide or refer, subject to the terms of the treatment plan.

If the Plan authorizes the assignment of an enrollee to a non-participating specialist provider, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

5.5.4 Referral to a Specialty Care Center

The Plan has a procedure by which an enrollee with

- a life-threatening condition or disease or
- a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time,

may receive a referral to a specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. If the Plan, or the primary care provider or the specialist designated in consultation with the Plan medical director, determines that the enrollee's care would most appropriately be provided by such a specialty care center, the Plan shall refer the enrollee to such center.

In no event shall the Plan permit an enrollee to elect to have a non-participating specialty care center, unless the Plan does not have an appropriate specialty care center to treat the enrollee's disease or condition within its network.

Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the Plan, in consultation with the primary care provider, if any, or a designated specialist, and the enrollee or the enrollee's designee.

If the Plan refers an enrollee to a specialty care center that does not participate in its network, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

For purposes of this paragraph, a specialty care center shall mean only such centers as are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

5.6 RESTRICTED RECIPIENT PROGRAM

It is the policy of the Plan to determine members who are inappropriately using their pharmacy benefits, misusing medical services, equipment or supplies, or abusive practices related to coordination of care, and restrict access to care. The members will be restricted to the use of single or limited number of pharmacies or provider. Primary Care Physicians are required to enforce restrictions as it relates to the OMIG and the Plan Restricted Recipient Program. Members who have already been assigned restrictions prior to August 1, 2011 are now the responsibility of the Plan. If a member has any restrictions, the primary care provider is responsible for assuring that the member only uses providers within their restriction. After August 1, 2011, providers will receive notice from the Plan regarding members who are assigned to them and have restrictions. If the providers have any questions, they can contact the Plan's Care Coordination Department at 1-800-765-3805.

