

## 6 SPECIALTY CARE

### 6.1 SCOPE OF SERVICE

The Specialist Provider agrees to provide specialty services to Plan members. It is the Specialist's responsibility to provide the PCP with copies of all medical information, reports, and discharge summaries resulting from the Specialist's provision of care. This system helps to ensure continuity of care.

Referrals are not required for a specialist consult except for those deemed Special Referrals which are defined in section 6.5 of this chapter.

Each time the Specialist provides services to a Plan member the encounter must be recorded and sent to the Plan using the CMS1500 universal claim form or 837 HIPAA compliant format. The claim form must include your NPI number, current CPT-4 codes, place of services codes, and appropriate ICD-9-CM codes. Submit claims to:

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

If you do not know your Plan provider number, call Provider Services.

Specialist Providers are monitored for compliance of appointment scheduling, medical records and care delivery standards. Failure to comply with these standards may result in sanctions and/or payment denial.

#### 6.1.1 Cost Sharing

Providers may not bill any Plan member for any service covered by the Plan. Our payment is payment in full for all services with the exception of any applicable permitted deductible, 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.

## **6.2 ROLE OF THE SPECIALIST**

Within the context of the Plan health care delivery system, a Specialist is a participating provider who has agreed to deliver specialty services to Plan Medicaid, Family Health Plus and Child Health Plus members. Specialist providers render services to members and submit to the PCP a report on the treatment of the member within thirty (30) days.

The specialty provider must:

1. 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 four (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,
  - for Ob/Gyn: initial prenatal visits within three (3) weeks during the first trimester, two (2) weeks during the second trimester and one (1) week thereafter,
  - initial visit for newborns to their PCP within two (2) weeks of hospital discharge,
  - initial family planning visits within two (2) weeks of request,
  - mental health or substance abuse follow-up visits pursuant to an emergency or hospital discharge with a Participating Provider within five (5) days, or as clinically indicated,
  - non-urgent mental health or substance abuse visits within two (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 MMC Enrollee
2. Comply with the Plan's one (1) hour waiting time standard for members in provider offices/centers; if waiting time will be longer; you must provide an explanation for the delay and offer the member the opportunity to reschedule the appointment.
3. Obtain approval from Plan's Chief Medical Officer to become a member's primary care provider if the member has a complex or chronic medical condition that requires ongoing combined specialty care and primary care services and provide primary care services to said member.

4. Have responsibility for care by residents that are treating Plan members under their supervision.
5. Encourage members to attend available enhanced services that promote wellness and prevent illness, such as: general health education classes, pneumonia and influenza immunizations for "at risk" populations, smoking cessation classes, childbirth education classes, parenting classes, nutrition counseling for pregnant women and diabetics, and extended care coordination for pregnant women.
6. Educate, screen and treat members for sexually transmitted diseases, and report information to the local health department in accordance with existing State and local laws and regulations.
7. Refer members in need to the Plan Case Management Program.
8. If you are a Specialist located in New York City, report other 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 Specialists should report any 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, Tuberculosis, Vaccine preventable diseases, Other reportable diseases, Poisonings (drugs, lead or other toxic agents), Injuries (animal bites and falls), outbreaks. For assistance, call the New York City Department of Health and Mental Hygiene Communicable Disease Program at 212-788-9830 or see their web site ([www.ci.nyc.ny.us/health](http://www.ci.nyc.ny.us/health)) for the current reportable disease list. Or, the New York State Department of Health Communicable Disease Program at 518-473-4439 or 866-881-2809 after hours.
9. Coordinate and track non-emergent transportation.
10. Use the New York City Department of Health and Mental Hygiene Asthma Action Plan for members with asthma, as appropriate.
11. Accept a standing referral for members with ongoing specialty medical care needs. The request must be submitted by the Member's PCP to the Plan Chief Medical Officer for approval.
12. Provide services to the HIV+ population as per AIDS Institute guidelines and protocols, as well as address the HIV prevention needs of uninfected members:
  - 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;
  - 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.
13. Maintain a legible medical record for each member with dated and signed entries that completely describe all encounters. 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 for a period of ten (10) years as indicated in your provider contract. 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.
14. Follow the Plan smoking cessation guidelines.
15. The Plan protects the rights of its members, and expects all Providers to protect the rights of their patients, to:
- Receive information about the Plan and managed care;
  - Be treated with respect and due consideration for his or her dignity and privacy;
  - 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.
  - Participate in decisions regarding his or her health care, including the right to refuse treatment;
  - 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
  - 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.
  - Plan members have the right to all of the above without any adverse regard from any Provider.

### **6.2.1 Claims**

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 Provider Name, and the correct Plan provider ID number.

### **6.2.2 State Department of Health (SDOH) Selective Contracting**

The New York State Department of Health (SDOH) issued directives and guidelines regarding low volume sites that cannot be utilized to provide services. The Plan abides by these guidelines and expects that every Plan contracted network provider and/or entity complies with these directives by not referring Plan members to these sites nor directly perform these services if they are on SDOH's list of low volume sites.

#### Breast Cancer Surgery

The Contractor agrees to refer or provide breast cancer surgery only at hospitals and ambulatory surgery centers designated as meeting high volume thresholds as determined by SDOH. SDOH will update the list of eligible facilities annually which is at [http://www.health.state.ny.us/health\\_care/medicaid/quality/surgery/cancer/breast/contract.htm](http://www.health.state.ny.us/health_care/medicaid/quality/surgery/cancer/breast/contract.htm)

#### Bariatric Surgery

Effective February 4, 2012, any hospital in New York State that meets the Center for Medicare and Medicaid Services' (CMS) minimum facility standards and is designated either by the American College of Surgeons and/or the American Society for Metabolic and Bariatric Surgery as a Medicare Approved Facility for Bariatric Surgery, will be reimbursed for bariatric surgical services for Medicaid fee-for-service and managed care recipients.

The approved list of centers is located at

<http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp>

#### Procedures for Obesity

Partial Gastrectomy procedures (sleeve resection of the stomach) when accompanied by a primary diagnosis of obesity, unspecified, morbid obesity or overweight will be considered part of APR-DRG 403 "Procedures for Obesity" and as such must be performed only at CMS approved facilities.

### **6.2.3 Transition of Care-Provider Left Network**

Consider a Member's request for Continuation of Care should you leave the Plan's 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 the 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, 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.

### **6.2.4 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 at 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.

## **6.3 HUMAN IMMUNODEFICIENCY VIRUS**

The 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.

## **6.4 SECOND OPINIONS**

The 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 find and/or select a physician for their second opinion.

## **6.5 SPECIAL REFERRALS**

Special referrals are authorized and dispensed when certain cases arise. The Plan does not require prior authorization of participating providers for standing referrals or referrals to specialty centers that are participating in the Plan's provider network.

### **6.5.1 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.

### **6.5.2 Standing Referrals to Non-Participating Providers**

An enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist. If the provider is participating in the Plan's network, no additional authorization is required from the Plan. As long as the PCP feels that the following conditions are met:

- Determines that such a standing referral is appropriate.
- Treatment plan approved by 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.

### **6.5.3 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 referral to 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 a 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 refer the enrollee to such specialist.

In no event shall the Plan be required to permit an enrollee to elect to have a non-participating specialist. Such referral 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.

Such specialist shall be permitted to treat the enrollee and may authorize such referrals, procedures, tests and other medical services as the enrollee's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan.

If an organization refers an enrollee to a non-participating 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.

If the Plan authorizes the transfer of primary care responsibilities to a specialist, the specialist then coordinates the member's care, completes referrals for needed services, and is responsible for all preventive care and health education activities as outlined in **Section 5.3**.

All members who have requested to have a specialist serve as their PCP are considered for possible enrollment in the Plan's Case Management services (see Section 12 for further information). Members whose request, to have the Specialist act as their PCP, is approved are automatically enrolled in Case Management.

#### **6.5.4 Referral to a Non-Participating 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,
- Plan does not have an appropriate specialty care center to treat the enrollee's disease or condition within the network,

may receive a referral to a non-participating specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition that is not available in the Plan's network... If the Plan, or the primary care provider or the specialist designated, in consultation with a medical director, determines that the enrollee's care would most appropriately be provided by such a specialty care center, Plan shall approve referral to such center.

In no event shall the Plan be required to 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 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.

