

14 ANCILLARY and HOSPITAL SERVICES

14.1 ANCILLARY SERVICES

The Plan's ancillary provider network consists of hospitals, freestanding ambulatory surgery centers, freestanding health clinics, vision providers, durable medical equipment, medical supplies and other ancillary providers. A full listing of the Plan provider network can be found on the Plan website (www.getnhp.com and www.suffolkhealthplan.com) and Provider Directory.

14.2 INPATIENT HOSPITAL CARE SERVICES IN AN ACUTE CARE/GENERAL HOSPITAL

REQUIRED AUTHORIZATIONS: All elective admissions require pre-admission certification. The admitting provider or hospital must contact the Plan's Care Coordination at least five (5) working days prior to the admission. This may be done by fax, our Provider Web Portal or by phone. For emergency and maternity admissions prior authorization is not required, however, the admitting provider or hospital must notify Plan's Care Coordination Department within twenty four (24) hours or the next business day after admission.

CLAIMS PROCESSING: For elective admissions, claims are denied unless precertification was obtained. For emergency admissions, claims are denied unless Plan is called within twenty four (24) hours or the next business day after admission. All inpatient stays may be subject to retrospective review, which may result in full or partial payment denial. Claim submission on the UB04 claim form must be forwarded to the Plan within ninety (90) days of the discharge date.

Claims should be submitted to:

**Neighborhood Health Providers (NHP)
Suffolk Health Plan (SHP)
P.O. Box 6008
Hauppauge, NY 11788-9007**

14.3 AMBULATORY SURGERY SERVICES

SITES/CONTACTS: Plan participating hospitals and freestanding ambulatory surgery centers.

REQUIRED AUTHORIZATION: A referral voucher is not required from the PCP to the Plan participating operating specialist. Prior authorization from the Plan is not required for Medicaid, Child Health Plus and Family Health Plus members – with the exception of certain procedures that are potentially cosmetic in nature. See the Appendix # 29 for a list of these procedures.

14.4 INPATIENT AND OUTPATIENT MENTAL HEALTH AND ALCOHOL AND DRUG TREATMENT SERVICES

SITES/CONTACTS:

The Plan contracts with Beacon Health Strategies to manage the delivery of mental health and substance abuse services for all Plan members. Services **MUST** be provided by a participating provider.

REQUIRED AUTHORIZATIONS: An authorization is required for all non-emergency related admissions. Hospitals, Providers, Members or the Member's Designee should call Plan Behavioral Health. For emergency admissions, please notify Plan Behavioral Health within one (1) business day.

Plan members may self – refer to a behavioral health professional for one (1) outpatient behavioral health visit. Additional outpatient therapy visits beyond the initial session requires the behavioral health practitioner to complete and submit an Authorization to Beacon Health Strategies.

Authorization requests for continued care **must be submitted** prior to the second session and/or fourteen (14) days prior to expiration of current authorization.

CLAIMS PROCESSING: Claims should be submitted directly to Beacon Health Strategies.

14.5 OUTPATIENT REHABILITATION THERAPIES

Physical Therapy, Occupational Therapy and Speech Therapy are limited to twenty (20) visits in a twelve (12) month period, similar to current limits for FHP. Restrictions do not apply to enrollees under the age of 21 or to the developmentally disabled population

14.5.1 Physical Therapy

SITES/CONTACTS: Plan participating hospitals, health centers and individual providers.

REQUIRED INITIAL AUTHORIZATION: Physical Therapy which also includes cardiac rehabilitation does not require a prior authorization or a referral unless non par provider. There is a twenty visit per calendar year limitation for CHP and FHP. This benefit limitation also applies to Cardiac Rehabilitation.

14.5.2 Occupational Therapy

SITES/CONTACTS: Plan participating hospitals, health centers and individual providers.

REQUIRED INITIAL AUTHORIZATION: Occupational Therapy does not require a prior authorization or a referral unless non par provider. There is a twenty visit per calendar year limitation for CHP and FHP.

14.5.3 Speech Therapy

SITES/CONTACTS: Plan participating hospitals, health centers and individual providers.

REQUIRED INITIAL AUTHORIZATION: The first visit for evaluation by a Speech Therapist does not require a referral or prior authorization. All subsequent visits require prior authorization.

AUTHORIZATION FOR CONTINUED SPEECH THERAPY SERVICES: Authorization requests may be submitted electronically online through the Plan's website, call Care Coordination (Precertification) line, send a fax or mail to Care Coordination

14.6 CHIROPRACTIC CARE

Chiropractic care is not a covered benefit.

14.7 HOME HEALTH CARE SERVICES

The Personal Care Service Program is now a Plan benefit. All requests for personal care services must be submitted to the Plan using the M11Q – Physician Form. A copy of this form may be obtained from the our provider web portal.

SITES/CONTACTS: Plan participating hospitals, Certified Home Health Agencies, and licensed Home Health Agencies

REQUIRED AUTHORIZATIONS: Prior authorization approval by the Plan is required for all home health care services. Call the Plan's Care Coordination Department line.

14.8 HOME TELEHEALTH SERVICES

SITES/CONTACTS: Plan participating NYSDOH Approved Home Telehealth Agencies are now reimbursed for the provision of services to patients who have conditions or clinical circumstances which require frequent monitoring; and where the provision of Telehealth services can appropriately reduce the need for an on-site or in-office visit or acute or long term care facility admission. Prior authorization is required.

As part of the screening process, the NYS approved agency must perform an in-person risk assessment to determine if the member can meet the criteria for the monitoring device. The Plan will require a copy of the assessment in advance of approval of Telehealth monitoring services.

REQUIRED AUTHORIZATIONS: Prior authorization approval by the Plan is required for all home Telehealth services. Call the Plan's Care Coordination Department line.

14.9 LABORATORY SERVICES

SITES/CONTACTS Plan participating hospitals, participating laboratory providers and any Medicaid approved independent laboratory.

REQUIRED AUTHORIZATIONS: Prior approval is not necessary for lab services. The Plan will reimburse non-participating laboratories at the Medicaid payment rate. Child Health Plus members should be made aware that they might be billed for payment above the Medicaid rate if they use a non-participating laboratory.

14.10 RADIOLOGY SERVICES

SITES/CONTACT: Plan participating hospitals and participating independent radiology centers.

REQUIRED AUTHORIZATIONS: MRIs, nuclear medicine, PET scans and all CT Scans requires precertification by calling the Care Coordination (Precertification) line. Ultrasounds, sonograms and echography do not require a pre-certification. Radiology services must be performed at a participating facility.

14.11 HEARING AND HEARING AIDS

SITES/CONTACTS: Please refer to listing on the Plan's website or in the Plan's Provider Directory.

REQUIRED AUTHORIZATION: The PCP or specialist must obtain prior authorization. Prior authorization is required if the hearing aid is over \$250. Hearing aids are covered in accordance with Medicaid Hearing Aid coverage manual.

14.12 ROUTINE VISION CARE

SITES/CONTACTS: In New York City, the Plan contracts with Davis Vision, a managed vision care company with a network of providers located throughout New York City to provide the preventive vision care benefit.

In Suffolk County, members may receive these services from any General Vision Services provider.

REQUIRED AUTHORIZATION: Members can self refer to a Davis Vision or General Vision Services participating provider to obtain preventive vision services. There is a listing of these providers on the Plan website and in the Provider Directory.

14.13 DURABLE MEDICAL EQUIPMENT

SITES/CONTACTS: Please see the listing of Durable Medical Equipment (DME) vendors on the Plan website or the Ancillary section of the Plan Provider Directory.

REQUIRED AUTHORIZATION: DME is covered in accordance with the Medicaid DME Coverage Manual. Authorization requests can only be submitted via Fax to 800-338-4195 or through our web portal. For a list of procedure codes for Durable Medical Equipment (DME) that require prior authorization see Tab xx in the Appendix section or visit our web site for an up to date listing.

DME EQUIPMENT REQUIRING PRECERTIFICATION	
<ul style="list-style-type: none"> • Multi-height and/or electric hospital beds • Oxygen concentrators, liquid oxygen delivery systems portable oxygen units • Bone stimulators • Compressors • Ultra-sonic nebulizers • Customized and/or motorized wheelchairs • Patients lift devices • Transcutaneous electric nerve stimulators (TENS) • Electromagnetic fracture non-union stimulators • Service parts and repairs • Unlisted equipment 	<ul style="list-style-type: none"> • Wheeled and heavy duty walkers • Dry and gel mattress • Powered air flotation bed • Volume ventilators • Alternating pressure pad replacements • Artificial larynx • Nasal continuous airway pressure • Apnea monitors • Certain home glucose monitors • Communications systems and devices • All rentals • Seat - lift chairs • Scooters • CPM

NOTE: Medical / Surgical supplies are not covered by the Plan for Medicaid and Family Health Plus members. Medicaid members can receive supplies using their Medicaid card under the Medicaid fee-for-service program. CHP coverage is limited for medical supplies to covered diabetic supplies and supplies that are part of a home health care visit.

14.14 PROSTHETIC AND ORTHOTIC SERVICES

SITES/CONTACTS: Please see the listing of Prosthetic and Orthotic Services vendors on the Plan website or the Ancillary section of the Plan Provider Directory.

REQUIRED AUTHORIZATION: Orthotics and prosthetics are covered in accordance with the Medicaid DME Coverage Manual. Orthopedic Shoes/Prescription Footwear requires prior authorization for all requests for Medicaid members. Not covered for CHP and FHP members. Authorization requests can only be submitted via Fax to 800-338-4195 or through our web portal.

14.15 *PRESCRIPTION DRUG SERVICES*

All pharmacy benefits are now covered by NHP and SHP for the Medicaid, Child Health Plus, and Family Health Plus program. They are being provided through our relationship with Express Scripts. For more information on the pharmacy program including our Drug Formulary please go to our website (www.getnhp.com or www.suffolkhealthplan.com).

