

12 UTILIZATION MANAGEMENT

12.1 OVERVIEW

SHP has outsourced and delegated Utilization Management to Royal HealthCare LLC, a Management Service Organization. All policies and processes contained herein have been mutually agreed to by both SHP and Royal.

12.2 UTILIZATION MONITORING AND EVALUATION

The utilization management process is comprised of monitoring activities conducted to meet internal and external review requirements and to ensure services are medically necessary. **Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interference with such person's capacity for normal activity, or threaten some significant handicap.** The circumstances under which utilization review occurs are pre-authorization of services, concurrent review of services or retrospective review of services.

12.2.1 PRE-AUTHORIZATION OF ELECTIVE HOSPITAL ADMISSIONS AND SELECTED AMBULATORY SERVICES

The following services require pre-authorization by SHP by calling the SHP Care Management line at **1-800-250-5007** or **after normal business hours please call 1-877-747-6789**. **A Referral Voucher Form is not sufficient to authorize. You may also fax the request for pre-authorization of services to 1-877-267-7900.** Authorization should be submitted within seven (7) days prior to the service. Payment will not be made unless SHP approval is given prior to the date of service.

- ✧ Admissions - Elective
- ✧ Cardiac Rehabilitation
- ✧ Continuity of care
- ✧ Cosmetic Surgery
- ✧ Dialysis
- ✧ Diagnostic Testing; MRI, Nuclear Medicine, PET Scans and NON- Maternity Related Sonograms ONLY
- ✧ DME greater than \$250.00
- ✧ Growth Hormone
- ✧ Home Health Care
- ✧ Obesity surgery

- ✧ Orthopedic shoes and shoe inserts
- ✧ Orthotics > \$250
- ✧ Pharmacy
 - Injectables that are not on the Medicaid formulary and administered in a physician office or clinic.
 - Non formulary drugs that are dispensed at a pharmacy
 - Formulary drugs for CHP members that require prior authorization, quantity limits or step therapy
- ✧ Prosthetics > \$250
- ✧ Out of network services-non emergent: All services are required to be performed by a participating provider. Medical necessity and the reason why a non par provider should provide a service over a participating provider is required with all requests.
- ✧ Speech therapy after first visit
- ✧ Standing Referrals to a Specialist
- ✧ Specialist as a Primary Care Provider
- ✧ Referral to a Specialty Care Center
- ✧ Treatment of Erectile Dysfunction

Standard Review

Prospective or “pre-certification” UM decisions are made regarding the requested service and the member or member’s designee and provider(s) are notified of determinations in writing and by telephone within three (3) business days of receiving all necessary information or as fast as the enrollee’s condition requires to make the decision but Care Management will complete the request within fourteen (14) days after we receive the request. If additional information is needed Care Management will inform the provider’s office before the fourteenth day. A written “Notice of Action-Adverse Determination” is sent to the member, requesting provider, and facility (see # 12.2.4 below). The provider is notified by telephone and in writing. **SHP delegates to the Provider telephonic notification to the Member for all determinations made by the Care Management Department.**

Expedited Requests

A provider/member may request an expedited review of a service authorization request if he indicates that a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

The expedited review is conducted within 3 business days after receipt of the service authorization request.

If SHP denies the request for expedited review, SHP will notify the provider/member that the request for an expedited review has been denied and that the request will be

handled under standard review timeframes of up to (14) fourteen calendar days after receipt of the request.

SHP delegates to the Provider telephonic notification to the Member for all determinations made by the Care Management Department.

Extensions

Timeframes for prior authorization review determinations may be extended by SHP, the member, member designee or provider for up to fourteen (14) calendar days if:

- ✧ The member, member's designee, or member's provider requests an extension orally or in writing
- ✧ SHP can demonstrate or substantiate that there is a need for additional information and how the extension is in the member's interest.

SHP must notify the member/provider of the extension in writing. The written notice must include:

- ✧ The reason for the extension;
- ✧ An explanation of how the delay is in the best interest of the enrollee;
- ✧ Any additional information that may be needed to make the determination;
- ✧ The right of the enrollee to file a complaint regarding the extension;
- ✧ The process for filing a complaint with SHP and the timeframes within which a complaint determination must be made;
- ✧ The right of the enrollee to designate a representative to file a complaint on behalf of the enrollee;
- ✧ The right of the enrollee to contact the NYSDOH regarding his or her complaint, including the NYSDOH's toll-free number for complaints;
- ✧ Statement that oral interpretation and alternate formats of written material for enrollees with special needs are available and how to access the alternate formats.

If SHP extends its review, the member/provider is notified of the service authorization determination by phone and in writing as fast as the member's condition requires and within (3) three business days after receipt of necessary information for prior authorization requests, but no later than the date the extension expires.

12.2.2 CONCURRENT REVIEW OF:

- ✧ emergency and maternity admissions (within 24 hours or the next business day)
- ✧ continued hospital stays

- ✧ the above ambulatory services

For concurrent review, the member's provider is notified of the determination by telephone and in writing within one (1) business day or as the enrollee's condition requires of receiving all the material SHP needs to make the decision but no more than fourteen (14) days of receipt of the request.

For expedited requests, SHP will complete the determination within one business day but no more than three (3) days of receipt of the request.

SHP delegates member telephonic notification to the provider for all determinations made by the Care Management Department.

Extensions

Timeframes for concurrent review determinations may be extended by SHP, the member, member designee or provider for up to fourteen (14) calendar days if:

- ✧ The member, member's designee, or member's provider requests an extension orally or in writing
- ✧ SHP can demonstrate or substantiate that there is a need for additional information and how the extension is in the member's interest.

SHP must notify the member/provider of the extension in writing. The written notice must include:

- ✧ The reason for the extension;
- ✧ An explanation of how the delay is in the best interest of the enrollee;
- ✧ Any additional information that may be needed to make the determination;
- ✧ The right of the enrollee to file a complaint regarding the extension;
- ✧ The process for filing a complaint with SHP and the timeframes within which a complaint determination must be made;
- ✧ The right of the enrollee to designate a representative to file a complaint on behalf of the enrollee;
- ✧ The right of the enrollee to contact the NYSDOH regarding his or her complaint, including the NYSDOH's toll-free number for complaints;
- ✧ Statement that oral interpretation and alternate formats of written material for enrollees with special needs are available and how to access the alternate formats.

If SHP extends its review, the member/provider is notified of the service authorization determination by phone and in writing as fast as the member's condition requires and within (3) three business days after receipt of necessary information for prior authorization requests, but no later than the date the extension expires.

12.2.3 RETROSPECTIVE REVIEW

SHP may reverse a pre-authorized treatment, service or procedure on retrospective review pursuant to section 4905(5) of the Public Health Law only when:

- ✧ Relevant medical information presented to SHP during retrospective review is materially different from the information that was presented during the pre-authorization review; and
- ✧ Relevant medical information presented to SHP on retrospective review existed at the time of the pre-authorization but was withheld from or not made available to SHP; and
- ✧ SHP was not aware of the existence of the information at the time of the pre-authorization review; and
- ✧ Had SHP 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 pre-authorization review.

In addition, inpatient and ambulatory claims may be screened against selection criteria, on a retrospective basis. Criteria used to conduct such retrospective review can include:

- ✧ DRGs with complications/comorbidities
- ✧ Readmissions
- ✧ Out of network admissions/services
- ✧ Emergency admissions/visits
- ✧ Encounter patterns for service over- or under-utilization

Medically unnecessary services may result in full or partial professional and/or hospital claims denial. Claims, which are not properly coded, may result in payment adjustment.

For retrospective review, SHP will make a decision within thirty (30) days of the receipt of all necessary information. The member and provider are notified in writing of the determination on the date of the determination.

12.2.4 NOTICE OF ACTION – ADVERSE DETERMINATIONS

A notice of action-adverse determination is a decision by SHP that an admission, extension of stay or other health care service has been reviewed and, based on the information provided, is not medically necessary. A clinical peer reviewer must make adverse determinations.

The Notice of Action-Initial Adverse Determination will be sent in writing to both the member and the provider and includes:

- Description of the actions
- Reasons for the action including the clinical rationale, if any;
- Enrollee's rights to file an action appeal orally or in writing
- An oral action appeal must be followed by a written signed action appeal

- The fact that there will be no retaliation by SHP if the member files an Action Appeal
- The right of the enrollee to designate a representative to file an Action Appeal
- Explanation that the appeal must be made within 90 days after the Notice of Action.
- The process for filing an Action Appeal including the mailing address for written appeals and the telephone number for an oral appeal
- The enrollee has the right to have to request an expedited appeal and the instructions on how to initiate an expedited appeal if care were delayed that could significantly increase the risk to an Enrollee
- Any additional information needed from any sources in order for SHP to make an Action Appeal determination
- Explanation that the Action Appeal will be completed within thirty (30) days of receipt of the Action Appeal request
- Toll free number, 1-877-747-6789 to contact Member Services on how to initiate an oral Action Appeal including assistance with interpreter services
- Fair hearing statement and notice entitled “Managed Care Action Taken” containing the member’s fair hearing and aid continuing rights (Medicaid and Family Health Plus members); and
- Notice of the right of the member to contact the New York State Department of Health (800-206-8125) with their complaint
- A clear statement that the notice constitutes the initial adverse determination, and specifically, use the terms “medical necessity” or “experimental/investigational”.
- A statement the specific clinical review criteria relied upon in making the determination is available upon request; and
- A statement that the enrollee has the right to have an external appeal
- Assistance in coordinating or submitting an Action Appeal request
- Statement for access to interpretation for other languages,

When an adverse determination is rendered without provider input, the provider and member have a right to reconsideration. The reconsideration will occur within one (1) business day of the request and will be conducted by the provider and the clinical peer reviewer making the initial adverse determination.

Failure of SHP to complete the utilization review determination within the required timeframes constitutes an adverse determination and is subject to appeal. Notice of denial as will be sent in writing as described above on the date that the review timeframes expire.

Reconsiderations

In the event that an adverse determination is made without attempting to discuss the matter with the member’s health care provider who specifically recommended the service, procedure or treatment under review, that health care provider will have the opportunity to ask for a reconsideration of the adverse determination. This review occurs within one (1) business day of the request. The member’s health care provider

and the physician reviewer who made the initial determination conduct the review. If the case is overturned, the denial is reversed.

12.2.5 TECHNICAL DENIALS

Providers who do not submit medical records for review within specified time frames will have claim payment denied in full.

12.2.6 NOTICE OF ACTION-DENIAL OF SERVICE

A notice of action-denial of service is a decision by SHP based on the provider's failure to provide appropriate notification to SHP, failure to cooperate in the concurrent review process or failure to obtain preauthorization (for non-emergent services). Providers who do not comply with SHP notification and precertification requirements (e.g., do not call admissions in to SHP within specified time frames or pre-certify required services) will have claim payment denied in full. Appeals will be considered if there are extraordinary circumstances. In addition, reasons for Notice of Action denials also include other non-clinical reasons such as non-covered services, member eligibility, other insurance coverage or no fault coverage. The written notification will include the address and telephone number to be used for filing an appeal.

12.3 ACTION APPEAL OF SERVICE AUTHORIZATION DENIALS

Actions appeals are completed by clinical staff, who were not involved in the initial decision or action. If any of the following applies, determinations must be made by qualified clinical personnel as specified in Appendix F of the Managed Medicaid Model Contract;The following are examples of denials where an Action Appeal applies:

- ✧ A denial of action appeal based on medical necessity, experimental, or investigational treatment.
- ✧ A denial based on non coverage or eligibility, failure to follow administrative process such as lack of prior authorization.
- ✧ Complaint regarding denial of expedited resolution of an Action Appeal.

The member or his or her designee will have sixty (60) days from the date of the notice of Action to file an Action Appeal. The appeal process provides an objective, impartial mechanism for adverse determination disagreement resolution. At anytime during the appeal process, the member has the right to obtain a copy of their medical record and may also provide information to support their appeal in writing or in person. All action appeals are completed within thirty (30) calendar days from receipt of the request of the appeal. The timeframe may be extended an additional fourteen (14) days upon request of SHP, the member or provider but the condition of the member is considered to determine if a delay in the decision could jeopardize the members' health condition.

The member/provider are provided reasonable opportunity to present evidence, and allegation of fact or law, in person as well as in writing. The member is informed of the

limited time to present such evidence in the case of an expedited Action appeal. The member or his or her designee may request both before and during the Action appeal process, to examine the member's case file, including medical records and any other documents and records considered during the Action appeals process. The member, his or her designee, or legal estate representative of a deceased member, a party to the Action appeal.

Whenever possible the SHP will use a physician who is in the same profession/specialty as the healthcare provider who typically manages the medical condition.

Both types of denials are subject to the "Action Appeal" process. All member rights to appeals and complaints including timeframes are included in the "Notice of Action" letter that is sent to the member and copied to the provider.

For Action Appeals of clinical matters, SHP ensures that all decisions are provided by a clinical peer reviewer who is qualified to review the appeal, including licensed, certified, registered health care professionals who were not involved in making the initial determination.

If the registered healthcare professional determines that the original determination should be upheld, the case is referred to a Peer Reviewer.

At the level of appeal, a clinical peer reviewer is a physician who possesses a current and valid non-restricted license to practice medicine and must be available within one (1) business day of receipt of the information.

Retrospective denial of service or adverse determinations are also subject to the "Action Appeal" process.

SHP members, members' designees and, in connection with retrospective adverse determinations, a member's health care provider, have a right to request an action appeal within sixty (60) days after SHP informed the member/provider of the "notice of action." The types of action appeals that are available are an "expedited" appeal and a "standard" appeal.

12.3.1 EXPEDITED ACTION APPEAL

SHP members, members' designees and, in connection with retrospective adverse determinations, a member's health care provider can call the Suffolk Health Plan toll free utilization review phone line at **1-800-250-5007** for expedited (urgent) appeals. An expedited appeal is used for adverse utilization review decisions involving:

- ✧ Continued or extended health care services, procedures or treatments;
- ✧ Additional services for a member undergoing a continued treatment course; or

- ✧ An adverse determination in which the provider believes an immediate appeal is warranted.

If SHP requires additional or necessary information to conduct an expedited appeal, SHP shall immediately notify the provider and/or member or the member's representative by telephone or fax informing them of the information required followed by written notification.

SHP will make a decision with regard to the expedited appeal within two (2) days of receipt of all necessary information. For Medicaid/FHP members, SHP will make a decision as fast as the enrollee's condition requires and within two (2) business days of receipt of necessary information but no more than 3 (three) business days of receipt of appeal. This time may be extended for up to 14 days upon enrollee or provider request; or if SHP demonstrates more information is needed and that the delay is in the best interest of the enrollee in which case SHP will notify the enrollee.

Notice to the member/provider of the Expedited action appeal determination shall include:

- ? The member's coverage type; all SHP members belong to a Health Maintenance Organization (HMO)
- ? SHP's contact person and telephone number
- ? Date the Expedited Action Appeal was filed and a summary of the Expedited Action Appeal
- ? Date the Expedited Action Appeal process was completed
- ? Statement indicating the action that SHP is taking
- ? Reason for the action
- ? A description of the member's fair hearing rights, if applicable, including a copy of the "Managed Care Action Taken" form
- ? The right of the member to contact the New York State Department of Health regarding his or her Complaint, at (800-206-8125)

For Expedited Action Appeals involving Medical Necessity or an experimental or investigational treatment, the notice must also include:

- ? A clear statement that the notice constitutes the final adverse determination and specifically use the terms "medical necessity" or "experimental/investigational"
- ? The member's coverage type; all SHP members belong to a Health Maintenance Organization (HMO)
- ? The procedure in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service
- ? A clear statement written in bolded text that the (45) forty-five day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the Action Appeal
- ? A copy of the "Standard Description and Instructions for Health Care Consumers to Request an External Appeal" and the External Appeal application form

The clinical rationale in the Expedited Action Appeal adverse determination letter must meet the following definition:

Reasons and clinical rationale means the individualized medical basis for an adverse determination. A statement of reasons and clinical rationale must, at a minimum, identify:

- ? The member and the nature of his/her condition(s);
- ? The medical service, treatment or procedure in question; and
- ? The bases or basis on which the SHP determined that the service, treatment or procedure is or was not medically necessary or experimental / investigational, which demonstrates that the SHP considered member specific information in its determination.

If SHP denies the request for an Expedited Action Appeal, SHP will send written notice of the denial within twenty-four (24) hours of the appeal determination. For Medicaid/FHP members SHP makes reasonable efforts to provide prompt oral notice of the denial to the member/provider within twenty-four (24) hours.

The notice, which may be combined with the acknowledgement, includes a statement that the request will be reviewed under Standard Action Appeal timeframes, including a description of the timeframes.

Expedited appeals not resolved to the satisfaction of the appealing party, may be re-appealed via the standard appeal process or through the external appeal process.

12.3.2 STANDARD ACTION APPEAL

SHP members, members' designees and, in connection with retrospective adverse determinations, a member's health care provider can file a standard appeal of a "Notice of Action - within sixty (60) days from the date SHP informed the member/provider of the service authorization denial decision. **Medicaid/FHP members have ninety (90) days to file a standard appeal. Standard action appeals should be submitted to Suffolk Health Plan; 4944 Parkway Plaza Boulevard, Suite 110; Charlotte, NC 28217.**

The SHP member, member's designee and, in connection with retrospective denials of service, a member's health care provider can either write to or call SHP to request a standard appeal. Members may designate their provider to appeal on their behalf in writing. SHP will acknowledge receipt of an action appeal request within fifteen (15) days. Oral appeals are followed up by a confirmation letter sent to the member or member's designee for their signature.

If SHP requires more information to conduct a standard internal action appeal, the member, member's designee and the member's health care provider shall be notified, in writing, within fifteen (15) days of receipt of the appeal, to identify and request the

necessary information. In the event that only a portion of such necessary information is received, SHP shall request the missing information, in writing, within five (5) business days of receipt of the partial information. The provider may call the Care Management Department at 1-800-250-5007 and ask for the Appeals Coordinator to request additional time to provide the information to SHP. Once we receive the additional information we will provide an action appeal notice within fourteen (14) days from the day we requested additional information.

Timeframes for completion of an Action Appeal may be extended for up to fourteen (14) days if:

- ✧ The enrollee, his or her designee or the provider requests an extension orally or in writing; or
- ✧ SHP can demonstrate or substantiate that there is a need for additional information and the extension is in the best interest of the member and so notifies the member or the member's designee. SHP maintains documentation of the extension determination within the Action Appeal case.

A Notice of the Enrollee extension must include:

- ? The reason for the extension
- ? An explanation of how the delay is in the best interest of the Enrollee
- ? Any additional information SHP requires to make the determination
- ? The Right of the Enrollee to file a Complaint regarding the extension.
- ? Explanation of how to file a complaint
- ? The right of the Enrollee to designate a representative to file a Complaint on behalf of the Enrollee and
- ? The right of the Enrollee to contact the New York State Department of Health, regarding his or her Complaint, including the SDOH's toll free number for complaints.

The notice, which may be combined with the acknowledgement, includes a statement that the request will be reviewed under standard Action Appeal timeframes, including a description of the timeframes. For Medicaid and FHP members, before and during the appeal review period, the enrollee or their designee may see their case file. The enrollee may present evidence to support their appeal in person or in writing.

SHP will make the standard appeal decisions within thirty (30) days of receipt of the appropriate information SHP needs to conduct the action appeal. **For Medicaid/FHP members**, SHP will make an appeal decision as fast as the member's condition requires, and no later than 30 days from the receipt of the appeal. SHP will notify the member or member's designee and provider, in writing, within two (2) business days of making the decision.

Failure by SHP to make a determination within the applicable time periods in this section shall result in a reversal of utilization review agent's adverse determination. In addition, the enrollee and SHP may jointly agree to waive the internal appeal process; if this occurs, SHP will provide written notification with information regarding filing an

external appeal to the member within 24 hours of the agreement to waive SHP's internal appeal process.

12.3.3 WRITTEN NOTIFICATION

If the original decision is overturned during the Action Appeal process, the member or member's designee and requesting provider are sent written notification that the determination has been overturned and is approved and includes the following:

- ? The member's coverage type; all SHP members belong to a Health Maintenance Organization (HMO)
- ? SHP's contact person and telephone number
- ? Date the Action Appeal was filed and a summary of the Action Appeal
- ? Date the Action Appeal process was completed
- ? Statement indicating the action that SHP is taking
- ? Presented in an understandable language which may include oral interpretation if necessary.

If the original determination is upheld, the written Action Appeal determination notice includes:

- ? The basis and clinical rationale for the determination
- ? The words "final adverse determination"
- ? The member's coverage type; all SHP members belong to a Health Maintenance Organization (HMO)
- ? SHP's contact person and telephone number, full name and address and the phone number
- ? Name and address of the UR agent, contact person and phone number
- ? Date the Action Appeal was filed and a summary of the Action Appeal
- ? Date the Action Appeal process was completed
- ? Statement indicating the action that SHP is taking
- ? Reason for the action
- ? A description of the member's fair hearing rights including a copy of the "Managed Care Action Taken" form, if applicable; how to request a fair hearing and the rules; the right to aid continuing; and the liability of the member for services if SHP's denial is upheld in the fair hearing.
- ? The right of the member or member's designee to contact the New York State Department of Health regarding his or her Complaint, at (800-206-8125)
- ? Presented in an understandable language which may include an oral interpretation and notice if necessary.
- ? Statement that enrollee may be eligible for external appeal and timeframes for appeal

For Final Adverse Determination (FAD's) Action Appeals involving Medical Necessity or an experimental or investigational treatment, the notice must also include:

- ? A clear statement that the notice constitutes the final adverse determination and specifically use the terms “medical necessity” or “experimental/investigational”
- ? The procedure in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service
- ? A clear statement written in bolded text that the (45) forty-five day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level Action Appeal
- ? A copy of the “Standard Description and Instructions for Health Care Consumers to Request an External Appeal” and the External Appeal application form

The clinical rationale in the Action Appeal adverse determination letter must meet the following definition:

Reasons and clinical rationale means the individualized medical basis for an adverse determination. A statement of reasons and clinical rationale must, at a minimum, identify:

- ✧ The member and the nature of his/her condition(s);
- ✧ The medical service, treatment or procedure in question; and
- ✧ The bases or basis on which the SHP determined that the service, treatment or procedure is or was not medically necessary or experimental / investigational, which demonstrates that the SHP considered member specific information in its determination.

SHP does not have a second level appeal therefore a member or the member’s designee may immediately request an External Action Appeal upon their receipt of the notification of the Final Adverse Determination.

12.3.4 EXTERNAL ACTION APPEAL

In accordance with 11 NYCRR 410, SHP members and providers have the right for an external appeal of a final adverse determination. **External appeals must be submitted within forty-five (45) days upon receipt of the final adverse determination.** An enrollee, the enrollee’s designee and, in connection with retrospective adverse determinations, an enrollee’s health care provider has the right to request an external appeal. External appeals may be filed:

- a. when the enrollee has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary and
- b. SHP has rendered a final adverse determination with respect to such health care service or
- c. Both SHP and the enrollee have jointly agreed to waive any internal appeal.

An external appeal may also be filed:

- d. enrollee has had coverage of a health care service denied on the basis that such service is not considered medically necessary or is experimental or investigational, and
- e. such denial has been upheld on appeal or both SHP and the member have jointly agreed to waive the internal appeal process
- f. and the member's attending physician has certified that the member has a life-threatening or disabling condition or disease
 - i) for which standard health services or procedures have been ineffective or would be medically inappropriate or
 - ii) for which there does not exist a more beneficial standard health service or procedure covered by the health plan or
 - iii) for which there exists a clinical trial
- g. and the member's attending physician, who must be licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's life threatening or disabling condition or disease, must have recommended either
 - i) a health service or procedure (including a pharmaceutical product meeting Public Health Law guidelines (PHL4900(5)(b)(B)) that based on two documents from the available medical and scientific evidence, is likely to be more beneficiary to the member than any covered standard health service or procedure; or
 - ii) a clinical trial for which the member is eligible. Any physician certification provided under this section must include a statement of the evidence relied upon by the physician in certifying their recommendation,
- h. and the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for SHP's determination that the health procedure is experimental or investigational.

Providers may request an external appeal in connection with a retrospective adverse utilization review determination when the decision is made on the grounds that a health care service is not medically necessary or is experimental or investigational. The New York State Departments of Health and Insurance have developed a separate form and instructions for providers. The form includes notification that the member or a person authorized pursuant to law to consent to health care for the member must sign the request and consent to the release of medical and treatment records for the health care provider to be eligible for an external appeal.

If a provider would like the "New York State External Appeal Application For Health Care Providers To Request An External Appeal of A Retrospective Final Adverse Determination,"

- ✧ Call Provider Services at 1-877-747-6789 and request a copy; OR
- ✧ Download a copy from the New York State Department of Insurance website at www.ins.state.ny.us

12.3.5 FAIR HEARING

SHP Medicaid, and Family Health Plus members may be eligible to access the State Fair Hearing Process in accordance with Federal and State statutory requirements. Fair Hearing does not apply to Child Health Plus members. When SHP denies services or benefits that have been requested by a physician, SHP must send the member a notice of action and a notice containing fair hearing rights, how to request a fair hearing, fair hearing rules, right to aid continuing and liability of enrollee for services if SHP denial is upheld in the fair hearing.

SHP will also notify the member of their rights to file complaints, complaint appeals and action appeals, with process and timeframes and the toll-free number for filing orally. SHP will always assist members to file complaints, complaint appeals and action appeals.

Enrollees also have the right to designate someone to act on their behalf, however, this request must be sent to SHP in writing. The member may elect to pursue the matter by requesting a state fair hearing, filing a grievance through SHP's internal process, filing a complaint with the New York State Department of Health (SDOH), seeking a utilization review appeal and/or any combination of these procedures.

For denials without a physician's order, the member must complete the internal grievance and appeals process or utilization review process prior to obtaining a notice containing fair hearing rights. SHP would be required to issue a notice of adverse determination. At the conclusion of the internal process, SHP must provide the member a notice containing fair hearing rights. The member may then request an external review from the state, file a complaint with the SDOH, request a fair hearing, or any combination of these procedures.

When SHP renders an adverse determination with respect to a termination, suspension or reduction of clinical treatment and/or service, SHP must notify the member of this adverse determination at least ten days prior to the effective date of the intended action and must send the member a notice of adverse determination and a notice containing fair hearing rights. The notice will contain information regarding the availability of aid continuing and the process by which the member may receive such assistance. The member may elect to pursue the matter by requesting a State fair hearing, filing a grievance through SHP's internal process, filing a complaint with the SDOH, seeking a utilization review appeal and/or any combination of these procedures.

12.4 CASE MANAGEMENT PROGRAMS

Case management is a process by which an individual's medical and social needs are defined and a comprehensive care plan is developed to address those needs. SHP views the Primary Care Provider as the member's "care manager". SHP also conducts case management services to assist our members and providers. Members who may need case management include those with disabilities, chronic and complex diseases and HIV/AIDS. Providers who identify members needing case management services should call **1-800-250-5007**

Suffolk Health Plan has Nurse Case Managers available to assist you and your staff with health promotion and education activities, appointment making assistance and transportation issues.

SHP is focusing on the areas of chronic care with an emphasis on Respiratory, Diabetes, Cardiac and HIV. In addition, a Maternity Case Manager is available to assist with high risk cases and perform post partum follow-up on all deliveries. Members are identified as candidates for Case Management following care in an Emergency Room, in-patient stay, multiple pharmacy fills, claims utilization, self referral or physician referral for the conditions indicated above. All members who request case management or from referrals from external sources, regardless of diagnoses are provided with case management services.

SHP strives to address the health care needs of new and existing members and identify those members who are at risk for a health care crisis that may require additional support and care coordination.

SHP Case Managers key responsibilities include:

- ❖ Performing health assessment of those members identified in the five focus groups
- ❖ Reaching out to any member who requires assistance in managing their health care needs and services.
- ❖ Arranging physician visits-especially those who have never seen their PCP or has not seen them in the last six months.
- ❖ Coordinate referrals to specialists.
- ❖ Providing education and educational literature.
- ❖ Monitoring health care status and compliance.
- ❖ Identifying socio-economic issues and coordinate assistance.
- ❖ Arranging transportation and provision of medical equipment when medically necessary.
- ❖ Coordinating referrals to educational programs within the community.
- ❖ Utilize community services and social supports to supplement the member's care provided by the physician.
- ❖ Coordinating care with the PCP and/or Specialist.

Physicians can make a referral to Case Management by calling the Care Management Department at **1-800-250-5007** and asking for a Case Manager. A highly trained Case Manager will discuss the case and, at the physician's request, contact the member and begin to assess the member's needs and assist the physician and the member with care coordination.

For more information contact the Care Management Department at **800-250-5007**.

WWW.SUFFOLK HEALTH PLAN.COM

www.suffolkhealthplan.com is the SHP web-site and available to both Provider and Members. The web-site contains useful telephone numbers and information including copy of the Provider Manual, Provider directory, past copies of the Provider Newsletter, SHP and the Specialty Referral form.

12.4.1 DIABETES

The New York State Department of Health evaluates the care provided to Medicaid managed care members with diabetes on an annual basis. SHP's focus is to improve the health of our diabetic members through the delivery of basic diabetic management services on an ongoing basis. Providers with diabetic members should insure that at a minimum their diabetic patients receive:

Hemoglobin A1C Testing: This test must be performed at least once a year with a result of ≤ 9.0 .

LDL-C Testing: This must be performed at least once every two years with a LDL<130.

Dilated Eye Exam: This test must be performed at least one a year.

Nephropathy Screening: This test must be performed once a year. (This screening can be done by conducting a microalbuminuria test or a simple urinalysis looking for protein during the year)

The rational for these recommendations include:

- Patients treated with oral hypoglycemic agents for diabetes should have a glycohemoglobin test performed twice a year to measure the long-term glucose control. Patients being treated with insulin should have a glycohemoglobin test performed 4 times a year. It is important to explain to patients the difference between this test and the self-testing they do at home or a random fasting or non - fasting blood sugar test.
- The most common cause of death in diabetics is heart disease. Controlling cholesterol is a major component of Diabetic Management. All persons with Diabetes should have a LDL-C test performed at least every two years.
- Annual dilated eye exams are an integral component of Diabetic Management. One of the best measures of the ongoing control of Diabetes is the condition of the retina. Most Diabetics should have a dilated eye exam every year. Patients with NIDDM who have excellent diabetic control (HgA1C <8) and who had no retinopathy noted on dilated exam during the prior year may be on an every two year schedule.

- Diabetic patients without previously diagnosed nephropathy must be monitored for this condition via a microalbuminuria test on a yearly basis. Patients with NIDDM who have excellent diabetic control (HgA1C <8) and who had a negative microalbuminuria test the prior year may be on an every two year schedule.

You can find the link to the Diabetic Risk Test on the American Diabetes Association website at www.suffolkhealthplan.com

Suffolk Health Plan has several excellent sample Diabetic Management Flow sheets available. These flow sheets can be used to document both care provided and patient condition. They also serve as a reminder for tests that need to be done. SHP can personalize the records for use in any clinic or private office. For more information or to refer a member to the Case Management Program call 1 -800-250-5007

12.4.2 ASTHMA CARE

In August 2003 the New York State Department of Health endorsed the Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma - 2003. A link on the SHP's web-site, www.suffolkhealthplan.com, will direct you to the New York State Department of Health Family & Community Health page where you can find a copy of this and other guidelines.

SHP recommends the use of the Asthma Action Plan that can help the provider formulate an appropriate treatment regimen. You can download a copy of the Asthma Action Plan as well as after Asthma Care educational materials by following the link provided on the SHP website, www.suffolkhealthplan.com.

To inquire about the SHP Case Management program call 1 -800-250-5007

12.4.3 MATERNITY CARE

SHP asks all prenatal care providers notify SHP when you become aware of a SHP member's pregnancy. You can call our Maternity Case Management program at 1-800-250-5007 and ask to speak to the Maternity Case Manager.

Our Maternity Case Manager is available to assist you and your staff with promoting the importance of early and ongoing prenatal care, health promotion activities, and assisting the member with making recommended appointments and obtaining transportation when needed. In addition, the Case Manager can coordinate services for high risk OB cases and circumstances.

12.4.4 DOMESTIC VIOLENCE

Nobody deserves to be abused!

Health care providers are often the first people called upon for help by victims of domestic violence, yet many cases either remain unrecognized or do not receive safe

and timely intervention. SHP recommends screening for domestic violence in all new patient visits, annual follow up visits, or when domestic violence is suspected (inclusive of domestic violence occurring in a same sex relationship).

The New York State Office for the Prevention of Domestic Violence has published ***“Domestic Violence Intervention – A Guide for Health Care Professionals.”*** This convenient reference guide helps practitioners recognize domestic violence and elicit information from victims, document findings and preserve evidence in ways that can be useful to victims, and give practical and compassionate support that empowers victims and keeps them safe. To request a copy of this guide, please call 1-212-808-4775 and ask to speak with a Provider Relations Representative. The New York State Office for the Prevention of Domestic Violence provides domestic violence training for health care and mental health providers. To request training, call **1-518-486-6262**.

You can offer patients the following Domestic Violence hot line numbers:

National Domestic Violence Hotline at 1-800-799-SAFE (7233) or TTY 1-800-787-3224.

In addition, SHP has a staff member who is the Plan’s **Domestic Violence Coordinator**. If you need the Domestic Violence Coordinator’s assistance or wish to refer a SHP member for assistance, please call 1-212-883-0883 and ask for Tina Rios.

12.5 REPORTS

Suffolk Health Plan generates reports of primary care, specialty care and ancillary service utilization through SHP’s Management Information System.

12.6 ENCOUNTER DATA

Providers are required to submit claims to SHP for services rendered to SHP members regardless of providers’ payment arrangements. Claims (or encounter forms) are required for both capitated and fee-for-service encounters so that SHP can monitor service utilization and fulfill regulatory reporting requirements.