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1. INTRODUCTION

Crystal Run Health Plans (CRHP) serves Orange and Sullivan Counties in New York State by improving the health of people living in the communities it serves through satisfying its Members’ needs, growing its Membership, and controlling health care and administrative expenses in the delivery of services. CRHP considers the providers in its network to be leaders in the delivery of high quality health care services. CRHP’s goal as a health insurer is to work with its providers to assure that Members receive regular preventive care and quality health care services, in the amount, duration and scope necessary to meet Member needs.

CRHP’s governing body and ownership are primarily composed of physicians who practice medicine and live and work in the local community. The goal of CRHP is to provide quality health care services to its Members and to undertake closer control of health care expenditures through increased communication and partnerships with providers, including its network providers.

1.1. The Provider Manual

The CRHP Provider Manual provides the information you need to know about its products, services, and claims processing requirements, and it is a reference for providers when questions arise. If certain situations require further explanation, providers should call Provider Services from 8:00 AM to 5:00 PM, Monday through Friday, at the phone numbers listed in Section 2 of this Provider Manual.

The Manual contains information specific to procedures required of CRHP’s network providers. This manual will be reviewed and updated regularly by CRHP when policies change. In the event information contained in this manual conflicts with the Provider Agreement, the Provider Agreement will prevail.

1.2. Commitment to Its Members

1.2.1. HIPAA Compliance, Privacy and Confidentiality

Since April 14, 2003, all health care institutions have been required to comply with the new federal privacy rules concerning how health information is shared, stored, and utilized. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule outlines privacy standards that protect medical records and other health information, and identify patient rights and responsibilities. All health information at CRHP is kept strictly confidential and is not released or disclosed to anyone outside CRHP without permission, except where required by law.

1.2.2. Service Excellence

CRHP take great pride in its provider network, which provides the highest level of quality care and services to its Members. CRHP is committed to ensuring that its providers receive the most current information, technology and tools available to support their success and their ability to provide for Members.
At CRHP, its focus is on operational excellence, striving to eliminate redundancy and streamline processes for the benefit and value of all of its partners.

1.2.3. Member Rights and Responsibilities

Members of CRHP have the right to:

- The right to receive medically necessary care;
- The right to timely access to care and services;
- The right to privacy about the Member’s medical record, including when the Member received treatment;
- The right to get information on available treatment options and alternatives presented in a manner and language the Member will understand;
- The right to get information in a language the Member will understand, including oral translation of such information at no cost to the Member;
- The right to get information necessary to give informed consent before the start of treatment;
- The right to be treated with respect and dignity;
- The right of the Member to obtain a copy of his/her medical records and to ask that the medical records be amended or corrected;
- The right of a Member to take part in health care decisions, including the right to refuse treatment (to the extent permitted by law), and to be informed of the medical consequences of that action;
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- The right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- The right to be told where, when and how to get services from CRHP, including how the Member can obtain covered services from out-of-network providers if such providers are not in the Provider Network;
- The right to complain to the New York State Department of Health or Local Department of Social Services; and, the right to use the New York State Fair Hearing System;
- The right to appoint someone to speak for the Member about care and treatment; and
- The right to make advance directives and plans about care.

Members of CRHP have the right to request the following information:

- Names, business addresses and official positions of board Members, officers, controlling persons, owners, or partners of the plan;
- Most recent annual certified financial statement of the plan, including balance sheet and summary of receipts and disbursements;
- Copy of the most recent individual, direct pay subscriber contracts;
Information relating to consumer complaints;
- Procedures for protecting the confidentiality of medical records and other Member information;
- Drug formularies used by the plan and the inclusion/exclusion of individual drugs;
- Written description of organizational arrangements and ongoing procedures of the plan's quality assurance program;
- Description of procedures followed in making decisions about experimental/investigational nature of drugs, medical devices or treatments in clinical trials;
- Individual health provider affiliations with participating hospitals; and
- Specific written clinical review criteria/information relating to a particular condition or disease which plan might consider in its UR process.

**Members of CRHP have a responsibility to:**
- Be an active partner in the effort to promote and restore health by:
  - Openly sharing information about symptoms and health history with provider;
  - Listening;
  - Asking questions;
  - Becoming informed about diagnosis, recommended treatment and anticipated or possible outcomes;
  - Following the plans of care agreed to (such as taking medicine and making and keeping appointments);
  - Returning for further care, if any problem fails to improve; and
  - Accepting responsibility for the outcomes decisions.
  - Participate in understanding health problems and developing mutually agreed upon treatment goals.
- Have all care provided, arranged or authorized by primary care physician (PCP):
- Inform PCP if there are changes in their health status;
- Share with PCP any concerns about the medical care or services that they receive;
- Permit CRHP to review medical records in order to comply with federal, state and local government regulations regarding quality assurance, and to verify the nature of services provided;
- Respect time set aside for appointments with providers and give as much notice as possible when an appointment must be rescheduled or cancelled;
- Understand that emergencies arise for providers and that appointments may be unavoidably delayed as a result;
- Respect staff and providers;
- Follow the instructions and guidelines given by providers;
- Show ID card and pay visit fees (where applicable) to the provider at the time the service is rendered;
- Become informed about CRHP policies and procedures, as well as the office
policies and procedures of their providers, in order to make the best use of the services that are available under the subscriber contract;

☐ Abide by the conditions set forth in the subscriber contract.
2. GENERAL PROVIDER INFORMATION

2.1. Contacting CRHP

2.1.1. CRHP Web Site

CRHP’s website offers valuable information including this provider manual, provider quick reference guide, prior authorization list, provider search tool, provider forms, and access to its online portal for checking claim status and member eligibility.

Utilizing our Provider Portal can reduce the number of calls a provider’s office needs to make to CRHP. This secure online service allows providers to check Member eligibility and benefits, submit claims for reimbursement, check on the status of a claim, and send and receive messages to communicate with CRHP personnel.

The CRHP website, including access to the Provider Portal, can be found at: www.crystalrunhp.com.

2.1.2. Useful Telephone Numbers

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Verification, Claim Status</td>
<td>1-844-638-6507</td>
</tr>
<tr>
<td>Beacon Health Options</td>
<td>1-844-231-7947</td>
</tr>
<tr>
<td>EDI Assistance</td>
<td>1-844-638-6507</td>
</tr>
<tr>
<td>Fraud &amp; Abuse Hotline</td>
<td>1-845-703-6368</td>
</tr>
<tr>
<td>Medical Management, Prior Authorization, Concurrent Review, Case Management</td>
<td>1-844-638-6507</td>
</tr>
<tr>
<td>Member Services</td>
<td>1-844-638-6506</td>
</tr>
<tr>
<td>Pharmacy Services – MedImpact</td>
<td>1-888-672-7166</td>
</tr>
<tr>
<td>Mail Order Pharmacy through PBM</td>
<td>1-844-638-6507</td>
</tr>
<tr>
<td>Provider Services</td>
<td>1-844-638-6507</td>
</tr>
<tr>
<td>Delta Dental – EPO/ PPO</td>
<td>1-800-468-0600</td>
</tr>
<tr>
<td>Healthplex Dental – Commercial HMO, Medicaid, Child Health Plus, Essential Plan</td>
<td>1-888-468-5175</td>
</tr>
<tr>
<td>Superior Vision</td>
<td>1-800-879-6901</td>
</tr>
</tbody>
</table>
2.1.3. CRHP Mailing Addresses

<table>
<thead>
<tr>
<th>Contact</th>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals and Grievances</td>
<td>CRHP</td>
</tr>
<tr>
<td></td>
<td>109 Rykowski Lane</td>
</tr>
<tr>
<td></td>
<td>Middletown, NY 10941</td>
</tr>
<tr>
<td>Claim Submissions</td>
<td>CRHP</td>
</tr>
<tr>
<td></td>
<td>PO Box 3630</td>
</tr>
<tr>
<td></td>
<td>Akron, OH 44309</td>
</tr>
<tr>
<td>Main Office (NO CLAIMS)</td>
<td>CRHP</td>
</tr>
<tr>
<td></td>
<td>109 Rykowski Lane</td>
</tr>
<tr>
<td></td>
<td>Middletown, NY 10941</td>
</tr>
<tr>
<td>Refund Checks</td>
<td>CRHP</td>
</tr>
<tr>
<td></td>
<td>PO Box 3630</td>
</tr>
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<td></td>
<td>Akron, OH 44309</td>
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</tbody>
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2.2. Credentialing and Re-Credentialing

Providers participating in the Crystal Run Health Plan, LLC (HMO, Medicaid, Child Health Plus and Essential Plan) and/or Crystal Run Insurance Co., Inc. (PPO or EPO) (collectively “CRHP”) must meet CRHP’s credentialing qualifications to become network participants, and continue to meet those qualifications at the time of re-credentialing. CRHP credentials all independent provider categories licensed by the New York State Office of Professions who provide care or services to its Members, including:

a. Medical Doctor (MD) and Doctor of Osteopathy (DO) (see exceptions below)
b. Nurse Provider
c. Certified Nurse Midwife
d. Physician Assistant
e. Acupuncturist
f. Audiologist
g. Certified diabetic educator
h. Certified Orthoptist
i. Chiropractor
j. Dentist
k. Mental Health Provider (Marriage and Family Therapist and Mental Health Counselor)
l. Nutritionist
m. Occupational therapist
n. Optometrist
o. Oral maxillofacial surgeon
p. Pharmacist
q. Physical therapist  
r. Podiatrist  
s. Psychologist  
t. Social worker  
u. Speech and language therapist

The following categories of hospital or facility based licensed independent providers are not required to complete the credentialing process:

a. Emergency room physician  
b. Anesthesiologists  
c. Pathologists  
d. Radiologists  
e. Hospitalists  
f. Urgent care physicians

Organizational Providers

An evaluation and assessment is conducted for several facility and ancillary providers contracted by the plan. At a minimum, the following providers are assessed:

a. Home health agencies  
b. Skilled nursing facilities  
c. Free standing surgical centers  
d. Hospitals

Provider Rights During the Credentialing Process:

1. Right to Inquire About Credentialing Status:  
   Each provider has the right to inquire about their credentialing status at any time. Provider may inquire by contacting Provider Services.

2. Right to Review  
   Providers have the right to review the information submitted in support of their credentialing applications with exception of peer review information. If during the review process, the provider detects an error in the credentialing documentation, the provider can request a correction of the information.

3. Right to Correct Erroneous Information  
   Providers have the right to correct erroneous information, variances and discrepancies in information. The provider is sent a written notification identifying the variance, discrepancy or erroneous information and is given an opportunity to correct the information within ten (10) business days.
4. Confidentiality
All information obtained during the credentialing process will remain confidential except as otherwise provided by law as part of its mission to provide available and accessible quality care, CRHP assures its Members that only providers meeting its credentialing and re-credentialing qualifications will participate in the provider network. The CRHP Credentialing Committee, comprised of network primary care providers and specialty care providers (at least one but no more than three network participating providers), the Chief Medical Officer, and other CRHP staff, is responsible for reviewing all credentialing and re-credentialing applications and making a determination to approve or deny network participation.

2.2.1. Initial Credentialing

Applications for credentialing may be obtained by contacting the CRHP Credentialing Department in writing or by telephone at 1-844-638-6507. It is the applicant’s obligation to submit all required information including licenses, registration certificates, and documentation of completion of medical or professional degree program, etc., in order to finalize the credentialing process. CRHP is committed to completing the initial credentialing process and notifying the applicant within ninety (90) calendar days of receiving a complete application. If, in spite of its best efforts or because of a third party’s failure to provide CRHP with necessary information or because of non-routine or unusual circumstances, additional time is needed, CRHP will notify the applicant, and will make its decision as soon as possible.

Among the minimum qualifications that a provider must meet are:

a. Have a valid license and biennial registration in the State of New York. License must be in good standing, free of restrictions and without probationary status.

b. Have a current, valid Controlled Substance Registration Certificate from the Drug Enforcement Administration (DEA number).

c. Have satisfactory primary source verification of
   i. Professional degree program(s);
   ii. Post-graduate education and training program(s), if applicable;
   iii. Professional specialty board certification;
   iv. Malpractice coverage and history; and
   v. Eligibility to participate in Medicare and Medicaid programs.

d. Maintain current malpractice liability coverage in the amount of at least
   i. $1.3/3.9 million for physicians;
   ii. $1.0/3.0 million for chiropractors, certified nurse midwives, dentists, nurse providers, registered physician assistants and podiatrists; and
   iii. $1.0/1.0 million for all other LIPs.

e. Board certification in the specialty that is relevant to their scope of practice, unless training has been completed within the past five years (see “f” below).

f. Certification must be achieved within five years of completion of training. Certification must be by the American Board of Medical Specialties (ABMS)
or American Osteopathic Association (AOA). Exceptions may be made on a case-by-case basis.

g. Must maintain board certification (physicians only). This will be evaluated at the time of re-credentialing.

h. Maintain medical staff privileges in a hospital having a contractual arrangement with CRHP. Requests for exemption from the medical staff Membership requirement will be considered on a case-by-case basis.

CRHP verifies credentialing information with several primary sources including but not limited to the state licensing agency, Office of Inspector General, American Medical Association, National Practitioner Data Bank, and other credentialing sources. Documentation obtained during the primary source verification process, is considered by the Credentialing Committee when making a recommendation on the participation status of the provider.

Not all requirements are applicable to every provider category. Additional information may be obtained from the Credentialing Department.

Upon completion of primary source verification, the Credentialing Committee reviews the provider’s application and credentialing documentation and takes one of the following three actions: recommend, pend recommendation, or deny recommendation for participation/continued participation of the provider in the CRHP Provider Network. These determinations will be reported to the Quality Management Committee. If a provider is denied participation in the Provider Network, the Credentialing Committee, at its sole discretion, may work with the provider in an effort to resolve outstanding issues. If a provider has been denied continued participation in the Provider Network upon recredentialing, the provider may appeal that determination as set forth herein.

Providers that have been newly approved for participation in the Provider Network will receive a letter informing them that they have been approved. Except in limited circumstances, based upon immediate need for services, CRHP will require all new providers to undertake orientation prior to being allowed to provide services to Members. All new providers will be required to complete orientation as soon as practicable and no later than six (6) months following approval. Orientation for new providers will be the responsibility of Provider Relations. Providers will have the opportunity to complete new provider orientation in a pre-scheduled group setting, or individually through an appointment.

2.2.2. Provisional Credentialing

If the completed application of a newly licensed individual provider or a health care provider who has recently relocated to New York and has not practiced here who joins a group practice (all of whose Members are participating network providers) is neither approved nor denied within ninety (90) days, that licensed provider shall be considered provisionally credentialed with regard to the “in network” portion of CRHP’s provider
network. Such provider will begin full network participation on the day following the 90th day of receipt of a complete credentialing application, and may not be deemed a primary care provider until such time. If the applicant is ultimately denied network participation, any amount paid by CRHP that exceed the out-of-network benefits payable under the Member’s benefit contract must be refunded to CRHP and neither the provider nor the group practice may pursue reimbursement from the Member, except for applicable in-network copayment.

2.2.3. Re-Credentialing

All providers must be re-credentialed every two years. No less than ninety (90) days before the provider is due for re-credentialing, the Credentialing Department will send a re-credentialing packet to the provider. The completed forms with all required attachments and documents must be returned within thirty (30) business days. An office site visit will be conducted for all primary care providers, OB/GYNs, and all high volume specialists. Performance and quality data relating to each provider will be collected and reviewed as part of the re-credentialing process. At a minimum, the data shall include:

a. Member complaints
b. Results of quality reviews
c. Utilization management performance
d. Member satisfaction surveys

Not all requirements are applicable to every provider category. Additional information may be obtained from the Credentialing Department.

Providers will be provided with any information and profiling data used to evaluate their performance. This will be done both on a routine basis and upon request. Upon request providers may schedule a review of their profile data to discuss unique cases affecting the quality of care ratings assigned. The provider may work cooperatively with CRHP on methods to improve performance.

The recredentialing process will mirror the credentialing process set forth in 2.2.1 above. If the applicant’s request for continued network participation is denied by the Credentialing Committee, written notification will be forwarded to the candidate within five (5) business days by certified mail, return receipt requested. This written notice of denial shall include:

i. A written explanation of the reason for the proposed action to terminate;
ii. Notification of the right to request a hearing or review, at the provider’s discretion, before a panel appointed by CRHP;
iii. A time limit of 30 days within which the LIP may request a hearing; and
iv. A statement that the hearing will be held within thirty (30) days after the receipt of the request for a hearing.
2.2.4. Right to a Hearing

1. A provider is required to request a hearing within 30 days of his/her receipt of notice to terminate network participation. If the provider does not request a hearing within 30 days, the network termination will be final and the provider will have no additional appeal rights. If a hearing request is received, the provider will be apprised, in writing, of the place, time and date of the hearing and will be provided a list of the witnesses expected to testify at the hearing on behalf of CRHP. The provider will also be told that the failure to appear at the hearing will not delay a decision by the hearing panel. Provider-requested hearing dates and times may be granted at the discretion of CRHP, provided that such dates fall within thirty (30) days of the provider’s request for a hearing.

2. The hearing panel will be comprised of at least three (3) persons appointed by CRHP. At least one member of the panel will be a clinical peer in the same discipline, and the same/similar specialty, as the provider under review. If the hearing panel consists of more than three persons, one-third or more of the panel members will be clinical peers.

3. The provider will have the following rights at the hearing:
   a. The right to call, examine and cross-examine witnesses;
   b. The right to present evidence that is deemed relevant by the hearing panel (the determination of relevancy to be made solely by the panel); and
   c. The right to submit a written statement at the close of the hearing.

4. After the hearing panel has convened, deliberated and rendered a decision, it will notify the provider, in writing, of the decision not more than fifteen (15) days after its adjournment. The notification will include a statement of the basis for the decision. Decisions will include one of the following, and will be provided in writing to the provider: (i) reinstatement; (ii) provisional reinstatement with conditions set forth by CRHP, or (iii) termination.

5. A decision by the hearing panel to terminate a provider shall be effective not less than thirty (30) days after the receipt by the provider of the hearing panel’s decision. In no event will the termination be effective earlier than sixty (60) days from the receipt of the initial notice provided to the provider. The date of receipt will be presumed to be five (5) days from the date of the initial notice.

6. Unless the decision to terminate the provider involves imminent harm to the Member, a determination of fraud, or final disciplinary action by a state licensing board or other governmental agency that impairs the Healthcare Professional's ability to practice, CRHP will allow a Member to continue an ongoing course of treatment with the provider during a transitional period of (i) up to ninety (90) days from the date of notice to the Member of the provider’s disaffiliation from CRHP's network; or (ii) if the Member has entered the second trimester of pregnancy at
the time of the provider’s disaffiliation, for a transitional period that includes the provision of post-partum care directly related to the delivery. Such care during the transitional period must be authorized by CRHP and will only be covered if the provider agrees (x) to continue to accept reimbursement from CRHP, as payment in full, those rates applicable prior to the start of the transitional period, (y) to adhere to CRHP’s quality assurance requirements and to provide to CRHP any necessary medical information related to such care; and (z) to otherwise adhere to CRHP’s policies and procedures regarding referrals, prior authorization, and preparation of applicable treatment plans.

7. The provider’s record will be noted with the appropriate status determination and all hearing correspondence and documentation.

8. When the decision of the hearing panel will adversely affect the provider’s clinical privileges in the network for a period of longer than thirty (30) days, CRHP will notify the New York State Board of Medical Examiners within fifteen (15) days from the date the adverse action was taken. Other regulatory and accrediting agencies will be notified, as required.

2.3. Responsibilities of Primary Care Physicians

In conformance with the Benefit Package, the PCP shall provide health counseling and advice; conduct baseline and periodic health examinations; diagnose and treat conditions not requiring the services of a specialist; arrange inpatient care, consultations with specialists, and laboratory and radiological services when medically necessary; coordinate the findings of consultants and laboratories; and interpret such findings to the Member and the Member’s family, subject to privacy and confidentiality requirements, and maintain a current medical record for the Member. The PCP shall also be responsible for determining the urgency of a consultation with a specialist and shall arrange for all consultation appointments within appropriate time frames. Primary Care Physicians are required to provide 24/7 accessibility for the medical care of their patients. Primary Care Physicians will provide care pursuant to those standards of care that are reflective of their professional requirements and generally accepted standards of medical practice.

2.4. Responsibilities of Specialists

A specialist provides services to a Member for a particular illness or injury. Specialists are responsible for adhering to CRHP’s policies and procedures regarding prior authorization requirements. Please reference Section 3.5.1 (Prior Authorization) for further information pertaining to prior authorization.

Specialist and sub-specialist physicians can be assigned as a Member’s PCPs when such an action is considered by CRHP to be medically appropriate and cost-effective. As an alternative, CRHP may restrict its PCP network to primary care specialties only, and rely on standing referrals to specialists and sub-specialists for Members who require regular visits to such physicians.
2.5. Access and Availability

2.5.1. Scheduling Appointments

Providers are contractually required to maintain 24-hour availability by telephone and maintain reasonable appointment availability standards for office visits, as follows:

- Adult base-line and routine physicals exam within 12 weeks from enrollment
- Specialist referrals (non-urgent) within 4-6 weeks
- Prenatal care initial visit
- 1st trimester – within 3 weeks
- 2nd trimester – within 2 weeks
- 3rd trimester – within 1 week
- Initial family planning visit within 2 weeks of request
- Initial PCP office visit for newborns within two weeks of hospital discharge
- Well-child and other routine pediatric visits within 4 weeks
- Routine adult visit within 4 weeks
- non-urgent sick visit within 48-72 hours, as clinically indicated
- urgent medical care within 24 hours
- emergency coverage 24 hours per day, 7 days a week (physician response to after-hours call within 30 minutes)
- Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a participating provider with 5 days of request, or as clinically indicated
- Non-urgent mental health or substance abuse visits with a participating provider within 2 weeks of request
- Members with appointments must be seen within 30 minutes of their scheduled appointment or arrival time, whichever is later. If a delay is unavoidable, the member should be informed and alternatives offered.
- Members must have access to a live voice for after-hours PCP and OB/GYN emergency consultation and care. If an answering machine is used, the message must direct Members to a phone number to call where they can reach a live voice.

2.6. Medical Record Keeping

CRHP requires participating providers to maintain medical records in a manner that is individualized, current, detailed, organized, confidential and complies with all state and federal laws and regulations. Medical records must be made available to both treating providers and CRHP without cost. In addition medical records must be made available to CRHP, and any of its delegated utilization review agents for purposes of utilization review and quality assurance activities. Medical records must also be made available to the New York State Department of Health, the Centers for Medicare and Medicaid Services, and local district social services offices, as applicable.
NOTE: Medical record documentation auditing and reporting are part of “health care operations” as defined by HIPAA and thus do not require patient authorization for release of protected health information.

Subject to the terms of a provider’s participation agreement, a participating provider may not charge CRHP or the New York State Department of Health for photocopying a patient’s medical record. New York State Public Health Law Article 1, Title 2, Section 18 (2.e) states that providers may impose reasonable charges when a patient requests copies of his/her medical records, not to exceed $0.75 per page. However, Members may not be denied access to their records due to inability to pay.

For additional information concerning medical record standards, please reference Sections 2.6 and 7.3.1.

2.7. Referrals

2.7.1. In-Network Referrals

Members of CRHP are encouraged to select a PCP. The PCP should be the first point of contact for Members’ non-emergent care. If necessary the PCP will coordinate care with a network specialist.

For HMO Individual and Small Group Non-Standard Plan ONLY Primary Care Physicians may refer members to any Specialty Care Physician or ancillary provider within the Crystal Run Health Plans network. Crystal Run Health Plans communicates to members that they should see their PCP for their health care needs and that the PCP will determine if they need to see a specialist. Crystal Run Health Plans does not require that a member return back to his/her PCP for a referral to a different participating specialist if a participating specialist recommends that he/she be treated by another specialist. Crystal Run Health Plans does not require PCPs to notify the Plan when a member is referred to a participating specialist. To ensure coordination of care, Crystal Run Health Plans does recommend that a specialist notify the member’s PCP when a referral to another specialist is made.

2.7.2. Out-of-Network Referrals

In the event CRHP determines that it does not have a network provider with appropriate training and experience to meet the particular health care needs of a Member, it shall approve a referral to an appropriate non-participating provider, pursuant to a treatment plan approved by CRHP in consultation with the Member’s PCP, the non-participating provider, and the Member or the Member’s designee. CRHP shall pay for the cost of the services in the treatment plan provided by the non-participating provider for as long as it is unable to provide the service through a network provider.

All out of network care requires prior authorization. Please reference Section 3.6.1 (Prior Authorization) for more information about services requiring prior
authorization.

2.7.3. Transitional Care for New Members

In the following circumstances, CRHP will permit a new Member to continue seeing his/her previous health care provider for a limited time, even if that provider is not participating with CRHP:

- If, on the effective date of enrollment, the Member has a life-threatening or degenerative and disabling disease or condition for which he/she is in an ongoing course of treatment, he/she may continue to see a non-participating provider who is caring for him/her, for up to sixty (60) days.
- If, on the effective date of enrollment, the Member has entered the second trimester of pregnancy, she may continue to see a non-participating provider who is caring for her through delivery and any post-partum care directly related to that delivery.

Transitional Care is available only if the provider agrees to:

- Reimbursement at rates applicable to in-network care;
- Adhere to CRHP’s quality assurance program and provide medical information related to the Member’s care; and
- Adhere to CRHP’s policies and procedures regarding prior authorization and a treatment plan approved by CRHP.

2.7.4. Continuation of Care When a Provider Leaves the Network

Note: The continuation of care rights described in this section do not apply to patients of a provider who leaves the CRHP network for cause.

CRHP will permit a Member to continue an ongoing course of treatment with a provider during a transitional period: (i) of ninety (90) days from the last day of the provider’s contractual obligation, or (ii) if the Member has entered the second trimester of pregnancy at the time of the provider’s disaffiliation, that includes the provision of post-partum care directly related to the delivery.

The provider must agree to:

- Continue to accept reimbursement at rates applicable prior to transitional care;
- Adhere to organization’s quality assurance program and provide medical information related to the Member’s care; and
- Adhere to CRHP’s policies and procedures regarding prior authorization and a treatment plan approved by the organization.
2.7.5. Self-Referrals for Specialist Services

Members may self-refer to participating providers for certain services including the following:

Women's Services

You do not need a referral from your PCP to see one of our providers if:

- you are pregnant,
- you need OB/GYN services
- you need family planning services
- you want to see a mid-wife
- you need to have a breast or pelvic exam

Family Planning

- advice and/or prescription for birth control
- pregnancy tests
- sterilization
- elective abortions in NYC or medically necessary abortion
- testing for sexually transmitted infections
- screening such as breast cancer exam and a pelvic exam

HIV counseling and testing

- HIV testing and counseling

Eye Care

- One dilated eye (retinal) examination once in any twelve (12) month if diagnosed with diabetes
- One eye exam and pair of eyeglasses every two (2) years or more often if medically needed

Mental Health/Chemical Dependence Emergencies

TB Diagnosis and Treatment Dental Services

- For covered dental services rendered by an Article 28 clinic operated by an academic health center
Urgent Care

2.7.6. Specialist as PCP

Members may request a referral to a Specialist as PCP, or to a specialty care center when:

a. The Member is diagnosed with a life-threatening condition or disease, or a degenerative, disabling condition or disease; and
b. Due to the condition/disease, the Member requires specialized medical care over a prolonged period of time.

When such referrals are requested, CRHP will request documentation of the Member’s treatment plan. CRHP will coordinate with the Member’s PCP and the Specialist in order to determine whether such referral will be approved.

2.8. Physician Assignment and Change Procedures

All CRHP Members are required to select a PCP to coordinate their health care needs. Members failing to select a PCP will have one assigned for them, but only after CRHP makes reasonable efforts to contact the Member to inform him/her of his/her rights to choose a PCP. If CRHP must assign a PCP for a Member, it will consider the Member’s geographic location, any special health needs, if known, and language needs, if known.

Members may change their PCP at any time during the first thirty (30) days from the date of the member's first PCP appointment by contacting CRHP member services. After the first thirty (30) days, the members may elect to change PCPs, without cause, every six (6) months. PCP assignments are effective as of the first day of the month. Requests for PCP changes will be effective no later than 45 days following the request, and no later than the first day of the second month following the request for change. CRHP cannot make retroactive PCP changes.

2.9. Provider Relations Services

CRHP is committed to meeting the needs of providers. In order to accomplish this, each Provider Relations Representative is assigned to both primary and specialty care providers in certain geographic areas.

The Provider Relations Representative will be available to the provider either by phone or visit to the provider's office to ensure that coordination with CRHP is as smooth as possible. Providers may contact Provider Services at the phone number listed in Section (Useful Telephone Numbers) or directly contact their Provider Relations Representative.

Provider Relations Representative may assist the provider with the following types of services:

- Changes to practice information such as Tax ID, name, phone numbers, address changes or opening of new office locations,
• Credentialing of new providers
• Orientations for new office staff
• On-going education for existing staff
• Contract or medical policy questions
• Fee schedule information
• Claim processing questions
• Assistance with conducting business with CRHP electronically

2.10. Provider Resignation and Termination

2.10.1. Provider Resignation

If a provider desires to retire or resign from participation in CRHP’s network, such retirement/resignation from the network will be in accordance with the terms of the Provider Agreement executed between CRHP and the provider.

2.10.2. CRHP Initiated Termination and Hearing Policies and Procedures

A provider may be afforded a hearing for termination from the provider network in the following circumstance:

1. When CRHP proposes to modify a participating provider’s clinical privileges due to quality concerns.
2. When CRHP proposes to terminate a participating provider’s agreement with CRHP prior to its termination date. This does not apply when the termination involves (i) imminent harm to Member, or (ii) a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs or limits the provider’s ability to practice.
3. After a participating provider’s clinical privileges have been suspended or terminated, except where such action was taken to avoid (i) endangering the health of a Member, (ii) based on a determination of fraud, or (iii) based on a final disciplinary action.

The hearing procedure described below is not available in any circumstance other than those listed above including, but not limited to (i) an initial denial of a provider’s application to CRHP for clinical privileges, (ii) when CRHP has suspended or restricted provider’s clinical privileges for a period of no longer than fourteen (14) days, during which time an investigation is being conducted to determine the need for any action, and (iii) when CRHP decides not to renew a provider’s agreement with CRHP.

CRHP will not terminate or refuse to renew an agreement with a provider solely because the provider has:
• Advocated on behalf of a Member;
• Filed a complaint against CRHP;
• Appealed a CRHP decision;
• Provided a Member with information regarding a condition or course of treatment, including the availability of other/additional therapies, consultation or tests;
• Provided a Member with information regarding the provisions, terms, or other requirements of CRHP products as they relate to the Member;
• Made a report to an appropriate governmental body regarding the policies or practices of CRHP, which the provider believes may negatively impact upon the quality of, or access to, Member care; or
• Requests a fair hearing or review, as provided in this Policy.

CRHP’s review and hearing policy will be as follows:

1. When CRHP receive information that raises quality concerns regarding a provider who has been granted clinical privileges, it will initiate a review and a notation will be placed in the provider’s record. A review will also be initiated when CRHP decides to terminate a provider, except where the decision to terminate involves imminent harm to a Member, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the provider’s ability to practice.

2. If the results of the review indicate that the action to be taken by CRHP requires a hearing, the provider will be notified, in writing, of the proposed action. Notice to the provider will include the following information:
   
   The proposed action;
   
   a. The reasons for the proposed action
   b. A statement that the provider has the right to request a hearing or review, at the provider’s discretion, before a panel appointed by CRHP;
   c. The time limit (which will not be less than thirty (30) days), for requesting a hearing;
   d. A statement that the hearing will be held within thirty (30) days after the date the provider’s hearing request is received; and
   e. A summary of the provider’s hearing rights.

3. If the provider does not request a hearing within thirty (30) days of the date of CRHP notice, the proposed action will be final and the provider will have no additional appeal rights. If a hearing request is received, the provider will be apprised, in writing, of the place, time and date of the hearing and will be provided a list of the witnesses expected to testify at the hearing on behalf of CRHP. The provider will also be told that the failure to appear at the hearing will not delay a decision by the hearing panel. Provider-requested hearing dates and times may be
granted at the discretion of CRHP, provided that such dates fall within thirty (30) days of the provider’s request for a hearing.

4. The hearing panel shall be comprised of at least three (3) persons appointed by CRHP. At least one member of the panel will be a clinical peer in the same discipline, and the same/similar specialty, as the provider under review. If the hearing panel consists of more than three persons, one-third or more of the panel members must be clinical peers.

5. The provider shall have the following rights at the hearing:

   a. The right to call, examine and cross-examine witnesses;
   b. The right to present evidence that is deemed relevant by the hearing panel (the determination of relevancy to be made solely by the panel); and
   c. The right to submit a written statement at the close of the hearing.

6. After the hearing panel has convened, deliberated and rendered a decision, it will notify the provider, in writing, of the decision not more than fifteen (15) days after its adjournment. The notification will include a statement of the basis for the decision. Decisions will include one of the following, and will be provided in writing to the provider: (i) reinstatement; (ii) provisional reinstatement with conditions set forth by CRHP, or (iii) termination.

7. A decision by the hearing panel to terminate a provider shall be effective not less than thirty (30) days after the receipt by the provider of the hearing panel’s decision. In no event will the termination be effective earlier than sixty (60) days from the receipt of the initial notice provided to the provider. The date of receipt will be presumed to be five (5) days from the date of the initial notice.

8. Unless the decision to terminate the provider involves imminent harm to the Member, a determination of fraud, or final disciplinary action by a state licensing board or other governmental agency that impairs the provider’s ability to practice, CRHP will allow a Member to continue an ongoing course of treatment with the provider during a transitional period of (i) up to ninety (90) days from the date of notice to the Member of the provider’s disaffiliation from CRHP’s network; or (ii) if the Member has entered the second trimester of pregnancy at the time of the provider’s disaffiliation, for a transitional period that includes the provision of post-partum care directly related to the delivery. Such care during the transitional period must be authorized by CRHP and will only be covered if the provider agrees (x) to continue to accept reimbursement from CRHP, as payment in full, those rates applicable prior to the start of the transitional period, (y) to adhere to CRHP’s quality assurance requirements and to provide to CRHP any necessary medical information related to such care; and (z) to otherwise adhere to CRHP’s policies and procedures regarding referrals, prior authorization, and preparation of applicable treatment plans.
9. The provider’s record will be noted with the appropriate status determination and all hearing correspondence and documentation.

10. When the decision of the hearing panel will adversely affect the clinical privileges of a provider for a period of longer than thirty (30) days, CRHP will notify the New York State Board of Medical Examiners within fifteen (15) days from the date the adverse action was taken. Other regulatory and accrediting agencies will be notified, as required.

11. Subject to the due process rights described above, CRHP reserves the right to terminate the Provider Network participation status of any participating provider without cause, as may be set forth in the participating provider agreement.

12. In the event that the provider’s license, certification or registration is restricted, revoked, surrendered or suspended by any state in which (s)he may hold a license, the provider may be terminated with the right to an appeal. In addition, such action may be taken should such restriction, suspension, revocation or termination occur with regard to the provider’s (i) professional liability coverage, (ii) DEA registration, or (iii) state Medicaid or federal Medicare privileges.

13. A provider that is terminated due to a case involving imminent harm to a Member, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the provider’s ability to practice is not eligible for a hearing or a review.

14. CRHP is legally obligated to report to the appropriate professional disciplinary agency, within thirty (30) days, the occurrence of any of the following:

   a. Termination of a provider for reasons relating to alleged mental or physical impairment, misconduct or impairment of Member safety or welfare.
   b. Voluntary or involuntary termination of a contract or employment, or other affiliation to avoid the imposition of disciplinary measures.
   c. Termination of a provider’s agreement with CRHP in the case of a determination of fraud, or in a case of imminent harm to a Member’s health.

15. CRHP will also report to the appropriate professional disciplinary agency, within thirty (30) days of obtaining knowledge of any information that reasonably appears to show that the provider is guilty of professional misconduct as defined in the New York State Education Law. Such reports will be made in writing and will include the following information:

   a. The name, address, profession and license number of the individual; and
   b. A description of the action taken by CRHP, including the reason for the action and the date thereof, or the nature of the action or conduct that led to the resignation, termination of contract or withdrawal, and the date thereof.
stated with sufficient specificity to allow a reasonable person to understand which of the reasons enumerated led to CRHP’s action, or the resignation or withdrawal of the individual, and if the reason was an act or omission of the individual, the particular act or omission.

16. Any report or information furnished to an appropriate professional discipline agency is confidential communication and will not be subject to inspection or disclosure in any manner, except upon formal written request by a duly authorized public agency, or pursuant to a judicial subpoena issued in a pending action or proceeding.
3. MEDICAL MANAGEMENT

3.1. Overview of Medical Management

Medical Management consists of those activities undertaken by CRHP to assure that Members receive medically necessary health care in a cost effective and efficient manner, and in the most appropriate setting for the intensity of services required. Medical Management (MM) is an interactive process between CRHP’s MM staff, the providers of care and Members. To accomplish its goals and objectives, the MM Program engages in a variety of activities that include:

- Member eligibility and benefits verification
- Prior authorization
- Concurrent review
- Retrospective review
- Discharge planning
- Case management
- Medical Management appeals management
- Medical policy creation and implementation
- Formulary development and maintenance

The MM Program coordinates with the Quality Management Program to monitor the quality of health care services delivered and the quality of service it provides; to identify opportunities or improvement in the quality of care and service; and to develop and implement improvement initiatives.

The Medical Management program is directed by the Chief Medical Officer (a board certified physician licensed in the State of New York) and the Director of Medical Management. The Medical Management Department is staffed by licensed physician reviewers; licensed, registered nurses who perform and supervise various utilization review activities; intake specialists; case management coordinators and appeals specialists. The Chief Medical Officer oversees utilization review decisions to ensure consistent application of medical necessity determinations.

Medical Management department staff works collaboratively with the member, the member’s family/significant other, and the member’s PCP to develop the plan of care, which will include:

- Short and long-term goals
- Frequency of provider office visits;
- Assistance with arranging any needed tests or procedures;
- Self-management strategies;
- Identification of barriers to meeting goals or complying with care management plans;
• Development of schedules for follow-up and communication with members;
• Development and communication of self-management plans for members;
• Providing educational materials;
• Identifying and coordinating care for those members that require services who with special needs including visual and hearing impairments, cognitive issues, mobility issues and other disabilities;
• Making referrals to community agencies.

CRHP uses a variety of methods to identify members that require or would benefit from plans of care. The methods used to identify members include but are not limited to:

  o Member orientation/welcome call
  o Member services inquiry review
  o Self-reports
  o Primary care and specialty care physician referrals
  o Encounter data review
  o Authorization data review
  o Other member and provider touchpoints

3.2. Medical Policy

The Medical Management Committee promulgates medical policies to assist the Medical Management Department in the determination of medical necessity of care, service, procedure or treatment, and to guide staff in determining if health care services are experimental and/or investigational. Medical policies are based upon published scientific evidence and/or are designed to clarify questions related to benefit coverage. Medical policies are subject to ongoing review and revision as a consequence of rapid changes in the field of medicine. Participating network physicians, as Members of the Medical Policy Subcommittee, are active participants in the process of establishing, reviewing and revising CRHP medical policies.

3.2.1. Utilization Review Standards and Criteria

CRHP utilizes nationally recognized standards and criteria, and medical policies recommended by the Medical Policy Subcommittee and adopted by CRHP in conducting its utilization review activities. Reviewers use these standards to evaluate the medical necessity, level of care, and proposed alternative care settings for inpatient and outpatient services. Utilization review criteria are available to providers upon request from the Medical Management Department, the Provider Relations Representative or on the provider portal.

3.2.2. Assessment of New Technology

Part of CRHP’s mission is to make recent advances in medical technology available
and affordable to its Members. Use of unproven technologies adversely affects both the cost and quality of services received by its Members. The Medical Policy Subcommittee has been charged with the task of evaluating new technologies and services as they become available to determine if they should be covered under Members’ benefit plans. Only after a recommendation by the Medical Management Committee will a new technology or service be covered by CRHP.

3.3. Definitions

THIS SECTION APPLIES ONLY TO COMMERCIAL LINES OF BUSINESS.
FOR MEDICAID DEFINITIONS, SEE SECTION 7.

3.3.1. Medically Necessary or Medical Necessity

“Medically Necessary” or “Medical Necessity” means health care services provided to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that CRHP determines are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
3. not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

3.3.2. Experimental and/or Investigational

“Experimental and/or Investigational” means a medical service, procedure, device or treatment is considered experimental and/or investigational if one or more of the following criteria are met:

1. An approval from federal or other governmental body is required and that approval has not been granted, or does not have unrestricted market approval from the Food and Drug Administration (FDA), or final approval from any governmental regulatory body for use in treatment of a specified condition is not granted; or,
2. The medical service, procedure, device or treatment is under investigation in a properly-controlled Phase I-III clinical trial; or,
3. There is insufficient or inconclusive medical and scientific evidence to permit evaluation of therapeutic value and benefit to the Member; or,
4. There is inconclusive medical and scientific evidence in peer-reviewed medical literature that there is a beneficial effect on health outcomes; or,
5. Evidence suggests the medical service, procedure, device or treatment under consideration is not as beneficial as any established alternatives; or,
6. Reliable evidence shows that the prevailing opinion among experts regarding the medical service, procedure, device or treatment requires further study or clinical trials to determine the safety and efficacy as compared with standard means of treatment.

A medical service, procedure, device or treatment that is considered experimental and/or investigational is not a covered benefit.

3.3.3. Emergency Condition

An “Emergency Condition” is a medical or behavioral condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy,
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Examples of medical conditions that CRHP considers to be Emergency Conditions are heart attacks, poisoning, multiple trauma and active labor. Situations where the Member was directed to the Emergency Room by a participating provider are deemed Emergency Conditions.

Examples of conditions CRHP does not ordinarily consider to be Emergency Conditions are head colds, flu, minor cuts and bruises, muscle strain and hemorrhoids.

3.3.4. Emergency Services and Stabilization

“Emergency Services” means a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

“To stabilize” is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility, or to deliver a newborn child (including the placenta).
3.4. Emergency Care

Emergency services rendered to a Member are not subject to prior authorization, nor shall reimbursement for such service be denied on retrospective review, provided that the emergency services were medically necessary to stabilize or treat an emergency condition. Neither the Member nor his/her health care provider is required to notify the Medical Management Department prior to the provision of emergency care and/or treatment, or emergency admission. Emergency services will be evaluated retrospectively to assure that the services provided were for the treatment of an Emergency Condition. Medically necessary services provided to a Member at the emergency room or freestanding urgent care center of a participating or non-participating provider for the treatment of an Emergency Medical Condition will be approved for payment.

Participating hospitals are required to notify CRHP of emergency admissions within 24 hours or the next business day when the service is provided on a weekend or holiday.

To notify CRHP of an inpatient admission, providers should have the following information readily available:

- Member name and date of birth
- Member ID number
- Name of attending physician
- Name of hospital or facility
- Date of admission
- Diagnosis and pertinent medical information

3.5. Member Eligibility and Benefits Verification

It is the responsibility of the provider or facility providing services to verify that the patient is a Member in one of the CRHP products, and that the services being provided are covered by the Member's benefits contract. Participating providers may check Member eligibility by calling CRHP at 1-844-638-6507 or by accessing the provider portal of the CRHP web site.

Each CRHP Member receives an identification card that contains valuable information including the Member's name, identification number, plan type, group number, co-payments associated with that plan, telephone numbers, and the address for claims submission. CRHP recommends that providers make a copy of both sides of the Member’s ID card and keep it as part of the Member medical record.

3.6. Utilization Review Activities

Utilization review is the process of evaluating a request for authorization to provide health care services to an enrolled Member to determine whether the request health care services is medically necessary for the diagnosis, management or treatment of an illness or injury. The
evaluation compares the request with established, written Medical Management standards and criteria adopted by the Medical Management Program. The Medical Management standards and criteria are continually reviewed and revised to reflect current standards of medical care. Utilization review may be performed prospectively (prior authorization), concurrently or retrospectively.

Utilization review will be conducted by:

- administrative personnel trained in the principles and procedures of intake screening and data collection, and under the supervision of a licensed health care professional,
- licensed health care professionals who are appropriately trained in the principles, procedures and standards of the Medical Management Program, or the Medical Director for Medical Management or physician designee (“clinical peer reviewers”) where the review involves an adverse determination.

The Chief Medical Officer is supported by other New York State licensed physicians, behavioral health clinicians and healthcare professionals. These professionals perform clinical reviews of medical information and/or peer-to-peer contact with attending/treating physicians and/or other healthcare providers when indicated. Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of stay in an amount, duration or scope that is less than requested (an adverse determination) is made by the Chief Medical Officer or his/her physician designee.

CRHP does not provide compensation, other financial incentive or anything of value to Medical Management Department staff based upon the rendering of adverse determinations or denials of claims to reduce payments.

Requests for utilization review may be submitted electronically, by telephone, facsimile or in writing to the Medical Management Department. Requests are typically submitted by the provider ordering the service or performing the service, but, in certain circumstances (such as a request for an out-of-network referral), the Member may submit a request. All utilization review requests are documented and their progress tracked in the CRHP management information system.

The Medical Management Department maintains a call center staffed by personnel trained to perform intake, discuss patient care and respond to requests and questions related to Medical Management activities. The call center is accessible by toll-free telephone 1-844-638-6507, Monday through Friday, from 8:30AM to 5:00PM. After normal business hours, the call center telephone system is designed to accept telephone calls, record messages and provide instructions to callers.

The Medical Management Department helps coordinate the activities of the attending physician or hospitalist in planning the Member’s discharge from the hospital and the transition of Members from one site or level of care to another. These activities include arranging for the provision of services in the home setting after discharge from the hospital or skilled nursing facility, and coordinating Member transfers from non-participating to
3.6.1. Prior Authorization

Medical Management staff conducts prior authorization reviews on all Member services that, in accordance with the Member contract, require CRHP approval prior to services being rendered. When the Medical Management Department receives a request for prior authorization, Medical Management staff will evaluate the request following written procedures and CRHP’s established, written Medical Management standards and criteria. Cases not meeting criteria or requiring additional evaluation are referred to the Chief Medical Officer, his designee or other clinical peer reviewer. The Member and requesting provider are notified telephonically and in writing once a determination is made.

Requests for Prior Authorization may be submitted electronically, by telephone, facsimile or in writing to the Medical Management Department. Requests are generally submitted by the provider’s office ordering the service or performing the service. In certain circumstances, the Member may initiate a Prior Authorization request. All requests for Prior Authorization are documented in CRHP’s management information system. In order to assure that the Prior Authorization request is efficiently processed, providers are encouraged to include the following information with the request:

- Patient's name and CRHP ID number
- Referring physician and CRHP Provider ID number
- Service, procedure or treatment being requested
- Service, procedure or treatment code, if available
- Patient diagnosis and diagnosis code, if available
- Facility name, if applicable
- Expected date of admission or service
- Type of service (e.g., outpatient, inpatient admission, home care, DME)
- Other insurance information for Coordination of Benefits (COB)

The Medical Management Department will contact the physician with any questions or requests for more information such as medical history, results of prior treatment, current clinical status and current treatment. However, Medical Management staff shall collect only information that is necessary to make a medical necessity determination. Once the Medical Management Department receives complete information it will review the request and make a determination. All adverse determinations will be made by a clinical peer reviewer. All determinations are communicated in writing to the facility, attending physician and/or Member. If approved, CRHP assigns an authorization number and enters it into the management information system. The requesting provider's office is notified of the determination and the authorization number, if assigned. It is the responsibility of the provider
performing the service to verify that CRHP has issued an authorization number prior to performing the service. Failure to make a Utilization Review determination within the applicable time frames set forth in Section 3.5.6 of this Provider Manual shall be deemed an adverse determination. CRHP will send Notice of Adverse Determination to the Member on the date the time frames expire.

3.6.1.1. Items Requiring Prior Authorization

Below is a list of services for which CRHP requires a Prior Authorization. Please note this list is current as of the printing of this manual and is subject to change. Please reference the online provider portal or contact the provider services telephone line for the current list of services requiring Prior Authorization.
<table>
<thead>
<tr>
<th>Services Requiring Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>3D Mammography</td>
</tr>
<tr>
<td>ABA Treatment of Autism Spectrum Disorder</td>
</tr>
<tr>
<td>Acute Inpatient Physical Rehabilitation</td>
</tr>
<tr>
<td>All surgical procedures provided in an ambulatory surgery center or outpatient hospital setting (excluding vasectomy, tubal ligation and screening colonoscopy for members &gt;50 years in a participating freestanding ambulatory surgery center)</td>
</tr>
<tr>
<td>Allergy Treatment (not testing)</td>
</tr>
<tr>
<td>Assistive Communication Devices for Autism Spectrum Disorder</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
</tr>
<tr>
<td>Chemotherapy</td>
</tr>
<tr>
<td>Clinical Trials</td>
</tr>
<tr>
<td>Cochlear Implants</td>
</tr>
<tr>
<td>Continuous Glucose Monitors and supplies</td>
</tr>
<tr>
<td>Durable Medical Equipment &gt;= $500</td>
</tr>
<tr>
<td>Elective Medical/Surgical Scheduled Inpatient Admissions</td>
</tr>
<tr>
<td>External Hearing Aids</td>
</tr>
<tr>
<td>Fecal DNA tests (e.g. Cologuard©)</td>
</tr>
<tr>
<td>Genetic Testing</td>
</tr>
<tr>
<td>Home Health Care and Home Infusion Therapy</td>
</tr>
<tr>
<td>Human Organ and Stem Cell Transplant Evaluation and Services</td>
</tr>
<tr>
<td>Hyperbaric Oxygen Therapy</td>
</tr>
<tr>
<td>Infertility Treatment</td>
</tr>
<tr>
<td>Inpatient Mental Health/Psychiatric Admissions*</td>
</tr>
<tr>
<td>Insulin Pumps and supplies</td>
</tr>
<tr>
<td>Mental Health and Substance Use Disorder services, outpatient and inpatient, are coordinated by Beacon Health Options. Contact Beacon for preauthorization requirements at 1-800-872 0727.</td>
</tr>
<tr>
<td>Neuro Psych Testing</td>
</tr>
<tr>
<td>Non-emergent Use of Land/Air Ambulance</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
</tr>
<tr>
<td>Out of Network Services</td>
</tr>
<tr>
<td>Outpatient Diagnostic Radiology Services</td>
</tr>
<tr>
<td><strong>Limit 3 Ultrasounds Per Pregnancy</strong></td>
</tr>
<tr>
<td>(except as follow up to a delivery where a mother was discharged prior to 48 hours (non C-section) or 96 hours (C-section) post delivery)</td>
</tr>
<tr>
<td>MRI, PET, CT, MRA, Nuclear Imaging</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapies after initial evaluation, outpatient only</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
</tr>
<tr>
<td>Radiation Therapy</td>
</tr>
<tr>
<td>Reconstructive Surgery Procedures</td>
</tr>
<tr>
<td>Referrals to Specialty Care Center</td>
</tr>
</tbody>
</table>
### Services Requiring Prior Authorization

Skilled Nursing Facility including sub-acute and rehabilitation

Sleep Studies

★ All Mental Health/Substance Use Disorder care is coordinated by Beacon Health Options. Contact them at 1-800-872-0727.

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#### Medical Drugs Administered in an Office, Home, or Outpatient Setting

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>NDC Code</th>
<th>Drug Name</th>
<th>NDC Code</th>
<th>Drug Name</th>
<th>NDC Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABILIFY MAINTENA® (aripiprazole)</td>
<td>J0401</td>
<td>LUPRON DEPOT® (leuprolide acetate)</td>
<td>J1950</td>
<td>ACTEMRA® (tocilizumab)</td>
<td>J3262</td>
</tr>
<tr>
<td>ACTEMRA® (tocilizumab)</td>
<td>J3262</td>
<td>MACUGEN® (pegaptanib)</td>
<td>J2503</td>
<td>ACTGAR GEL® (corticotrpin)</td>
<td>J0800</td>
</tr>
<tr>
<td>ADAGEN® (pegademase)</td>
<td>J2504</td>
<td>MAKENA® (hydroxyprogesterone caproate)</td>
<td>J1725</td>
<td>ALDURAZYME® (laronidase)</td>
<td>J1931</td>
</tr>
<tr>
<td>ALTRAP® (ziv-afilbercept)</td>
<td>J9400</td>
<td>MYOBLOC® (rimabotulinumtocin B)</td>
<td>J0587</td>
<td>ARALAST® (alpha proteinase inhibitor)</td>
<td>J0256</td>
</tr>
<tr>
<td>ARALAST® (alpha proteinase inhibitor)</td>
<td>J0256</td>
<td>NAGLAZYME® (galsufase)</td>
<td>J1458</td>
<td>ARCALYST® (rilonacept)</td>
<td>J2793</td>
</tr>
<tr>
<td>ARZERRA® (ofatumumab)</td>
<td>J9302</td>
<td>NULOJIX® (belatacept)</td>
<td>C9286 / J0485</td>
<td>AVONEX® (interferon beta-1a)</td>
<td>J1826</td>
</tr>
<tr>
<td>BELEODAQ® (belinostat)</td>
<td>J9032</td>
<td>OPIVO® (nivolumab)</td>
<td>J9999 / C9399</td>
<td>BONIVA®IV (ibandronate)</td>
<td>J1740</td>
</tr>
<tr>
<td>BLINCYTO® (blinatumomab)</td>
<td>J0490</td>
<td>ORENCIA® (abatacept)</td>
<td>J0129</td>
<td>BOTOX® (onabotulinumtoxin A)</td>
<td>J0586</td>
</tr>
<tr>
<td>BONLYSTA® (belimumab)</td>
<td>J0939</td>
<td>PERJETA® (pertuzuzmab)</td>
<td>J9306</td>
<td>CAYSTON® (aztreonam for inhalation)</td>
<td>J7699</td>
</tr>
<tr>
<td>CARLAM® (certolizumab pegol)</td>
<td>J0717</td>
<td>PLEXIN® (capsaicin 8% patch)</td>
<td>J7335</td>
<td>CEREXYZE® (imiglucerase)</td>
<td>J1786</td>
</tr>
<tr>
<td>CINRYZE® (C1 inhibitor, human)</td>
<td>J0598</td>
<td>RECLAST® (zoledronic acid)</td>
<td>J3489</td>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
</tr>
<tr>
<td>CINRYZE® (C1 inhibitor, human)</td>
<td>J0598</td>
<td>REMICADE® (infliximab)</td>
<td>J1745</td>
<td>DOLVE® (onabotulinumtoxin A)</td>
<td>J0586</td>
</tr>
<tr>
<td>CINRYZE® (C1 inhibitor, human)</td>
<td>J0598</td>
<td>RISPERDAL CONSTA® (risperidone LA)</td>
<td>J2794</td>
<td>ELAPRASE® (infursulfase)</td>
<td>J1743</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>RITUXAN® (rituximab)</td>
<td>J9310</td>
<td>ELELYSO® (taliglucerase – alfa)</td>
<td>J3060</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>SIMPONI ARIA® (golimumumab)</td>
<td>J1602</td>
<td>ENTYVIO® (vedolizumab)</td>
<td>J3380</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>SOLIRIS® (eculizumab)</td>
<td>J3100</td>
<td>ERTIBUX® (cetuximab)</td>
<td>J9055</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>STELARA® (ustekinumab)</td>
<td>J3357</td>
<td>EYLEA® (afilbercept)</td>
<td>J0178</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>SUPPRELIN LA® (histralin) implant</td>
<td>J9226</td>
<td>FABRIZYME® (agalsidase)</td>
<td>J0180</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>SYLVANT® (acyclovir)</td>
<td>C9399 / J3590</td>
<td>FACTOR PRODUCTS</td>
<td>SYNAGIS® (palivizumab)</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>SYNRSIBO® (omacetaxine mepesuccinate)</td>
<td>C9297</td>
<td>FLOLAN® (epoprostanol)</td>
<td>J1325</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>TEFLAR® (ceftaroline fosamil).</td>
<td>J0712</td>
<td>GAZZYVA® (obinutuzumab)</td>
<td>J9301</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>TEMODAR® oral (temozolomide)</td>
<td>J8700</td>
<td>GLASSIA® (proteinase inhibitor)</td>
<td>J0257</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>TEMODAR® oral (temozolomide)</td>
<td>J8700</td>
<td>GRANIX® (tbo-filgrastim)</td>
<td>J1446</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>TESTOPEL® (testosterone pellets) implant</td>
<td>S0189</td>
<td>HALAVEN® (eribulin mesylate)</td>
<td>J9179</td>
</tr>
<tr>
<td>CYRAMZAZ® (ramucirumab)</td>
<td>J9308</td>
<td>TYSABRI® (natalizumab)</td>
<td>J2323</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Medical Drugs Administered in an Office, Home, or Outpatient Setting

<table>
<thead>
<tr>
<th>Medical Drug</th>
<th>J Code</th>
<th>J Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>HALDOL DECANOATE® (haloperidol)</td>
<td>J1631</td>
<td>TYVASO® (treprostinil)</td>
</tr>
<tr>
<td>HERCEPTIN® (trastuzumab)</td>
<td>J9355</td>
<td>VECTIBIX® (panitumumab)</td>
</tr>
<tr>
<td>HIZENTRA® (immune globulin, sq)</td>
<td>J1559</td>
<td>VENTAVIS® (iloprost)</td>
</tr>
<tr>
<td>ILARIS® (canakinumab)</td>
<td>J0638</td>
<td>VIMIZIM® (elosulfase alfa injections)</td>
</tr>
<tr>
<td>INFERTILITY INJECTIONS (Unless excluded by plan)</td>
<td>VORAXAZE® (glucarpidase)</td>
<td>J3590 / C9293</td>
</tr>
<tr>
<td>INVEGA SUSTENNA (paliperidone palmitate ER)</td>
<td>J2426</td>
<td>VPRIV® (velaglucerase)</td>
</tr>
<tr>
<td>IVIG PRODUCTS (immune globulin)</td>
<td>XEOMIN® (incobotulinumtoxin A)</td>
<td>J0588</td>
</tr>
<tr>
<td>KADCYLA® (trastuzumab emtansine)</td>
<td>J9354</td>
<td>XGEVA® (denosumab)</td>
</tr>
<tr>
<td>KEYTRUDA® (pembrolizumab)</td>
<td>J9271</td>
<td>XIAFLEX® (collagenase, clostridium histolyticum)</td>
</tr>
<tr>
<td>KRISTEXXA® (pegloticase)</td>
<td>J2507</td>
<td>XOFIGO® (RADIUM Ra 223 dichloride)</td>
</tr>
<tr>
<td>KYPROLIS® (carfilzomib)</td>
<td>J0947</td>
<td>XOLAIR® (omalizumab)</td>
</tr>
<tr>
<td>LEMTRADA® (alemtuzumab)</td>
<td>J0202</td>
<td>YERVOY® (ipilimumab)</td>
</tr>
<tr>
<td>LEUKINE® (sargramostim)</td>
<td>J2820</td>
<td>ZEMAIRA® (alpha proteinase inhibitor)</td>
</tr>
<tr>
<td>LUCENTIS® (ranibizumab)</td>
<td>J2778</td>
<td>ZOLADEX® (goserelin acetate implant)</td>
</tr>
<tr>
<td>LUMIZYME® (alglucosidase)</td>
<td>J0221</td>
<td>ZYPREXA RELPREVV® (olanzapine LA)</td>
</tr>
</tbody>
</table>

*a No Prior Authorization for Medicaid Members  
b No Prior Authorization for Oncology Indication

**All Mental Health/Substance Use Disorder care is coordinated by Beacon Health Options. Contact them at 1-800-872-0727.**

### 3.6.2. Concurrent Review

Medical Management staff performs concurrent review on inpatient stays on admission (emergency admissions only where there is no prior authorization) and continuing inpatient stays to monitor the medical necessity of continuing inpatient care. Medical Management staff also conducts concurrent review on requests for an extension of previously approved outpatient services and continuing treatment. Concurrent review of inpatient hospital stays are conducted telephonically. Licensed utilization review staff will obtain the clinical information necessary to make a determination from the hospital’s UR coordinators and or hospitalists managing the patients. If the attending physician disagrees or for other cases not meeting criteria or requiring additional evaluation, the case is referred to the Chief Medical Officer, his/her designee or other clinical peer reviewer. The Member and requesting provider (and facility, where appropriate) are notified telephonically and in writing once a determination is made. Failure to make a Utilization Review determination within the applicable time frames set forth in Section 3.5.6 of this Provider Manual shall be deemed an adverse determination. CRHP will send a Notice of Adverse Determination to the Member on the date the time frames expire.
3.6.3. Reconsideration

In the event the Chief Medical Officer, his/her designee or other clinical peer reviewer renders an adverse determination without having discussed the case with the provider who requested the health care service, procedure or treatment under review, that provider shall have the opportunity request a reconsideration of the adverse determination. Except in cases of retrospective reviews, the reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the Member’s provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer is not available. Written confirmation will follow the oral notification of the Medical Management determination made during the reconsideration. If the reconsideration results in the adverse determination being upheld, the Member and provider retain all rights of appeal.

3.6.4. Retrospective Review

Medical Management staff undertakes retrospective review in situations where health care services have been provided before CRHP has had the opportunity to review the services (such as out-of-area or out-of-network care). Both inpatient and outpatient services may be subject to retrospective review. Cases not meeting criteria or requiring additional evaluation are referred to the Chief Medical Officer, his/her designee or other clinical peer reviewer. The Member and requesting provider are notified in writing once a determination is made. Failure to make a Utilization Review determination within the applicable time frames set forth in Section 3.5.6 of this Provider Manual shall be deemed an adverse determination subject to an Action Appeal. CRHP will send Notice of this Action to the Member on the date the time frames expire.

CRHP may reverse a pre-authorized service, procedure or treatment on Retrospective Review only when:

- The relevant medical information presented to CRHP upon Retrospective Review is materially different from the information that was presented during the prior authorization review;
- The relevant medical information presented to CRHP upon Retrospective Review existed at the time of the prior authorization but was withheld from or not made available to CRHP;
- CRHP was not aware of the existence of the information at the time of the prior authorization review; and
- Had CRHP been aware of the information, the service, procedure or treatment being requested would not have been authorized.

This determination is to be made using the same specific standards, criteria or procedures as used during the prior authorization review.
Providers may file a Standard Appeal in accordance with Section 3.6 (Commercial) or 7.8.5 (Medicaid) of this Provider Manual related to retrospective reviews and denials.

### 3.6.5. Written Notification of Initial Adverse Determination

All adverse determinations of initial requests for service (whether prior authorization, concurrent review or retrospective review) are communicated in writing to the Member (or Member’s designee) and provider. The adverse determination letter contains the following information, as applicable to the case:

a. The name and CRHP ID number of the Member;

b. A statement of the reviewer’s understanding of the pertinent facts of the Member’s appeal;

c. The titles and qualifications of the individuals who participated in the utilization review, including consultants;

d. A clear explanation of the clinical rationale for the denial, including a description or reference to the documentation used as the basis for the decision, and the reviewer’s consideration of Member-specific clinical information;

e. When citing Clinical Guidelines or Medical Policy, the guideline or section of the policy which applies to the denial is cited. A copy of the citation may be sent with the letter when appropriate to the issue;

f. Instructions for requesting a written statement of the clinical rationale and a copy of the criteria used to make the decision, as applicable to the issue (if not attached to the letter);

g. A description of the denied healthcare service including, as appropriate, the dates of service and the name of the facility and/or provider requesting to provide the service, and the claim amount (if applicable);

h. The signature of the Chief Medical Officer on all medical necessity denial letters;

i. The name and telephone number of CRHP’s contact person;

j. If additional information is needed for the review of an appeal, the notice will include what information is needed and why it is needed;

k. Instructions on how to initiate standard and expedited appeals including a clear statement that:

   i. The notice constitutes the initial adverse determination and specific use of the terms medical necessity or experimental or investigational;

   ii. The Member may be eligible for an external appeal;

   iii. The Member may file a standard or expedited appeal;

   iv. If the Member completes the expedited internal appeal process and CRHP upholds it adverse determination, the Member may then file either a standard internal appeal or an external appeal;
v. If the Member completes the standard internal appeal process and CRHP upholds its denial, the Member may then apply for an external appeal within 4 months of receipt of the final adverse determination notice; and

vi. The Member and CRHP may jointly agree to waive CRHP’s appeal process and the Member may apply for an external appeal within four (4) months of that agreement.

3.6.5.1. Notice of Adverse Determination

CRHP will provide written notice of its determinations made in the course of the utilization review process. The intent of the written notification is to provide full disclosure of the clinical rationale for determinations and, in the case of adverse determinations, to notify the Member of his/her right to appeal, and provide clear instructions for such an appeal.

All notices are written in easily understood language and are accessible to non-English speaking and visually impaired Members. Notices shall include a statement that oral interpretation and alternate formats of written material for Members with special needs are available and how to access the alternate formats.

1. Member Notice Regarding a CRHP-Initiated Extension

Notice to the Member regarding a CRHP-initiated extension shall include:

a. the reason for the extension;

b. an explanation of how the delay is in the best interest of the Member;

c. any additional information CRHP requires from any source to make its determination;

d. the right of the Member to file a Complaint regarding the extension;

e. the process for filing a Complaint with CRHP and the time frames within which a Complaint determination must be made;

f. the right of a Member to designate a representative to file a Complaint on behalf of the Member;

g. the right of the Member to contact the New York State Department of Health regarding the Member’s Complaint, including the Department of Health’s toll-free number for Complaints; and

h. a statement that oral interpretation and alternate formats of written material for Members with special needs are available and how to access the alternate formats.
2. Member and Provider Notice of an Action

1. CRHP will provide written Notice of Action to Members and providers in accordance with CRHP’s contractual Agreement with the New York State Department of Health including, but not limited to the following circumstances:

   a. CRHP makes a coverage determination or denies a request for a referral, regardless of whether the Member has received the benefit;
   b. CRHP determines that a service does not have appropriate authorization;
   c. CRHP denies a claim for services provided by a non-participating provider for any reason;
   d. CRHP denies a claim or service due to medical necessity;
   e. CRHP rejects a claim or denies payment due to a late claim submission;
   f. CRHP denies a claim because it has determined that the Member was not eligible for MMC coverage on the date of service;
   g. CRHP denies a claim for service rendered by a participating provider due to lack of a referral;
   h. CRHP denies a claim because it has determined it is not the appropriate payor; or
   i. CRHP denies a claim due to a participating provider billing for benefit package services not included in the provider agreement between CRHP and the participating provider.

2. CRHP is not required to provide written Notice of Action to Members and providers in the following circumstances:

   a. When there is a prepaid capitation arrangement with a participating provider and the participating provider submits a fee-for-service claim to CRHP for a service that falls within the capitation payment;
   b. If a participating provider of CRHP itemizes or “unbundles” a claim for services encompassed by a previously negotiated global fee arrangement;
   c. If a duplicate claim is submitted by the Member or a participating provider, no notice is required, provided an initial notice has been issued;
   d. If the claim is for a service that is carved-out of the MMC benefit package and is provided to a MMC Member through Medicaid fee-for-service; however, CRHP should notify the provider to submit the claim to Medicaid;
   e. If CRHP makes a coding adjustment to a claim (up-coding or
down-coding) and its provider agreement with the participating provider includes a provision allowing CRHP to make such adjustments;

f. If CRHP has paid the negotiated amount reflected in the provider agreement with a participating provider for the services provided to the Member and denies the participating provider’s request for additional payment; or

g. If CRHP has not yet adjudicated the claim; if CRHP has pended the claim while requesting additional information, a notice is not required until the coverage determination has been made.

3. Notice to the Member and provider of an Action shall include:

a. The description of the Action CRHP has taken or intends to take;

b. The reasons for the Action, including the clinical rationale, if any, and;

i. for adverse determinations and payment denials where the reason for denial, in whole or in part, is that the service is not covered by the prepaid benefit package, a statement, as applicable and as known by CRHP, that the requested services may be a benefit available through fee for service Medicaid, which may include a statement, if applicable, directing the Member to contact a FFS provider to arrange for such services;

ii. for Actions involving personal care services, the content required in Section 3.5.5.1(B)(13) of this Provider Manual, below.

4. For Actions that include the clinical rationale, the statement of clinical rationale for an adverse determination will include:

a. the Member’s name and CRHP ID number;

b. a statement of the reviewer’s understanding of the pertinent facts of the Member’s appeal, including the medical service, treatment or procedure in question; and

c. a clear explanation of the basis for the denial, including a description or reference to the documentation used for the determination, and the reviewer’s consideration of Member-specific clinical information;

5. For Actions that include an adverse determination, the Member’s right to file an Action Appeal, including:

a. the fact that CRHP will not retaliate or take any discriminatory
action against the Member because he/she filed an Action Appeal;

b. the right of the Member to designate a representative to file Action Appeals on his/her behalf;

c. the address and phone number for filing an appeal.

6. The process and time frame for filing an Action Appeal with CRHP, including an explanation that an expedited review of the Action Appeal can be requested if a delay would significantly increase the risk to the Member’s health, a toll-free number for filing an oral Action Appeal and a form, if used by CRHP, for filing a written Action Appeal;

7. A description of what additional information, if any, must be obtained by CRHP from any source in order for CRHP to make an Appeal determination;

8. The timeframes, including possible extensions, within which the Action Appeal determination will be made;

9. The right of the Member to contact the New York State Department of Health with his/her Complaint, including the Department of Health’s toll-free number for Complaints;

10. The notice entitled “Managed Care Action Taken” for denial of benefits or for termination or reduction in benefits, as applicable, containing the Member’s fair hearing and aid continuing rights;

11. For Actions based on a determination that a requested out-of-network service is not materially different from an alternate service available from a participating provider, the notice of Action shall also include:

a. notice of the required information for submission when filing an Action Appeal from the MCO’s determination;

b. a statement that the Member may be eligible for an External Appeal;

c. a statement that if the denial is upheld on Action Appeal, the Member will have 45 days from the receipt of the final adverse determination to request an External Appeal;

d. a statement that if the denial is upheld on an expedited Action Appeal, the Member may request an External Appeal or request a standard Action Appeal; and

e. a statement that the Member and CRHP may agree to waive the internal appeal process, and the Member will have forty-five (45) days to request an External Appeal from receipt of written notice of that agreement.
12. For Actions based on issues of Medical Necessity or an experimental or investigational treatment, the notice of Action shall also include:

a. a clear statement that the notice constitutes the initial adverse determination and specific use of the terms “medical necessity” or “experimental/investigational”;
b. a statement that the specific clinical review criteria relied upon in making the determination is available upon request;
c. a statement that the Member may be eligible for an External Appeal;
d. a statement that the Member may file a standard or expedited Action Appeal;
e. a statement that if the denial is upheld on Action Appeal, the Member will have forty-five (45) days from receipt of the final adverse determination to request an External Appeal;
f. a statement that if the denial is upheld on an expedited Action Appeal, the Member may request an External Appeal or request a standard Action Appeal; and
g. a statement that the Member and CRHP may agree to waive the internal appeal process, and the Member will have forty-five (45) days to request an External Appeal from receipt of written notice of that agreement.

13. For all service authorization determinations involving personal care services, the determination notice, whether adverse or not, shall include the number of hours per day, number of hours per week, and the personal care services function:

a. that were previously authorized, if any;
b. that were requested by the Member or their designee, if so specified in the request;
c. that are authorized for the new authorization period; and
d. the original authorization period and the new authorization period, as applicable.

3. Notice of Determination of an Action Appeal

1. CRHP shall ensure that all notices are in writing and in easily understood language and are accessible to non-English speaking and visually impaired Members. Notices shall include a statement that oral interpretation and alternate formats of written material for Members with special needs are available and how to access the alternate formats.
2. Notice to the Member that the Member’s request for an expedited Action Appeal has been denied shall include that the request will be reviewed under standard Action Appeal time frames, including a description of the time frames. This notice may be combined with the acknowledgement.

3. Notice to the Member regarding a CRHP-initiated extension shall include all items in the section entitled “Member Notice Regarding a CRHP- Initiated Extension”, above.

4. Notice to the Member of Action Appeal Determination shall include:
   a. date the Action Appeal was filed and a summary of the Action Appeal;
   b. date the Action Appeal process was completed;
   c. the results and the reasons for the determination, including the clinical rationale, if any;
   d. If the determination was not in favor of the Member, a description of the Member’s fair hearing rights, if applicable; and
   e. the right of the Member to contact the New York State Department of Health regarding the Member’s Appeal, including the Department of Health’s toll-free number for Appeals.

5. For Action Appeals involving personal care services, the number of hours per day, number of hours per week, and the personal care services function:
   a. that were previously authorized, if any;
   b. that were requested by the Member or the Member’s designee, if so specified in the request;
   c. that are authorized for the new authorization period, if any; and
   d. the original authorization period and the new authorization period, as applicable.

6. For Action Appeals involving Medical Necessity or an Experimental/Investigational treatment, the notice must also include:
   a. the Member’s name and CRHP ID number, and the coverage type;
   b. a statement of the reviewer’s understanding of the pertinent facts of the Member’s Action Appeal, including the procedure in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service;
   c. the titles and qualifications of the individuals who participated in the Action Appeal, including consultants;
d. in the case of an adverse determination of an Action Appeal:

7. a clear explanation of the clinical rationale for the denial, including a description or reference to the documentation used as the basis for the decision, and the reviewer’s consideration of Member-specific clinical information;

8. when citing the Clinical Guidelines or Medical Policy, the guideline or section of the policy which applies to the denial is cited. A copy of the citation may be sent with the letter when appropriate to the issue;

9. instructions for requesting a written statement of the clinical rationale and a copy of the criteria used to make the decision, as applicable to the issue (if not attached to the letter);

10. a description of the denied healthcare service including, as appropriate, the dates of service and the name of the facility and/or provider requesting to provide the service, and the claim amount (if applicable);

11. A clear statement that the notice constitutes the final adverse determination, and specifically use of the terms “medical necessity” or “experimental/investigational;”

12. statement that the Member is eligible to file an External Appeal and the timeframe for filing, and if the Action Appeal was expedited, a statement that the Member may choose to file a standard Action Appeal with CRHP or file an External Appeal;

13. a copy of the “Standard Description and Instructions for Health Care Consumers to Request an External Appeal” and the External Appeal application form; and

14. CRHP contact person and telephone number.

3.6.6. Utilization Review Determination/Notification Time Frames – Commercial

Medical Management Initial Determination Timeframes – Commercial Products

These timeframes take into consideration the requirements of several regulatory bodies, including the New York State Public Health Law (Article 49, section 4903), the Department of Labor (DOL), and NCQA. Determinations not made within these timeframes will automatically result in an adverse determination subject to appeal.
<table>
<thead>
<tr>
<th>Type of Review</th>
<th>If You Have All Necessary Information To Make A Decision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service (non-urgent)</td>
<td>Decision, verbal notification and written notification must be completed within three (3) business days.</td>
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<tr>
<td></td>
<td>Within fifteen (15) business days of the original request, send a written request to the Member/provider for the specific information needed. The request must specify the time period given to the Member/provider to provide the needed information. The Member/provider is provided forty-five (45) calendar days to provide the information. If the information is received within forty-five (45) days, the decision, telephonic and written notification must be made within three (3) business days of receipt of the information. If no information or incomplete information is received by the end of the forty-five (45) days, the decision must be made within fifteen (15) calendar days after the forty-five (45) days, using the information already received.</td>
</tr>
<tr>
<td>Pre-Service (urgent)</td>
<td>Decision, verbal notification and written notification must be completed within 72 hours.</td>
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<td></td>
<td>Within 24 hours of the original request, send a written request to the Member/provider for the specific information needed. The request must specify the time period given to the Member/provider to provide the needed information. The Member/provider must be given at least 48 hours to provide the information. Once the information is received, the decision, verbal and written notification must be made within 48 hours of receipt of the information. If no information or incomplete information is received by the end of the 48 hours, the decision must be made within 48 hours of the end of the 48 hours, given using the information already received.</td>
</tr>
<tr>
<td>Concurrent – Non-Urgent (non-inpatient)</td>
<td>Decision, telephonic notification and written notification must be</td>
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<td>Within one (1) business day of the original request, send a written request to the Member/provider for the specific information</td>
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<tr>
<td>Type of Review</td>
<td>If You Have All Necessary Information To Make A Decision:</td>
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<td>completed within one (1) business day.</td>
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<td></td>
<td>Notification of continued or extended services must include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.</td>
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<tr>
<td>Type of Review</td>
<td>If You Have All Necessary Information To Make A Decision:</td>
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<tr>
<td>Concurrent – Urgent (inpatient)</td>
<td>Decision, verbal notification and written notification must be completed within 24 hours.</td>
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<td>Notification of continued or extended services must include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.</td>
</tr>
<tr>
<td>Post-Service</td>
<td>Decision and written notification must be completed within thirty (30) calendar days.</td>
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<td>No verbal notification is required on post-service decisions.</td>
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</tbody>
</table>
3.6.7. Medical Management Initial Determination Timeframes – Medicaid Managed Care and CHPlus

These timeframes take into consideration the requirements of several regulatory bodies, including the New York State Public Health Law (Article 49, section 4903), the Medicaid Managed Care/Family Health Plus Model Contract Appendix F, the Department of Labor (DOL), and NCQA. Determinations not made within these timeframes will automatically result in an adverse determination subject to appeal.

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>If You Have All Necessary Information To Make A Decision:</th>
<th>If You Still Need Information To Make A Decision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service (Non-urgent)</td>
<td>Decision, verbal notification and written notification to Member and provider must:</td>
<td>Send a written request to the Member/provider for the specific information needed. Decision, verbal notification and written notification to Member and provider must be completed within 3 business days of the receipt of all necessary information, but not more than fourteen (14) calendar days after receipt of original request.</td>
</tr>
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<td>- be completed within three (3) business days of the receipt of all necessary information; or</td>
<td>If a Member requests an expedited review and CRHP denies the request, CRHP must send a notice stating that it has denied the expedited request and will review the case within standard timeframes.</td>
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<td>- as expeditiously as the Member's condition requires and within three (3) business days of the receipt of an expedited authorization request, or in all other cases, within three (3) business days of receipt of all necessary information but not more than fourteen (14) calendar days after receipt of original request.</td>
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<tr>
<td>Type of Review</td>
<td>If You Have All Necessary Information To Make A Decision:</td>
<td>If You Still Need Information To Make A Decision:</td>
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<td>denied the expedited request and will review the case within standard timeframes.</td>
<td>Send a written request to the Member/provider for the specific information needed. If CRHP does not receive the information in time to make a determination within three (3) business days of original request, and it is in the Member’s best interest to have a fourteen (14) calendar day extension, CRHP must send a notice of extension. The Member, the Member’s designee or the provider may also request an extension.</td>
</tr>
<tr>
<td>Pre-Service (Urgent)</td>
<td>If a Member requests an expedited review, CRHP will conduct such expedited review if CRHP believes, or the provider indicates, that a delay would seriously jeopardize the Member’s life or health, or ability to attain, maintain, or regain maximum functions. If CRHP approves the request for an expedited review, the decision, verbal notification and written notification to Member and provider must be completed within three (3) business days from the receipt of the request.</td>
<td>Once the information is received, the decision, verbal and written notification must be made within three (3) business days of the receipt of the request or no later than the date the extension expires, whichever is shorter. If no information or incomplete information is received by the end of the specified time period given, the decision, verbal and written notification must be made within three (3) business days of the original request or no later than the date the extension expires using whatever information has already been received.</td>
</tr>
<tr>
<td>Type of Review</td>
<td><strong>If You Have All Necessary Information To Make A Decision:</strong></td>
<td><strong>If You Still Need Information To Make A Decision:</strong></td>
</tr>
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</tr>
<tr>
<td>Concurrent (Non-urgent, non-inpatient)</td>
<td>Decision, verbal notification and written notification to Member and provider must be completed within one (1) business day of the receipt of all necessary information but never more than fourteen (14) calendar days from the date of the request. Notification of continued or extended services must include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.</td>
<td>Send a written request to the Member/provider for the specific information needed. If CRHP does not receive the information in time to make a determination within fourteen (14) calendar days of original request, and it is in the Member’s best interest to have a fourteen (14) calendar day extension, CRHP must send a notice of extension. The Member, the Member’s designee or the provider may also request an extension. Once the information is received, the decision, verbal and written notification must be made within one (1) business day of the receipt of the necessary information or no later than the date the extension expires, whichever is shorter. If no information or incomplete information is received by the end of the specified time period given, the decision, verbal and written notification will be made within fourteen (14) calendar days of the date of the original request.</td>
</tr>
<tr>
<td>Type of Review</td>
<td>If You Have All Necessary Information To Make A Decision:</td>
<td>If You Still Need Information To Make A Decision:</td>
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<tr>
<td>Concurrent (urgent, inpatient)</td>
<td>Decision, verbal notification and written notification to Member and provider must be completed within one (1) business day of the receipt of all necessary information but never more than three (3) business days from the date of the request. Notification of continued or extended services must include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.</td>
<td>Send a written request to the Member/provider for the specific information needed. If CRHP does not receive the information in time to make a determination within three (3) business days of original request, and it is in the Member’s best interest to have a fourteen (14) calendar day extension, CRHP must send a notice of extension. The Member, the Member’s designee or the provider may also request an extension. Once the information is received, the decision, verbal and written notification must be made within one (1) business day of the receipt of the necessary information or no later than the date the extension expires, whichever is shorter. If no information or incomplete information is received by the end of the specified time period given, the decision, verbal and written notification will be made within three (3) business days of the date of the original request.</td>
</tr>
<tr>
<td>Post-Service</td>
<td>Decision and written notification to the provider, and in some cases the Member, must be completed within thirty (30) calendar days of receipt of necessary information. No verbal notification is required on post-service decisions. Notice to be mailed to Member on the date of a payment denial, in whole or in part.</td>
<td>Provider and Member are notified of the need for additional information within thirty (30) calendar days of receipt of the request. Provider and Member are provided forty-five (45) calendar days for submission of the requested additional information. CRHP will make a determination and provide notice to the Member and provider within fifteen (15) calendar days of the earlier of the receipt of information or the end of the forty-five (45) calendar day time period.</td>
</tr>
</tbody>
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3.7. Internal Appeal of an Adverse Determination

THIS SECTION APPLIES ONLY TO COMMERCIAL LINES OF BUSINESS. FOR MEDICAID APPEALS, SEE SECTION 7.

An internal appeal of a medical necessity determination means the appeal of a health care service that is eligible for benefits but has been denied, modified, or delayed by a decision of a qualified, licensed professional in the Medical Management Department of CRHP based on a finding that the service is not medically necessary. This includes appeals based upon a CRHP determination that the medical service, procedure, device or treatment is considered experimental and/or investigational.

CRHP’s appeal process is designed to investigate and resolve Member appeals expeditiously and within time frames established by regulatory and accreditation agencies. CRHP has processes in place to assure that the appeal process is reasonably accessible to those who do not speak English or have other disabilities that impact communication. A Member may designate a representative to act on his/her behalf at any stage of the appeal process. The Member must provide CRHP with written confirmation of the representative designation by completing and signing a “Designation of Representation (DOR)” form or its equivalent. If a Member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative or other designee of the Member, as appropriate may submit the appeal. The designated representative may be a health care provider or attorney or other individual who agrees to serve in that role.

After notification of an adverse determination, a Member has up to one hundred eighty calendar days to file an appeal. The appeal process allows all parties involved in a Member’s care, including the Member, provider or facility, the opportunity to submit additional information relating to an appeal. The Member, the Member’s representative and, in connection with retrospective adverse determinations, the Member’s health care provider, have the option to request an internal appeal of a denial of service either by telephone or in writing. CRHP will acknowledge appeals within fifteen (15) days of receipt. If an appeal requires additional information to make a determination, CRHP will request that information, in writing, within fifteen (15) days of receipt of the appeal. If only a portion of the necessary information is received, CRHP will request the additional information in writing within five (5) business days of receipt of the partial information.

The Member and CRHP may jointly agree to waive the internal appeal process. If this occurs, CRHP will send the Member a written letter detailing the external appeal process within twenty-four (24) hours of the agreement to waive the internal appeal process.

All appeals are thoroughly investigated and documented. CRHP maintains a file on each appeal and considers the appeals file to be confidential information. No discriminatory action will be taken against a Member or provider as a result of filing an appeal. An internal appeal undergoes review by the Chief Medical Officer, a CRHP Medical Director, and/or peer clinical reviewer who was not involved in the initial determination and not a subordinate of the clinical peer reviewer who made the initial adverse determination. Peer clinical reviewers will be
available within one business day. Internal appeals will be reviewed in a standard or expedited
time frame dependent upon the exigencies of the case.

An Expedited Internal Appeal may be filed by the Member with regard to:

- Continued or extended health care services, procedures or treatments;
- Additional services for Members undergoing a course of continued treatment; or
- When the provider believes an Expedited Internal Appeal is warranted.

A determination related to an Expedited Internal Appeal will be made within the lesser of
seventy-two (72) hours or two (2) business days of receipt of necessary information to resolve
the appeal, and communicated telephonically or by facsimile. If additional information is
required to conduct an expedited appeal, the Member and health care provider will be
contacted immediately both in writing and via telephone to request that information. Written
notice will follow within twenty four (24) hours of the determination but no later than seventy-
two (72) hours of receipt of the appeal request. For denials of continued inpatient stay, the
denial letter is faxed to the Member at the facility prior to cessation of benefits. Expedited
appeals not resolved to the satisfaction of the appealing party may be re-appealed through
either the standard appeal process or through the external appeal process. Members have the
right to an external appeal of a final adverse determination.

Determination of a Standard Internal Appeal related to a service not yet provided to the
Member (pre-service appeal) will be made within thirty (30) calendar days of the appeal request.
Written notification of the determination will be provided to the Member or the Member’s
designee (and the health care provider if he/she requested the review) within two (2) business
days after the determination is made, but no later than thirty (30) calendar days after receipt of
the appeal request. Failure of CRHP to make a determination within sixty (60) days of receipt
of the appeal request shall be deemed to be a reversal of the adverse determination. Members
have the right to an external appeal of a final adverse determination.

Determination of a Standard Internal Appeal related to a service already provided to the
Member (post-service appeal) will be made within sixty (60) calendar days
of the appeal request. Written notification of the determination will be provided to the Member or the
Member’s designee (and the health care provider if he/she requested the review) within two (2) business
days after the determination is made, but no later than sixty (60) calendar days
after receipt of the appeal request. Failure of CRHP to make a determination within sixty (60)
days of receipt of the appeal request shall be deemed to be a reversal of the adverse
determination.

3.7.1. Written Notice of Adverse Determination to an Internal Appeal

All adverse determinations of internal appeals are communicated in writing to the
Member (or Member’s designee) and provider. The adverse determination letter
contains the following information, as applicable to the case:

a. The name and CRHP ID number of the Member, and the coverage type;
b. A statement of the reviewer's understanding of the pertinent facts of the Member's appeal;

c. The titles and qualifications of the individuals who participated in the appeal review, including consultants;

d. A clear explanation of the clinical rationale for the denial, including a description or reference to the documentation used as the basis for the decision, and the reviewer's consideration of Member-specific clinical information;

e. When citing the Clinical Guidelines or Medical Policy, the guideline or section of the policy which applies to the denial is cited. A copy of the citation may be sent with the letter when appropriate to the issue;

f. Instructions for requesting a written statement of the clinical rationale and a copy of the criteria used to make the decision, as applicable to the issue (if not attached to the letter);

g. A description of the denied healthcare service including, as appropriate, the dates of service and the name of the facility and/or provider requesting to provide the service, and developer/manufacturer of service, and the claim amount (if applicable);

h. A clear statement that the notice constitutes the final adverse determination;

i. The signature of CRHP's Chief Medical Officer;

j. The name and telephone number of CRHP's contact person;

k. The name and address of the utilization review agency, contact person and telephone number

l. A statement that the Member may be eligible to request an external appeal and the time frames for requesting such an appeal (explanation of the external appeal process and copy of an external appeal application are included with the adverse determination of appeal letter); and

m. A statement of ERISA rights, if applicable.

3.8. External Appeal

A Member has the right to an external appeal of a final adverse determination by CRHP (CRHP only provides one level of internal appeal). A Member, the Member's designated representative, and, in connection with a retrospective adverse determination, a Member's health care provider has the right to request an external appeal when:

a. The Member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract, denied on appeal, in whole or in part, on the basis that such health care service is not medically necessary; and

b. CRHP has rendered a final adverse determination with respect to such health care service or both CRHP and the Member have jointly agreed to waive any internal appeal;

OR
a. The Member has had coverage of a health care service denied on the basis that the service is experimental and/or investigational, and the denial has been upheld on appeal, or both CRHP and the Member have jointly agreed to waive any internal appeal, and

b. The Member’s attending physician has certified that the Member has a life-threatening or disabling condition or disease for which
   i. standard health services or procedures have been ineffective or would be medically inappropriate; or
   ii. there does not exist a more beneficial standard health service or procedure covered by CRHP; or
   iii. there exists a clinical trial; and
   iv. The Member’s attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the Member’s life-threatening or disabling condition or disease, must have recommended either;
      1. a health service or procedure (including a pharmaceutical product as defined by PHL 4900(5)(b)(B)) that, based on two documents from the available medical and scientific evidence is likely to be more clinically beneficial to the Member and for which the adverse risk of the requested service would not likely be substantially increased over any standard health service or procedure covered by CRHP, or
      2. a clinical trial for which the Member is eligible.

Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his/her recommendation and the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for CRHP’s determination that the health service or procedure is experimental and/or investigational.

With respect to the clinical trials referenced in Section b (iii) above, the clinical trial for which the provider is requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

a. the National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;
b. an entity that has been identified by the NIH as a qualified non-governmental research entity; or
c. an Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

In order for a Member to be eligible for an external appeal related to a rare disease where that term is defined as a condition or disease that:

a. is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or
b. affects less than 200,000 United States residents per year; and

c. for which there does not exist a standard health service or procedure covered by the Member’s health benefits plan that is more clinically beneficial than the requested health service or treatment;

A certifying physician (defined as a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat the rare disease), other than the Member’s treating physician, must certify in writing that the Member has a rare disease as defined above, and based on the physician’s credible experience, there is no standard treatment that is likely to be clinically more beneficial to the Member than the requested health service or procedure; the requested health service or procedure is likely to benefit the Member in the treatment of his/her Rare Disease; and that such benefit outweighs the risks of such health service or procedure. Further, the certifying physician must disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of a denial of the rare disease treatment.

A Member has four (4) months from the time the notice of the final adverse determination from the internal appeal is received from CRHP to file the external appeal application.

A Member and/or the Member’s healthcare provider may request an expedited external appeal only if the appeal concerns:

a. an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized; or

b. the Member’s healthcare provider must attest that the patient has not received the treatment and a thirty (30) day timeframe would seriously jeopardize the patient’s life, health, or ability to regain maximum function; or

c. a service for which a delay would pose an imminent or serious threat to the patient’s health.

The Member may request an expedited internal and external appeal at the same time. Once an external appeal is expedited, any necessary information that is absent will immediately be requested from the Member and provider via both written communication and telephone. Even if all information is not received, a decision will be made within seventy-two (72) hours.

Providers may request an external appeal on their own behalf to obtain payment when CRHP makes a concurrent or retrospective adverse determination denying health care services as not medically necessary, experimental and/or investigational, a clinical trial or a rare disease treatment.

To request an external appeal, the Member or provider must complete the New York State External Appeal Application. You may obtain an external appeal application from the New York State Insurance Department at 1-800-400-8882, or its website health.state.ny.us, or by calling CRHP at 1-844-638-6507. If the provider requests the application from CRHP, CRHP will send the application form to the provider within three (3) business days of receipt of the request. The application will instruct the provider where to send the external appeal.
The Member must release all pertinent medical information concerning his/her medical condition and request for services.

Providers appealing on their own behalf must request an external appeal within forty-five (45) days of the final adverse determination. CRHP may charge the health care provider a fee of up to $50.00 dollars per external appeal. In the event the external appeal agent overturns the final adverse determination of CRHP, the fee shall be refunded to the provider.

CRHP may charge the Member a fee of up to $25.00 per external appeal provided that, in the event the external appeal agent overturns the final adverse determination of CRHP, such fee shall be refunded to the Member. CRHP shall not require the Member to pay any such fee if the Member is a recipient of medical assistance or if the payment of such fee shall pose a hardship to the Member as determined by CRHP.

If the Member is covered by a self-insured employer, the Member is not eligible to submit an external appeal.

An independent external appeal agent approved by New York State will review the request to determine if the denied service is medically necessary and should be covered by CRHP. All external appeals are conducted by clinical peer reviewers.

The decision of the external appeal agent is final and binding on both the Member and CRHP. If the external appeal agent upholds the adverse determination, CRHP will not cover the requested service. If the external appeal agent reverses the adverse determination, CRHP will cover the service in accordance with the terms of the Member’s health benefits contract.

For standard appeals, the external appeal agent must make a decision within thirty (30) days of receiving the application for external appeal. Five (5) additional business days may be added if the agent needs additional information. If the agent determines that the information submitted is materially different from that considered by CRHP, CRHP will have three (3) additional business days to reconsider its decision. The Member will be notified within two business days of the agent’s decision.

For expedited appeals, the external appeal agent will make a decision within three (3) business days. The agent will make every reasonable effort to notify the Member and CRHP of the decision immediately by phone or fax. This will be followed immediately by a written notice.

3.9. Case Management Services

Crystal Run Health Plan will maintain a case management program that is an intensive, high touch approach focused on population management, community outreach, proven care management strategies, and person-centered, individualized care planning for the delivery and coordination of services and medical care. This model places value on the identification and achievement of optimal outcomes and the utilization of best practices. CRHP will provide case management services including coordination, oversight, data collection and analysis related to case management activities.
Features of these activities include the following:

- CRHP employs a member-centric, holistic and culturally sensitive approach to care management.
- All care management services will be provided by personnel that have expertise and experience in providing care management services to populations such as CRHP members.
- Where care management services exist in provider practices, CRHP care managers will work collaboratively and communicate regularly to avoid duplication of efforts.
- CRHP will provide case management (CM) services taking into account any communication barriers the member may have, including those related to language and/or disability.
- CRHP care management staff is specifically trained on:
  - coordinating with and leveraging medical, behavioral health, community-based and facility-based clinical, service and support providers,
  - providing information about accessing behavioral health and community-based and facility-based service and support providers
  - furnishing lists of community supports available and
  - assisting with accessing and coordinating wrap around services and non-covered services.

Members, providers and staff are periodically educated on the availability of the CM services and additional community resources in several ways, including:

- mailings, newsletters, website, member and provider orientations, member and provider services interactions, through case managers, and through physician to patient interactions.
- CRHP maintains a database of community and wrap around resources which is accessible to CRHP front line clinical staff.

CRHP identifies members for Case Management who have the potential for a life-threatening disease or illness. This may include the following conditions: cancer, transplant, and chronic pain.

Members who are pregnant, homeless, HIV positive, have chronic mental health or substance abuse conditions or cognitive disabilities or are in foster care are eligible for Care Management.

Members are identified for case management by:

- Health risk assessment responses
- Utilization reports, including but not limited to:
  - Inpatient and outpatient precertification
  - Pharmacy claims/authorizations
  - Claims history or high dollar reports
- Predictive modeling
- Referrals from:
• Medical Management Department Staff
• Any member of the ICT
• Members/Caregivers
• Discharge Planners/non-CRHP Care Managers
• Social Services Agencies
• New York State Department of Health new-enrollee medical and pharmacy claims data

Automatically due to:

• Eligibility category (ex., Foster Care, Developmental Disability)
• Disease/diagnosis
4. PHARMACY MANAGEMENT

4.1. Pharmacy Benefit Manager

CRHP is committed to providing Members with affordable access to prescription drugs. For those Members with prescription drug coverage, CRHP has partnered with MedImpact for the provision of pharmacy benefit management services. MedImpact offers the ability to minimize the impact of increased pharmacy spend, and, through Member education and wellness programs, as well as the use of generic substitutes, keep pharmacy costs lower than the national average.

For general inquiries or questions about pharmacy benefit authorizations, providers can call the Pharmacy Services at the phone number listed in Section 2.1.2 (Useful Telephone Numbers).

**Note:** Prescription drug benefits are an optional rider added onto a group health plan, and not all plans have prescription drug benefits. Products with prescription drug benefits will show the MedImpact logo on the Member CRHP ID card, or the Member will be able to produce a MedImpact ID card.

4.2. Three-Tier Drug CRHP

A three-tier prescription plan is a pharmacy benefit design that financially rewards patients for using generic and preferred drugs by requiring the patient to pay progressively higher copayments for preferred brand-name and non-preferred brand-name drugs.

Tiers are groups of drugs that fall within description and pricing groups:

- **Tier 1:** Tier 1 drugs are usually limited to generic drugs, the lowest cost drugs. Tier 1 drugs cost the least and are associated with the lowest co-pays or coinsurance.
- **Tier 2:** Tier 2 is usually comprised of brand name drugs or more expensive generics. Tier 2 drugs provide a middle-value copay or coinsurance.
- **Tier 3:** The more expensive brand name drugs, are also considered non-preferred. Tier 3 drugs will cost more than the lower tiers and are usually associated with the highest copay or coinsurance.

The three-tier prescription benefit focuses on cost-sharing. Members using Tier 3 drugs will be responsible for the highest out-of-pocket expenses.

4.3. Open and Closed Formulary Programs

A drug formulary or preferred drug list is a continually updated list of medications and related products supported by current evidence-based medicine, judgment of physicians, pharmacists and other experts in the diagnosis, treatment of disease and preservation of health. The primary purpose of the formulary is to encourage the use of safe, effective and most affordable medications. There are two basic formulary types:
Open Formulary
The payer generally provides coverage for all formulary and non-formulary drugs. The payers include the health plan, the employer, or the pharmacy benefit management company acting on behalf of CRHP or the employer. However, some drug classes such as those for cosmetic use or over-the-counter drugs may be excluded from coverage by plan design. Providers are encouraged to prescribe formulary agents. Members may or may not incur additional out of pocket expenses for using non-formulary drugs.

Closed Formulary
Non-formulary drugs are not reimbursed by the payer. Formulary exception policies allow Members and providers reimbursement and access to non-formulary medications where medically appropriate.

The list of drugs on the formulary is subject to change. Up to date information can be obtained via the Provider Portal or by calling Pharmacy Services at the phone Medical Management listed in Section 2.1.2 (Useful Telephone Medical Managements).

4.4. Prior Authorization of Prescription Medications
CRHP requires prior authorization for coverage of certain prescription medications. The list of drugs requiring prior authorization is subject to change. Up to date information can be obtained via the Provider Portal or by calling Pharmacy Services at the phone Medical Management listed in Section 2.1.2 (Useful Telephone Medical Managements).

To obtain prior authorization, providers should call the Pharmacy Services phone Medical Management listed in Section 2.1.2 (Useful Telephone Medical Managements).

4.5. Step Therapy Program
The Step Therapy Program promotes the use of clinically sound generics and cost-effective therapeutic alternatives in select therapeutic classes. The program provides recommendations for prescribing first-line medications. The program applies to Members with prescription drug benefits that include prior authorization requirements.

The program requires prior authorization for certain drugs within select categories. The Step Therapy Program applies to Members who have not had a trial of the recommended generic or lower-cost drug within the last year. Providers may contact the Pharmacy Services department at the phone Medical Management listed in Section 2.1.2 (Useful Phone Medical Managements) with any questions.

4.6. Drug Utilization Review
Drug Utilization Review (DUR) is an authorized, structured, ongoing review of health care provider prescribing, pharmacist dispensing, and patient use of medication. There are three forms of DUR: prospective (before dispensing), concurrent (at the time of prescription dispensing), and retrospective (after the therapy has been completed). Appropriate use of an
integrated DUR program can curb drug misuse and abuse and monitor quality of care. DUR can reduce hospitalization and other costs related to inappropriate drug use.

The following is a partial listing of the Drug Utilization Review (DUR) concurrent edits performed by its integrated system at the time the prescription is filled at the retail pharmacy or at the mail order pharmacy:

- Drug/Drug Duplicate
- Refill Too Soon
- Drug to Drug Interactions
- Drug to Allergy Interactions
- Drug to Age interactions
- Drug to Gender
- Drug to Disease
- Over Utilization
- Fraud

To promote safe and cost-effective drug prescribing, the system supports over 300 edits and the entire spectrum of NCPDP concurrent DUR options is administered. The same edits are performed on all claims whether they are dispensed from a retail location or its mail order facility.

The following is a partial list of data elements that are captured and reviewed for retrospective DUR:

- NDC Medical Management
- Dispensing Date
- Quantity
- Days’ Supply
- Pharmacy ID
- Physician ID
- Ingredient Cost
- Member Co-payments

4.7. Specialty Pharmacy

Specialty drugs are Medications generally prescribed for people with complex or ongoing medical conditions such as multiple sclerosis, hemophilia, hepatitis, and rheumatoid arthritis. These medications also typically have one or more of the following characteristics: injected or infused, but some may be taken by mouth; unique storage or shipment requirements;
additional education and support required from a health care professional; usually not stocked at retail pharmacies.

As specialty drugs consume a greater portion of prescription plan costs, MedImpact has implemented several programs to reduce wasteful spending, promote clinically appropriate and cost effective therapies, increase safety through clinical review of dosing and drug selection and determine the most cost effective channel for drug fulfillment. The clinical intervention programs are coordinated by a Clinical Pharmacist who will contact the prescribing provider to review the proper label use, dosing and drug selection. The most cost effective method of delivery is determined; whether the method is through the specialty pharmacy, home delivery of retail pharmacy venues.

The list of specialty drugs is subject to change, and prior authorization requirements for drugs apply. Up to date information can be obtained via the Provider Portal or by calling Pharmacy Services at the phone Medical Management listed in Section 2.1.2 (Useful Telephone Medical Managements).
5. **BEHAVIORAL HEALTH SERVICES**

5.1. **Behavioral Health Services**

Behavioral Health services will be provided by certified clinical staff as well as paraprofessional associates that are available for assistance by contacting Beacon Health Options at 1-800-872-0727.

All adverse determinations regarding requests for behavioral health services are reviewed and made by the Medical Director for Behavioral Health, a licensed professional, in consultation with the Member’s provider(s).

5.2. **Behavioral Health Referrals**

5.2.1. **Who May Refer**

5.2.1.1. **Member Self-Referral (Medicaid Only)**

A. Members who receive benefits through CRHP’s Medicaid Program may self-refer to a participating CRHP behavioral health provider for one mental health and one substance abuse assessment within a twelve (12) month period. At enrollment, all Members receiving benefits through CRHP’s Medicaid Program are informed of their right to self-refer for these benefits, and are provided with information regarding participating behavioral health providers.

B. Providers are required to contact CRHP in order to verify that the Member has not used all of their self-referral benefits for the current twelve (12) month period.

C. Except in the case of an emergency or valid self-referral by a Member receiving benefits through CRHP’s Medicaid Program, all behavioral health services require prior authorization by Beacon Health Options.

5.2.1.2. **Provider or Member Contact CRHP (Medicaid and CHP)**

A. Members may contact CRHP directly in order to obtain a referral(s) from the Behavioral Health Department.

B. Behavioral health providers must contact Beacon Health Options in order to obtain prior authorization for elective (non-emergent) Member care. In emergency situations, the provider should treat the Member and subsequently notify Beacon Health Options as soon as possible, and not later than 48 hours, or the next business day, after evaluation/treatment of the Member and stabilization of acute symptoms.
5.3. **Prior Authorization Required**

All behavioral health covered services that are elective (non-emergent) in nature, except those Member self-referral services outlined above. Failure to obtain prior authorization may result in denial of coverage and non-payment for services rendered. Behavioral health services requiring prior authorization include:

A. Initial evaluation and treatment;
B. Medically necessary continued treatment;
C. Services or visits beyond those currently authorized;
D. Any change in the level of care;
E. Referral to another provider;
F. Referral for psychological or neuropsychological testing;
G. Referral for electro-convulsive therapy (ECT).

5.4. **Types of Behavioral Health Referrals and Services**

5.4.1. **Routine Referral and Services**

Routine referral and services include those situations in which the Member is not in imminent danger or further deterioration, which may result in crisis if the Member is not seen. In these situations, the provider must call the Beacon Health Options to request a prior authorization before rendering any service. Participating behavioral health providers are expected to schedule an initial evaluation appointment with the Member within two weeks of the Member’s initial contact.

5.4.2. **Urgent Referral and Services**

Urgent referral and services include those situations in which the Member has experienced significant deterioration and/or stressors exist contributing to the Member’s inability to cope wherein, unless the Member receives support or intervention within a few days, further deterioration or crisis is likely to occur. All initial chemical dependency contacts are considered urgent. In these situations, the provider must call the Beacon Health Options to request a prior authorization before rendering any service. Participating behavioral health providers are expected to provide face-to-face intervention within twenty-four (24) hours of the Member’s request for care.

5.4.3. **Emergent Referral and Services**

Emergent referral and services include those situations in which clear and present danger exists for the Member, another person, or the environment if immediate intervention does not occur. In these situations, no authorization or referral is required. Providers must call within 48 hours of the initial service to initiate the review process for authorization for additional non-emergent services. Participating
behavioral health providers are expected to provide face-to-face intervention within ninety (90) minutes of the initial Member contact. In rural areas where such timeframe may not be feasible, local police, sheriffs, crisis intervention services or ambulance services may be necessary in order that the Member can be safely transported to a clinician for evaluation within a reasonable timeframe given the circumstances.

5.5. Coordination of Care and Case Management

CRHP believes that effective working relationships between treating providers, including the Member’s PCP, and treatment sites results in improved continuity and coordination of care, increased quality of care received, efficiency and effectiveness of delivered services, and increased Member satisfaction. All treating providers involved in the delivery of behavioral health and related services should document collaborative efforts in the Member’s medical record.

Behavioral health providers are encouraged to communicate with the Member’s PCP:

A. For the exchange of clinical information, when necessary, that may assist in diagnosis and treatment;
B. When the PCP’s support for a treatment plan would enhance Member satisfaction and compliance;
C. When there are possible medical co-morbidities and/or medication interactions that need to be considered; and
D. When the Member’s PCP has requested communication.
5.6. Behavioral Health Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medicaid</th>
<th>Child Health Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Mental Health</strong></td>
<td>Unlimited benefit that is authorized based on medical necessity. Visits authorized for a mental health condition. In addition, members are allowed one self-referred visit to an in-network Beacon Health Options participating provider within a twelve (12) month period. SSI enrollees receive all mental health services through FFS.</td>
<td>CRHP Members have an unlimited benefit based on medical necessity. Visits are authorized for a mental health condition.</td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse</strong></td>
<td>All outpatient substance abuse services are covered by FFS.</td>
<td>CHP Members have an unlimited benefit based on medical necessity. Visits are authorized for a substance abuse condition.</td>
</tr>
<tr>
<td><strong>Inpatient Mental Health and Chemical Dependence (Substance Abuse) Combined</strong></td>
<td>All medically necessary inpatient days are covered. SSI enrollees receive all mental health services through FFS.</td>
<td>All medically necessary inpatient days are covered.</td>
</tr>
<tr>
<td><strong>Inpatient Detoxification</strong></td>
<td>Covered for unlimited days in a general acute care hospital setting.</td>
<td>All medically necessary inpatient days are covered.</td>
</tr>
<tr>
<td><strong>Inpatient Chemical Dependency Rehabilitation</strong></td>
<td>Covered, based on medical necessity. SSI enrollees receive services through FFS.</td>
<td>All medically necessary short-term rehabilitation days are covered.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medicaid</td>
<td>Child Health Plus</td>
</tr>
<tr>
<td>--------------</td>
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<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Transportation</td>
<td>Services covered by FFS.</td>
<td>Emergent Ground transportation is covered under the Child Health Plus Program.</td>
</tr>
</tbody>
</table>
6. BILLING AND CLAIMS POLICIES AND PROCEDURES

CRHP pledges to provide accurate and efficient claims processing. To make this possible, CRHP requests that providers submit claims promptly and include all necessary data elements.

6.1. General Requirements for Claims Submission

In 1994, New York State enacted Public Health Law Section 2807-c(4), which required hospitals, outpatient clinics, and physicians to submit health care claims to third-party payers electronically, using electronic formats chosen by the New York State Department of Health. These formats have since been replaced by federally required formats; however, the requirement to submit electronically still exists. Physicians who annually submit fewer than 1,200 claims to third-party payers for direct payment are exempt from this requirement, but only upon obtaining a waiver from the Department of Health.

The federal Health Insurance Portability and Accountability Act (HIPAA) require all providers who submit claims electronically to do so using national HIPAA claims formats and standards.

6.1.1. New York State Clean Claim Submission Guidelines for CMS-1500

The New York State Department of Insurance has claim submission guidelines (Regulation No. 178, 11 NYCRR 230.1) that help interpret the prompt pay law. CRHP utilizes these guidelines in determining what constitutes a “clean” claim. The guidelines specify that:

- A health insurer cannot reject a claim submitted on a CMS-1500 form as incomplete if the claim contains accurate responses in specified fields, unless otherwise specified.
- In situations where one or more of the required fields is not appropriate to a specific claim, the submitter may leave the field blank.
- CRHP may request additional information if needed to determine liability or make payment.

6.1.2. Timely Filing of Claims

CRHP requires that participating providers submit and follow-up on claims in a timely manner. Claims should be submitted as soon as possible after rendering services (or after the processed date of a primary payer’s explanation of benefits). Timely filing limits for physician claims are set forth in the provider’s participating provider agreement with CRHP.

6.2. Electronic Claims

CRHP accepts electronic claims in data file transmissions. Electronic claim files sent directly to CRHP are permitted only in the standard HIPAA formats.
Providers who have existing relationships with clearinghouses such as *Emdeon* MD (CRHP Payer ID: 46120), NDC, and HDS can continue to transmit claims in the format produced by their billing software. These clearinghouses are then responsible for reformatting these claims to meet HIPAA standards and passing the claims on to CRHP.

Please note that for all EDI submissions, the NPI (National Provider Identifier) Medical Management is required, as well as the Member’s 11-digit identification Medical Management. When care is coordinated, the referring provider’s name and NPI or UPIN are also required.

### 6.3. Paper Claims

As stated in Section 6.1 (General Requirements for Claims Submission), providers who have not obtained a waiver must submit claims to CRHP electronically, using HIPAA claim formats and standards. In addition, the requirements related to the national provider identifier (NPI) apply to paper claims as well.

The following are important points to observe to ensure timely processing:

- Use original forms. Do not use photocopies;
- Do not use red ink to fill in data field or attachment information;
- Entries should be typed and dark enough to be legible;
- Forms should be properly aligned prior to printing to ensure information prints in the appropriate field;
- When submitting multi-page claims, ensure identifying information is present on each page (Provider ID, NPI, Patient Acct#, etc.);
- When including attachments, be sure to include appropriate identifying information such as the Provider ID, NPI, Patient Acct#, etc.; and
- Submit paper claims to the claims address specified in the Section 2.1.3 (CRHP Mailing Addresses).

### 6.4. Claims Processing

#### 6.4.1. NYS Prompt Payment Law

Under New York State prompt payment law, CRHP is required to decide, within thirty (30) calendar days after receipt of an electronic claim, whether to pay, deny, or require additional information. When a claim is submitted on paper, Crystal Run must deny the claim or request additional information within thirty (30) days of receipt of the claim or pay the claim within forty-five (45) days of receipt.

If CRHP pays a claim more than thirty (30) calendar days (electronic submission) or more than forty-five (45) calendar days (paper submission) after receiving it, CRHP will, in most cases, apply interest at the annual rate set by the Commissioner of Taxation. CRHP will make adjustments and/or pay interest when a claim was
incorrectly paid due to CRHP error, but only if the original claim was a “clean” claim.

6.5. Claims Payment

CRHP pays participating providers for covered services provided to its Members based on the fee schedule set forth in the provider’s participation agreement. CRHP will deduct copayments, coinsurance, and deductibles from the amount paid to the provider, as applicable.

CRHP will issue its providers a “remittance advice,” which is a summary of claims submitted. It shows the date of service, diagnosis, and procedure performed as well as all payment information (i.e., money applied to the Member’s deductible or copayment, and denied services.) In the event that a Member submits a claim, the Member will receive an Explanation of Benefits (EOB) in accordance with requirements of the New York Insurance Law.

In the event of an erroneous payment or overpayment by CRHP, providers may return CRHP’s check or write a separate check from their account for the full amount paid in error. Providers should include a copy of the remittance advice, supporting documentation noting the reason for the refund, and any EOBs from other insurance carriers, if applicable. If CRHP has paid in error and the provider has not returned the payment, money will be deducted from future claims paid. The related claim information will be shown on the remittance advice as a negative amount. The address for refunds can be found in Section 2.1.3. (CRHP Mailing Addresses).

Participating providers may not bill CRHP Members for services covered by CRHP, or the difference between the contracted rate and provider charges. Members are responsible for payment of applicable copays, co-insurance and/or permitted deductibles.

Should a provider perform a service that is not covered by CRHP, the provider is required to advise the Member that the service is not covered and state the cost of the service.

6.6. Claims Payments Reconsiderations

If a provider disagrees with CRHP’s processing/payment of a claim, the provider may contact Provider Services to request that the claim be investigated. If the provider is not satisfied with the outcome, the claim may then be submitted for review through CRHP’s appeal process.

6.7. Encounter Data

Providers are required to submit encounter data per the MED2 encounter submission requirements for the following MEDICAID capitated services:

- Behavioral health
- Dental
- Vision
• Laboratory

Please note the encounter submissions pertain to Medicaid services only at this time.

6.8. **Surprise Bills**

Effective March 31, 2015, NYS enacted a new law designed to protect consumers and members of health plans from surprise bills when services are performed by a non-participating (out-of-network) provider at a participating Crystal Run Health Plan (CRHP) hospital or ambulatory surgical center or when a participating CRHP provider refers a member to a non-participating provider. In addition to surprise bills, the law also protects members from bills related to the receipt of emergency services.

CRHP will reimburse all Surprise Bills & Emergency Services according to the respective policy that can be found on our provider portal at [www.crystalrunhp.com](http://www.crystalrunhp.com). CRHP has established a process to identify surprise bills in our claims system but in the event that a member receives one, please submit them to us for payment. Instructions on how to do this, can be found on our provider and member portals.

A CRHP Provider Relations Representative is available to assist you with any questions or concerns you may have regarding Surprise Bills. They can be reached at 845-725-0117. For additional information on Surprise Bills, please visit the New York State Department of Financial Services website at [http://www.dfs.ny.gov/consumer/hprotection.htm](http://www.dfs.ny.gov/consumer/hprotection.htm).
7. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

7.1. Overview of Quality Assessment and Performance Improvement

The Quality Management Program (QMP) functions as an integrated activity within CRHP. The QMP Program provides a mechanism to oversee and coordinate the quality management and improvement of all aspects of CRHP’s health care delivery system and administrative services. All departments participate in the QMP Program. The QMP Program is reviewed and revised on an annual basis in order to remain responsive to the changing requirements of CRHP’s Membership and the health care service delivery environment. All network providers are required to participate in the QMP Program.

Members are afforded the opportunity to participate in CRHP quality activities through satisfaction surveys, telephone contact with Member Services representatives, and the filing of complaints and grievances.

Oversight of the QMP Program is the responsibility of the QMP Committee. It is comprised of network primary care and specialty care providers and ancillary providers, the Chief Medical Officer, CRHP’s Medical Director(s), the Operations Manager, the Director of Medical Management, and the Manager of Quality.

QMP Program activities have been divided into four categories:

1. Population Health and Wellness
2. Clinical Quality
3. Network Quality
4. Service Quality

7.2. Population Health and Wellness

The aim of the population health and wellness activities is to keep Members and providers informed about scientifically based, nationally recognized preventive health care guidelines and to facilitate the receipt of services based upon those guidelines. On a biennial basis, the QMC Committee reviews prenatal, pediatric, adolescent, and adult guidelines with input from participating providers. The QMC Committee utilizes multiple nationally recognized sources including, but not limited to, the:

- American Academy of Family Physicians
- American Academy of Pediatrics
- American Cancer Society
- American College of OB/GYN
- Centers for Disease Control and Prevention
- New York State Child/Teen Health Program
- United States Preventive Services Task Force
Preventive health guidelines are disseminated using various methods of communication to both providers and Members for educational and quality improvement purposes. Members may also access general health information through other health plan resources that encourage wellness, including health coaching, nurse triage and health information lines.

Programs that support Population Health and Wellness include:

- family planning and reproductive care
- prenatal and maternity care
- focused screening program for high risk mothers and newborns
- pediatric immunizations and child well care
- screening for breast, cervical and colon cancer
- smoking cessation support
- nutrition and healthy eating
- weight reduction
- stress reduction

Disease Management programs for Members with chronic illnesses and programs to facilitate coordination and continuity of care are also part of CRHP’s population health activities. Quality indicators are monitored against standards and goals, and opportunities for improvement are pursued.

7.3. Clinical Quality

Clinical quality activities focus on improving the quality of clinical services provided to Members. This is accomplished by reviewing, adopting and disseminating scientifically based, nationally recognized clinical care guidelines to CRHP network providers. CRHP tracks and trends compliance with clinical guidelines and shares those findings with the provider network.

CRHP monitors and evaluates medical care provided for the management of acute and chronic conditions. CRHP assists those with high prevalence chronic conditions to improve their health status and ability to self-manage.

Activities that support the clinical quality activities include:

- disease management for high prevalence chronic conditions (asthma, chronic obstructive pulmonary disease, coronary artery disease, heart failure and diabetes mellitus)
- case management services for Members with high intensity medical and ancillary service needs (see Section 3.8 “Case Management Services”)
- predictive modeling using a proprietary algorithm
- depression screening
- tracking and trending of
  - acute hospitalizations for asthma, diabetic ketoacidosis
o acute hospitalization after ambulatory surgery
o complications after inpatient surgery
o hospital readmission rates, including those for alcohol and/or substance abuse and repeat detoxification
o hospital follow-up after major affective disorder
o use of emergency room for non-emergent conditions

7.3.1. Medical Record Review

Quality Assurance staff will undertake periodic and ad hoc medical record review and will grade providers on the quality of their medical record development and maintenance. Medical records are either reviewed at the provider’s office or copies of the requested medical records are sent to CRHP and reviewed at CRHP’s offices.

Each medical record is reviewed for the following items:

o Each patient has a unique medical record and record identification Management;  
o Patient name and ID Medical Management on each page;  
o There is a personal/biographical database that includes patient’s address, home and daytime; telephone Medical Managements, emergency contact person, and parent or guardian if patient is a minor;  
o There is a complete and updated problem list;  
o Medication allergies and adverse reactions are prominently noted;  
o There is a completed growth chart for children under 14 years of age;  
o There is a completed immunization record for all children 18 and under;  
o For patients 14 and over, there is notation concerning use of tobacco, alcohol and controlled substances;  
o All entries are dated, legible, signed and in sequence by date;  
o There is a complete history (medical and social) and physical examination in the chart;  
o Each entry includes patient complaint with relevant history, physical findings, assessment/diagnosis and treatment plan;  
o There is a plan for return visits or other follow-up after each visit; and  
o Results of laboratory data, diagnostic tests, consult reports, etc. are filed in an orderly manner.

Medical records must be retained by providers for a minimum Management of six (6) years after last date of service, or until three (3) years after the patient reaches majority age, whichever is later. Medical records must be available to CRHP at all times, and to the Department of Health, the LDSS and CMS, upon request.
For the provision of prenatal care and related services, medical records must be centralized.

The Quality Management Department prepares a report for each provider that has undergone an audit. If practice-specific documentation problems are identified, the providers in that practice must prepare and implement a corrective action plan. A repeat medical record review will be conducted after six months to verify that the corrective action plan was successful in correcting the documentation deficiencies. In addition, a CRHP-wide analysis of medical record documentation is presented to the QMP Committee each year.

7.3.2. HIV Counseling, Testing and Treatment of HIV Positive Members

7.3.2.1. Routine Testing

Healthcare providers are expected to offer HIV testing to all patients in accordance with New York Public Health law. The key provisions of the law are as follows:

a. HIV testing must be offered to all persons between the ages of 13 and 64 receiving hospital or primary care services with limited exceptions noted in the law. The offering must be made to inpatients, persons seeking services in emergency departments, persons receiving primary care as an outpatient at a clinic or from a physician, physician assistant, nurse practitioner or midwife.

b. Written consent for HIV testing is not required.

c. Consent for HIV testing may be part of a general consent to medical care, though specific opt out language for HIV testing must be included.

d. Consent for rapid HIV testing can be oral and noted in the medical record.

e. Prior to being asked to consent to HIV testing, patients must be provided information about HIV required by the Public Health Law.

f. Health care and other HIV test providers authorizing HIV testing must arrange, with the consent of the patient, an appointment for medical care for those confirmed as positive.

g. HIV test requisition forms submitted to laboratories will be simplified and no longer require provider certification of informed consent having been obtained.

h. Deceased, comatose or persons otherwise incapable of providing consent, and who are the source of an occupational exposure, may now be tested for HIV in certain circumstances anonymously without consent.

i. Release of HIV related medical information requires written consent from the member.
7.3.2.2. Testing Pregnant Women

Healthcare providers must provide HIV information and recommend HIV testing, preferably at the first prenatal visit, for all women who present for care in any care setting.

Additionally, providers should routinely recommend repeat testing in the third trimester, preferably between 34 and 36 weeks, for all women who test negative for HIV early in pregnancy. Repeat testing is strongly recommended for women who have continued high-risk behaviors during pregnancy or who acquire any other sexually transmitted infections during pregnancy.

Providers should offer testing during labor and delivery for any woman who does not have documented third trimester HIV test results.

7.3.2.3. Reporting Requirements

All initial determinations or diagnoses of HIV infection, HIV-related illness and AIDS must be reported to the NY Department of Health by physicians and other persons authorized to order diagnostic tests or make medical diagnoses as soon as possible after post-test counseling but no later than fourteen (14) days after the provider’s receipt of a positive laboratory result or after diagnosis, whichever is sooner.

Reports, including names and addresses of the protected individual, contact information and other information as may be specified by the DOH, shall be made in a manner and format as prescribed by the NY Department of Health. Information reported shall also include names and addresses, if available, of contacts, including spouses, known to the physician or other person authorized to order diagnostic tests or make medical diagnoses, or provided to them by the protected person, the date each contact was notified if contact notification has already been done; and information, in relation to each reported contact, required by an approved domestic violence screening protocol. After receiving the report, the Commissioner of Health or his/her authorized representative may request the individual making the report or the person who ordered the diagnostic tests to provide additional information as may be required for the epidemiologic investigation, case finding and analysis of HIV infection, HIV-related illness and AIDS and to implement Article 21, Title III. Notwithstanding this subdivision, test results from New York State-approved anonymous test sites shall not be reported unless the test subject chooses to supply identification and convert the anonymous tests result to a confidential test result.

7.3.2.4. Counseling of HIV Positive Members

With respect to positive and indeterminate/inconclusive results, the provider
who ordered the HIV test is responsible for ensuring post-test counseling, referral and linkage to care as appropriate. Post-test counseling shall address:

a. Strategies for coping emotionally with the test results;

b. Discrimination issues relating to employment, housing, public accommodations, health care and social services;

c. The importance of taking precautions to prevent HIV transmission to others;

d. The ability to release or revoke the release of confidential HIV-related information;

e. HIV reporting requirements for the purposes of epidemiologic monitoring of the HIV/AIDS epidemic;

f. The importance of contacts being notified to prevent transmission, and allowing early access of exposed persons to HIV testing, health care, and prevention services, and a description of notification options and assistance available to the protected individual;

g. An assessment of the risk of domestic violence in conformance with a domestic violence screening protocol developed by the commissioner pursuant to law;

h. The requirement that known contacts, including a known spouse, will be reported and that protected persons will also be requested to cooperate in contact notification efforts of known contacts and may name additional contacts they wish to have notified with the assistance of the provider or authorized public health officials;

i. Non-disclosure of the protected individual's name or other information about them during the contact notification process;

j. The provider's responsibility for making an appointment for newly diagnosed persons to receive follow-up HIV medical care;

k. The availability of medical services and the location and telephone Medical Managements of treatment sites, information on the use of HIV chemotherapeutics for prophylaxis and treatment and peer group support, access to prevention, education and support services and assistance, if needed, in obtaining any of these services; and

l. Prevention of perinatal transmission.

7.4. Network Quality

The aim of Network Quality activities is to assure that quality providers are serving CRHP Members and performing services in a professional and culturally sensitive manner. The Quality Assurance Department conducts a variety of activities in this regard.

7.4.1. Credentialing and Re-Credentialing

Licensed professional health care providers are required to undergo credentialing
before they can become participating providers in the CRHP network. Every three (3) years, each credentialed provider must be re-credentialed to assure ongoing compliance with credentialing requirements (for greater detail, see Section 2.2 (Credentialing and Re-Credentialing)).

### 7.4.2. Medical Records Documentation Audit

Medical record reviews are conducted for primary care providers (internal medicine, family practice and pediatrics), OB/GYN physicians and other high-volume specialists annually. The reviewers evaluate providers’ compliance with documentation requirements as well as quality of care issues such as continuity of care, adherence to clinical and preventive guidelines, Member access and patterns of over and under-utilization.

### 7.4.3. Monitoring Access and Availability

CRHP performs periodic geo-access surveys to assure that there is an appropriate geographic distribution of primary care providers and specialists within the service area.

Providers are contractually required to maintain 24-hour availability by telephone and maintain reasonable appointment availability standards for office visits, as follows:

- Adult base-line and routine physicals exam within twelve (12) weeks from enrollment
- Specialist referrals (non-urgent) within 4-6 weeks
- Prenatal care initial visit
- 1st trimester – within three (3) weeks
- 2nd trimester – within two (2) weeks
- 3rd trimester – within one (1) week
- Initial family planning visit within two (2) weeks of request
- Initial PCP office visit for newborns within two weeks of hospital discharge
- Well-child and other routine pediatric visits within four (4) weeks
- Routine adult visit within four (4) weeks
- non-urgent sick visit within 48-72 hours, as clinically indicated
- urgent medical care within 24 hours
- emergency coverage 24 hours per day, seven (7) days a week (physician response to after-hours call within 30 minutes)
- Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a participating provider with five (5) days of request, or as clinically indicated
- Non-urgent mental health or substance abuse visits with a participating provider within two (2) weeks of request
Members with appointments must be seen within thirty (30) minutes of their scheduled appointment or arrival time, whichever is later. If a delay is unavoidable, the member should be informed and alternatives offered.

Members must have access to a live voice for afterhours PCP and OB/GYN emergency consultation and care. If an answering machine is used, the message must direct Members to a phone Medical Management to call where they can reach a live voice.

On a quarterly basis, CRHP monitors 24-hour telephone availability utilizing random telephone calls to providers and provider access surveys. Quality Assurance staff will make four after-hour calls in an attempt to reach a provider and will record the Medical Management of rings before the answering service responds and the time for the physician to call back.

On a quarterly basis, the Quality Management staff will conduct an appointment availability survey of randomly selected major delivery sites. Over the course of a year, all major delivery sites will be surveyed. The survey is designed to ascertain the time it takes to get an appointment of varying types relative to the standards noted above. Information supplied by the providers will be validated by a random review of the office scheduling system or appointment logs. The Manager of Quality Management will review, analyze and report on the appointment availability surveys to the QMP Committee with recommendations for corrective actions, if warranted.

The QMP Committee will review the findings and recommendations of the Manager of Quality Assurance and recommendations for corrective actions. In addition, the QMP Committee will monitor the implementation and outcomes of any recommended corrective action plans.

### 7.4.4. Continuity and Coordination of Care

CRHP in collaboration with the patient centered medical home designated practices of Crystal Run Health Care will maintain nurse case managers in the offices of participating providers to perform high risk case management with patients. These nurses coordinate home services when necessary, conduct medication reconciliation and coordinate specialist visits. A hospital-based nurse case manager coordinates transitions from hospital to home or other appropriate setting. A care team, led by a nurse provider, provides post-hospital visits to individuals unable to come to the physician’s office.

### 7.4.5. Cultural Competency

CRHP is committed to assuring that all Members, providers and employees are treated with dignity and respect concerning their values, culture, class, race, age, sexual orientation, ethnic background and religion. CRHP values the cultural diversity of its Members and recognizes the impact it has on the care and service delivered. All CRHP employees participate in cultural diversity training when hired and annually thereafter.
The Quality Management Department supports interventions that improve the effectiveness of Member/provider health care encounters where values and/or language may adversely affect the outcome of the encounter. Such interventions may include providing translation services for Members, cultural diversity and sensitivity training for CRHP employees and the provider network.

7.4.6. Patient Safety

CRHP endeavors to create an environment that encourages and facilitates patient safety. The QMP Program is a key component in those efforts through its monitoring of hospital-based sentinel events (nosocomial infections, falls, pressure ulcers, surgical complications, medication errors, and hospital readmissions), skilled nursing facility sentinel events, drug utilization review, office site visits, medical records review, and access and availability. In addition, the distribution of clinical practice guidelines raises Member awareness and knowledge of safe and appropriate medical practices. CRHP encourages collaborative initiatives with network providers, hospitals and ambulatory surgery facilities in addressing patient safety issues.

7.5. Service Quality

The aim of the service quality activities is to improve the services provided to Members by participating providers and by CRHP, and to improve administrative services provided by CRHP to participating providers.

7.5.1. Satisfaction Surveys

Member satisfaction is evaluated on an annual basis utilizing a survey instrument (CAHPS) that assesses Member satisfaction with care and service. Member complaints, grievances and disenrollment data are tracked and trended yearly. This information is reviewed, analyzed and incorporated into a report that is presented to the QMP Committee. The report's findings assist the Committee's identification of opportunities for improvement. Prioritized interventions are included in the Annual Quality Improvement Work CRHP.

Provider satisfaction is monitored on an annual basis utilizing a survey instrument. This information is reported to the QMP Committee and utilized in development of the Annual Quality Management Work Plan.

7.5.2. Complaints and Grievances

CRHP maintains a robust process to investigate and respond expeditiously to Member and provider complaints and Member grievances. In addition to resolving individual complaints and grievances, CRHP tracks and trends these items to identify quality of care and quality of service issues that represent opportunities for system process improvement. No discriminatory action will be taken against a Member or provider as a result of filing a complaint or grievance.
7.5.3. Utilization Management Surveillance

Utilization management guidelines are designed to assure that medically necessary services are provided in the appropriate setting and under medically indicated circumstances. Overzealous application of utilization management guidelines has the potential to prevent Members from obtaining medically indicated and necessary services. The QMP Program is designed to prevent under- and over-utilization from occurring by:

- Establishing a reporting system that monitors indications of inadequate service to Members;
- Implementing procedures governing Member benefits and corporate administrative decisions that are influenced by input from the Chief Medical Officer whose first responsibility is assuring quality, not controlling costs;
- Auditing clinical records for evidence of poor quality of care without respect to the Medical Management of visits or use of clinical services;
- Maintaining grievance procedures that safeguard against the potential dangers of inappropriate utilization controls;
- Monitoring patterns of provider practice to identify patterns of over- and under-utilization and implementing corrective action as appropriate;
- Reviewing adverse determinations of care, service or treatment to identify patterns associated with the provision of care; and
- Evaluating utilization review criteria and pre-authorization guidelines on an on-going basis.

7.6. Definitions

THIS SECTION APPLIES ONLY TO MEDICAID MANAGED CARE AND CHP. FOR COMMERCIAL LINES OF BUSINESS, SEE SECTION 3.

7.6.1. Action

“Action” means an activity of CRHP that results in:

a. the denial or limited authorization of a Service Authorization Request, including the type or level of service;

b. the reduction, suspension, or termination of a previously authorized service;

c. the denial, in whole or in part, of payment for a service;

d. failure to provide services in a timely manner as defined by CRHP’s appointment availability standards;

e. failure of the CRHP to act within the timeframes for resolution and
notification of determinations regarding Complaints, Action Appeals and Complaint Appeals;

f. in rural areas, as defined by 42 CFR §412.62(f)(a), where enrollment in the MMC program is mandatory and there is only one MCO, the denial of a Member’s request to obtain services outside the MCO’s network pursuant to 42 CFR §438.52(b)(2)(ii); or

g. the restriction of a Member to certain network providers under CRHP’s Recipient Restriction Program.

7.6.2. Action Appeal

“Action Appeal” means a request for a review of an Action.

7.6.3. Complaint

“Complaint” means a Member’s expression of dissatisfaction with any aspect of his or her care other than an Action. A “Complaint” means the same as a “grievance” as defined by 42 CFR §438.400 (b).

7.6.4. Complaint Appeal

“Complaint Appeal” means a request for a review of a Complaint determination.

7.6.5. Emergency Medical Condition

A medical or behavioral condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or

Serious impairment to such person's bodily functions;
Serious dysfunction of any bodily organ or part of such person; or
Serious disfigurement of such person.

Examples of medical conditions that the Plan considers to be Emergency Conditions are heart attacks, poisoning, multiple trauma and active labor. Situations where the member was directed to the Emergency Room by a participating provider are deemed Emergency Conditions.

Examples of conditions we do not ordinarily consider to be Emergency Conditions are head colds, flu, minor cuts and bruises, muscle strain and hemorrhoids.
7.6.6. **Emergency Services**

A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

“To stabilize” is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility, or to deliver a newborn child (including the placenta).

7.6.7. **Experimental and/or Investigational**

“Experimental and/or Investigational” means a medical service, procedure, device or treatment is considered experimental and/or investigational if one or more of the following criteria are met:

a. An approval from federal or other governmental body is required and that approval has not been granted, or does not have unrestricted market approval from the Food and Drug Administration (FDA), or final approval from any governmental regulatory body for use in treatment of a specified condition is not granted; or,

b. The medical service, procedure, device or treatment is under investigation in a properly-controlled Phase I-III clinical trial; or,

c. There is insufficient or inconclusive medical and scientific evidence to permit evaluation of therapeutic value and benefit to the Member; or,

d. There is inconclusive medical and scientific evidence in peer-reviewed medical literature that there is a beneficial effect on health outcomes; or,

e. Evidence suggests the medical service, procedure, device or treatment under consideration is not as beneficial as any established alternatives; or,

f. Reliable evidence shows that the prevailing opinion among experts regarding the medical service, procedure, device or treatment requires further study or clinical trials to determine the safety and efficacy as compared with standard means of treatment.

A medical service, procedure, device or treatment that is considered experimental and/or investigational is not a covered benefit.

7.6.8. **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, interfere with such person’s capacity for normal
activity, or threaten some significant handicap.

7.6.9. Post-Stabilization Care Services

“Post-stabilization Care Services” means covered services, related to an Emergency Medical Condition, that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under the circumstances to improve or resolve the Member's condition.

7.7. Program Requirements

7.7.1. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is Medicaid's comprehensive and preventive child health program for individuals under the age of 21 and is referred to as the Child Teen Health Program (C/THP). The C/THP is a package of early and periodic screens for children and adolescents under the age of 21. It includes early and periodic screening, including inter-periodic screening and, diagnosis and treatment services. Care and services must be provided in accordance with periodicity schedules and guidelines periodically developed and released by the New York State Department of Health. It requires that any medically necessary health care service listed at Section 1905(a) of the Social Security Act be provided to an EPSDT recipient, even if the service is not available to the rest of the Medicaid population under the state's Medicaid plan. The purpose is to correct or ameliorate defects, and physical and mental illnesses and conditions discovered through screening services.

7.7.1.1. Child Teen Health Program

New York State follows EPSDT guidelines through its Child Teen Health Program (C/THP), the services for which are included in the MMC and CHPlus prepaid benefit package for children and adolescents up to 21 years of age.

The following QARR measures are being utilized to measure CRHP compliance with the C/THP standards:

- Well Child Visit
- Lead Screening
- Well Child Visits for Children 3, 4, 5, or 6 Years of Age
- Well-Care Visits for the Adolescent and Young Adult (ages 12 to 21 years)
- Immunizations
- Use of Appropriate Medications for People with Asthma
• Annual Dental Visit
• Appropriate Treatment for Upper Respiratory Infection
• Appropriate Testing for Pharyngitis
• Adolescent Preventive Care Measures

7.7.2. Immunization

The Centers for Disease Control and Prevention (CDC) lists a schedule by age/age range when each vaccine or series of shots is recommended. Information about each vaccine, record sheets, and other printable vaccine information is available on the CDC’s website at www.cdc.gov/vaccines.

All providers administering vaccines to children under age 19 covered by one of CRHP’s Medicaid plans must participate in the New York Vaccine for Children (NYVFC) program. NYVFC provides the vaccines free of charge. For more information about VFC, which vaccines are available, and how to obtain vaccines, providers should contact VFC at (347) 396-2405.

7.7.3. Vision Care Services

7.7.3.1. Covered Services

Vision Care Services are provided through Block Vision. Medicaid Members may self-refer for vision services, but it is important to check eligibility prior to administering services because coverage can vary among the various government programs.

The contact phone Medical Managements for Block Vision can be found in Section 2.1.2 (Useful Telephone Medical Managements) in this Provider Manual.

7.7.4. Dental Services

Because Members of government programs do not need a referral or preauthorization to access dental care services, it is very important for providers who provide dental care services to check eligibility and benefits by calling Healthplex Dental’s Customer Service. Benefit limitations and other requirements can vary among the government programs. Member eligibility for covered services will be based on the information the provider supplies to Customer Service at the time of the call and on the Member’s current benefit history.

The contact phone Medical Managements for Healthplex Dental can be found in Section 2.1.2 (Useful Telephone Medical Managements) in this Provider Manual.
7.7.5. Prohibition on Member Payments

Providers participating in the New York State Medicaid Program and Medicaid Managed Care plans agree to accept payment as payment in full for services provided. Demanding or collecting any reimbursement in addition to claims made under the Medicaid program, except where permitted by law, is prohibited.

7.7.6. Medicaid Member Transportation

In the event of an emergency, if a Member requires transportation, call 911.

For non-emergent transportation for Medicaid Members, either the Member or provider may call Medical Answering Services (MAS), the Medicaid Program’s transportation manager.

- Orange County - 1-855-360-3543
- Sullivan County - 1-855-360-3542

If possible, the call to MAS to arrange transportation should be made at least three days prior to the medical appointment. When calling, have the following information ready:

- Member’s Medicaid ID Medical Management
- Appointment date and time
- Address where the appointment is scheduled

Non-emergency transportation includes personal vehicle, bus, taxi, ambulette, and public transportation.

7.7.7. Medicaid Managed Care Self-Refer Services

a) Mental Health and Chemical Dependence Services

CRHP Medicaid Managed Care Members are eligible to make a self-referral for one mental health assessment from a Participating Provider and one chemical dependence assessment from a Detoxification or Chemical Dependence Participating Provider in any calendar year period without requiring preauthorization or referral from the Member’s Primary Care Provider.

b) Vision Services

CRHP Medicaid Managed Care Members are eligible to self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for refractive vision services and, for Members diagnosed with diabetes, for an annual dilated eye (retinal) examination.
c) Diagnosis and Treatment of Tuberculosis

Medicaid Managed Care Members may self-refer to public health agency facilities for the diagnosis and/or treatment of TB.

d) Family Planning and Reproductive Health Services

Medicaid Managed Care Members may self-refer to family planning and reproductive health services.

e) Article 28 Clinics Operated by Academic Dental Centers

Medicaid Managed Care Members may self-refer to Article 28 clinics operated by academic dental centers to obtain covered dental services.

7.8. Member Complaints and Appeals

THIS SECTION APPLIES ONLY TO MEDICAID MANAGED CARE, and CHPLUS. FOR COMMERCIAL APPEALS, SEE SECTION 3.

CRHP will provide Members with any reasonable assistance in completing forms and other procedural steps for filing a Complaint, Complaint Appeal or Action Appeal, including, but not limited to, providing interpreter services, toll-free Medical Managements with TTY/TDD and interpreter capability. The Member may designate a representative to file Complaints, Complaint Appeals and Action Appeals on his/her behalf.

CRHP will not retaliate or take any discriminatory action against the Member because he/she filed a Complaint, Complaint Appeal or Action Appeal.

CRHP’s procedures for accepting Complaints, Complaint Appeals and Action Appeals include:

   a. toll-free telephone Medical Management;
   b. designated staff to receive calls;
   c. “live” phone coverage Monday through Friday from 8:30AM to 5:30PM; and
   d. a telephone system available to take calls and a plan to respond to all such calls no later than the next business day after the calls were recorded.

CRHP ensures that personnel making determinations regarding Complaints, Complaint Appeals and Action Appeals were not involved in previous levels of review or decision-making. If any of the following applies, determinations will be made by qualified clinical personnel:

   a. a denial Action Appeal based on lack of medical necessity;
   b. a Complaint regarding denial of expedited resolution of an Action Appeal; or
c. a Complaint, Complaint Appeal, or Action Appeal that involves clinical issues.

The Member may request to view their appeal file at any time during the appeal process. The Member may also present evidence to support their appeal in person or in writing.

### 7.8.1. Complaint/Grievance

The Member, or the Member’s designee, may file a Complaint regarding any dispute with CRHP orally or in writing. If the Complaint is related to an Action, the Member has ninety (90) calendar days from the date of the action to file a Complaint. Written Complaints may be submitted either by letter or CRHP supplied form. CRHP does not require a Member to file a Complaint in writing.

CRHP will provide written acknowledgment of any Complaint not immediately resolved, including the name, address and telephone Medical Management of the individual or department handling the Complaint, within fifteen (15) business days of receipt of the Complaint. The acknowledgement will identify any additional information required by CRHP from any source to make a determination. If a Complaint determination is made before the written acknowledgement is sent, CRHP may include the acknowledgement with the notice of the determination (one notice).

Complaints shall be reviewed and thoroughly investigated and documented by a qualified professional in the QMP Department. Complaints pertaining to clinical matters are reviewed by one or more licensed, certified or registered health care professionals in addition to whichever non-clinical personnel CRHP designates.

If a Member files a Complaint regarding difficulty accessing a needed service from a participating provider, and, as part of or in addition to the Complaint, requests the service be authorized directly by CRHP, CRHP will review such Service Authorization Request and make a Service Authorization Determination, in accordance with the procedures for prior authorization.

Whenever a delay would significantly increase the risk to a Member’s health, Complaints will be resolved within forty-eight (48) hours after receipt of all necessary information and no more than seven (7) days from the receipt of the Complaint.

All other Complaints will be resolved within forty-five (45) days after the receipt of all necessary information and no more than sixty (60) days from receipt of the Complaint.

### 7.8.2. Complaint Determination Notice

Complaint determinations by CRHP are communicated in writing to the Member or the Member’s designee and include:

a. the detailed reasons for the determination;

b. in cases where the determination has a clinical basis, the clinical rationale
for the determination;

c. the procedures for the filing of a Complaint Appeal, including a filing form; and

d. notice of the Member’s right to contact the Department of Health regarding his/her Complaint, including the Department of Health’s toll-free Medical Management for Complaints.

7.8.3. Complaint Appeal

The Member or designee has sixty (60) business days after receipt of the notice of the Complaint determination to file a written Complaint Appeal. Complaint Appeals may be submitted by letter or by a form provided by CRHP.

The review timeframe for Medicaid appeals begins on the date the appeal is received, either orally or in writing. Within fifteen (15) business days of receipt of the Complaint Appeal, CRHP will provide written acknowledgment of the Complaint Appeal, including the name, address and telephone Medical Management of the individual designated to respond to the Appeal. CRHP will indicate what additional information, if any, must be provided for CRHP to render a determination. In the event that only a portion of the missing information is provided to CRHP, CRHP will, within five (5) business days, request the remainder of the missing information. Complaint Appeals of clinical matters will be decided by personnel qualified to review the Appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer.

Complaint Appeals of non-clinical matters will be thoroughly investigated and documented by a qualified professional in the QMP Department. A determination will be made by qualified personnel at a higher level than the personnel who made the original Complaint determination.

Complaint Appeals shall be decided and notification provided to the Member no more than: two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to an Member’s health; or thirty (30) business days after the receipt of all necessary information in all other instances.

7.8.4. Complaint Appeal Determination Notice

The notice of CRHP’s Complaint Appeal determination includes:

a. the detailed reasons for the determination;

b. the clinical rationale for the determination in cases where the determination has a clinical basis;

c. notice that the Member has the option to contact the State Department of Health with his/her Complaint, including the Department of Health’s toll-free Medical Management for Complaints; and
d. instructions for an External Appeal, if applicable.

7.8.5. Action Appeal

The Member, or the Member’s designee, will have sixty (60) business days from the date of the notice of Action to file an Action Appeal. A Member requesting a fair hearing within ten (10) days of the notice of Action or by the intended date of an Action, whichever is later, that involves the reduction, suspension, or termination of previously approved services, may request “aid continuing” in accordance with the State’s Fair Hearing requirements. The Member may file an Action Appeal orally or in writing. Oral Action Appeals will be followed by a written, signed, Action Appeal. CRHP will provide a written summary of an oral Action Appeal to the Member (with the acknowledgement or separately) for the Member to review, modify if needed, sign and return to CRHP. If the Member or provider requests expedited resolution of the Action Appeal, the oral Action Appeal does not need to be confirmed in writing.

CRHP will send a written acknowledgement of the Action Appeal within fifteen (15) days of receipt. If a determination is reached before the written acknowledgement is sent, CRHP may include the written acknowledgement with the notice of Action Appeal determination (one notice).

CRHP will provide the Member reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. CRHP will inform the Member of the limited time to present such evidence in the case of an expedited Action Appeal. If only a portion of the necessary information is received, CRHP will request the additional information in writing within five (5) business days of receipt of the partial information. CRHP will allow the Member or the Member’s designee, both before and during the Action Appeals process, to examine the Member’s case file, including medical records and any other documents and records considered during the Action Appeals process. CRHP will consider the Member, the Member's designee, or legal estate representative of a deceased Member a party to the Action Appeal.

The Member and CRHP may jointly agree to waive the internal appeal process. If this occurs, CRHP will send the Member a written letter detailing the external appeal process within 24 hours of the agreement to waive the internal appeal process.

The Member may request an expedited review of an Action Appeal. An Expedited Action Appeal may be filed by the Member with regard to:

- Continued or extended health care services, procedures or treatments;
- Additional services for Members undergoing a course of continued treatment; or
- When the provider believes an Expedited Internal Appeal is warranted.

Expedited resolution of an Action Appeal will be conducted when CRHP determines
or the provider indicates that a delay would seriously jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum Medical Management function, or when the Action involved a Concurrent Review Request. Written notice of a final adverse determination of an expedited Action Appeal will be transmitted to the Member within twenty-four (24) hours of CRHP’s determination. CRHP will make reasonable efforts to provide oral notice of its expedited Action Appeal determination to the Member and provider at the time the determination is made.

If CRHP denies the Member’s request for an expedited review, CRHP will handle the request under standard Action Appeal resolution time frames. CRHP will make reasonable efforts to provide prompt oral notice to the Member of the determination to deny the Member’s request for expedited review and send written notice to the Member within two (2) days of this determination. Notice to the Member that the Member’s request for an expedited review has been denied shall include a statement that the request will be reviewed under standard time frames, including a description of the time frames and a statement that oral interpretation and alternate formats of written material for Members with special needs are available and how to access the alternate formats. This Notice may be combined with the acknowledgement. If additional information is needed to process and expedite appeal, CRHP will immediately contact the Member and the Member’s health care provider by telephone or facsimile, and will also follow up with written notification.

Action Appeals of clinical matters will be decided by personnel qualified to review the Action Appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer. The clinical peer reviewer will be available within one (1) business day. Action Appeals of non-clinical matters shall be determined by qualified personnel at a higher level than the personnel who made the original determination.

CRHP will resolve Action Appeals as quickly as the Member’s condition requires, and no later than thirty (30) days from the date of the receipt of the Action Appeal. CRHP will resolve expedited Action Appeals as quickly as the Member’s condition requires, within two (2) business days of receipt of necessary information and no later than three (3) business days of receiving the Action Appeal.

Time frames for Action Appeal resolution may be extended for up to fourteen (14) days if:

a. the Member, the Member’s designee, or the provider requests an extension orally or in writing; or
b. the CRHP can demonstrate or substantiate that there is a need for additional information and the extension is in the Member’s interest. CRHP will send notice of the extension to the Member. CRHP must maintain sufficient documentation of extension determinations to demonstrate, upon Department of Health’s request, that the extension was justified.

CRHP will make a reasonable effort to provide oral notice to the Member, the Member’s designee, and the provider where appropriate, for expedited Action Appeals at the time the Action Appeal determination is made. CRHP will send written notice to the Member, the Member’s designee, and the provider where appropriate, within two (2) business days of the Action Appeal determination. Failure of CRHP to make a determination within sixty (60) days of receipt of the appeal request shall be deemed to be a reversal of the adverse determination.

In addition to the Member’s right to file an Action Appeal, a provider may file a Standard Appeal for a retrospective denial made by CRHP.

### 7.8.6. Action Appeal Determination Notice

Notice to the Member of Action Appeal Determination shall include:

- a. date the Action Appeal was filed and a summary of the Action Appeal;
- b. date the Action Appeal process was completed;
- c. the results and the reasons for the determination, including the clinical rationale, if any;
- d. If the determination was not in favor of the Member, a description of the Member’s fair hearing rights, if applicable; and
- e. the right of the Member to contact the New York State Department of Health regarding the Member’s Appeal, including the Department of Health’s toll-free Medical Management for Appeals.
- f. A statement that the notice is available in other languages and formats for special needs and how to access these formats.

For Action Appeals involving personal care services, the Medical Management of hours per day, Medical Management of hours per week, and the personal care services function:

- a. that were previously authorized, if any;
- b. that were requested by the Member or the Member’s designee, if so specified in the request;
- c. that are authorized for the new authorization period, if any; and
- d. the original authorization period and the new authorization period, as applicable.
For Action Appeals involving Medical Necessity or an Experimental/Investigational treatment, the notice must also include:

a. the Member’s name and CRHP identification Medical Management, and the coverage type;
b. a statement of the reviewer’s understanding of the pertinent facts of the Member’s Action Appeal, including the procedure in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service;
c. the titles and qualifications of the individuals who participated in the Action Appeal, including consultants;
d. in the case of an adverse determination of an Action Appeal:
   i. a clear explanation of the clinical rationale for the denial, including a description or reference to the documentation used as the basis for the decision, and the reviewer’s consideration of Member-specific clinical information;
   ii. when citing the Clinical Guidelines or Medical Policy, the guideline or section of the policy which applies to the denial is cited. A copy of the citation may be sent with the letter when appropriate to the issue;
   iii. instructions for requesting a written statement of the clinical rationale and a copy of the criteria used to make the decision, as applicable to the issue (if not attached to the letter);
   iv. a description of the denied healthcare service including, as appropriate, the dates of service and the name of the facility and/or provider requesting to provide the service, and the claim amount (if applicable);
   v. A clear statement that the notice constitutes the final adverse determination, and specifically use of the terms “medical necessity” or “experimental/investigational;”
   vi. statement that the Member is eligible to file an External Appeal and the timeframe for filing, and if the Action Appeal was expedited, a statement that the Member may choose to file a standard Action Appeal with CRHP or file an External Appeal;
   vii. a copy of the “Standard Description and Instructions for Health Care Consumers to Request an External Appeal” and the External Appeal application form;
   viii. CRHP’s contact person and telephone Medical Management; and
   ix. The name and address of the utilization review agency, contact person and telephone Medical Management.

7.8.7. External Appeal

A Member has the right to an external appeal of a final adverse determination by CRHP (CRHP only provides one level of internal appeal). A Member, the Member’s designated representative, and, in connection with a retrospective adverse
determination, a Member’s health care provider has the right to request an external appeal when:

a. The Member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract, denied on appeal, in whole or in part, on the basis that such health care service is not medically necessary; and

b. CRHP has rendered a final adverse determination with respect to such health care service or both CRHP and the Member have jointly agreed to waive any internal appeal;

OR

a. The Member has had coverage of a health care service denied on the basis that the service is experimental and/or investigational, and the denial has been upheld on appeal, or both CRHP and the Member have jointly agreed to waive any internal appeal, and

b. The Member’s attending physician has certified that the Member has a life-threatening or disabling condition or disease for which
   i. standard health services or procedures have been ineffective or would be medically inappropriate; or
   ii. there does not exist a more beneficial standard health service or procedure covered by CRHP; or
   iii. there exists a clinical trial; and
   iv. the Member’s attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the Member’s life-threatening or disabling condition or disease, must have recommended either:
      (x) a health service or procedure (including a pharmaceutical product as defined by PHL 4900(5)(b)(B)) that, based on two documents from the available medical and scientific evidence is likely to be more clinically beneficial to the Member and for which the adverse risk of the requested service would not likely be substantially increased over any standard health service or procedure covered by CRHP, or
      (y) a clinical trial for which the Member is eligible.

Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his/her recommendation and the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for CRHP’s determination that the health service or procedure is experimental and/or investigational.

With respect to the clinical trials referenced in Section b(iii) above, the clinical trial for
which the provider is requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

a. the National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;
b. an entity that has been identified by the NIH as a qualified non-governmental research entity; or
c. an Institutional Review Board of a facility that has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

In order for a Member to be eligible for an external appeal related to a rare disease where that term is defined as a condition or disease that:

a. is currently, or has been, subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or
b. affects less than 200,000 United States residents per year; and
c. for which there does not exist a standard health service or procedure covered by the Member’s health benefits plan that is more clinically beneficial than the requested health service or treatment;

a certifying physician (defined as a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat the rare disease), other than the Member’s treating physician, must certify in writing that the Member has a rare disease as defined above, and based on the physician’s credible experience, there is no standard treatment that is likely to be clinically more beneficial to the Member than the requested health service or procedure; the requested health service or procedure is likely to benefit the Member in the treatment of his/her Rare Disease; and that such benefit outweighs the risks of such health service or procedure. Further, the certifying physician must disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of a denial of the rare disease treatment.

A Member has 4 months from the time the notice of the final adverse determination from the internal appeal is received from CRHP to file the external appeal application.

A Member and/or the Member’s healthcare provider may request an expedited external appeal only if the appeal concerns:

a. an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized; or
b. the Member’s healthcare provider must attest that the patient has not received the treatment and a 30 day timeframe would seriously jeopardize
the patient’s life, health, or ability to regain maximum function; or

c. a service for which a delay would pose an imminent or serious threat to
the patient’s health.

The Member may request an expedited internal and external appeal at the same time. Once an external appeal is expedited, any necessary information that is absent will immediately be requested from the Member and provider via both written communication and telephone. Even if all information is not received, a decision will be made within seventy-two (72) hours.

Providers may request an external appeal on their own behalf to obtain payment when CRHP makes a concurrent or retrospective adverse determination denying health care services as not medically necessary, experimental and/or investigational, a clinical trial or a rare disease treatment.

To request an external appeal, the Member or provider must complete the New York State External Appeal Application. You may obtain an external appeal application from the New York State Insurance Department at 1 (800) 400-8882, or its website health.state.ny.us, or by calling CRHP at 1-844-638-6507. If the provider requests the application from CRHP, CRHP will send the application form to the provider within three (3) business days of receipt of the request. The application will instruct the provider where to send the external appeal. The Member must release all pertinent medical information concerning his/her medical condition and request for services.

Providers appealing on their own behalf must request an external appeal within forty-five (45) days of the final adverse determination. CRHP may charge the health care provider a fee of up to $50.00 dollars per external appeal. In the event the external appeal agent overturns the final adverse determination of CRHP, the fee shall be refunded to the provider.

CRHP may charge the Member a fee of up to $25.00 per external appeal provided that, in the event the external appeal agent overturns the final adverse determination of CRHP, such fee shall be refunded to the Member. CRHP shall not require the Member to pay any such fee if the Member is a recipient of medical assistance or if the payment of such fee shall pose a hardship to the Member as determined by CRHP.

If the Member is covered by a self-insured employer, the Member is not eligible to submit an external appeal.

An independent external appeal agent approved by New York State will review the request to determine if the denied service is medically necessary and should be covered by CRHP. All external appeals are conducted by clinical peer reviewers.

The decision of the external appeal agent is final and binding on both the Member and CRHP. If the external appeal agent upholds the adverse determination, CRHP will not cover the requested service. If the external appeal agent reverses the adverse
determination, CRHP will cover the service in accordance with the terms of the Member’s health benefits contract.

For standard appeals, the external appeal agent must make a decision within thirty (30) days of receiving the application for external appeal. Five (5) additional business days may be added if the agent needs additional information. If the agent determines that the information submitted is materially different from that considered by CRHP, CRHP will have three additional business days to reconsider its decision. The Member will be notified within two (2) business days of the agent’s decision.

For expedited appeals, the external appeal agent will make a decision within three (3) business days. The agent will make every reasonable effort to notify the Member and CRHP of the decision immediately by phone or fax. This will be followed immediately by a written notice.
ATTACHMENT A
Crystal Run Health Plan
Medicaid Managed Care Benefit Grid

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Physician (PCP) Required</strong></td>
<td>Members joining CRHP Medicaid are required to choose a PCP from the CRHP Medicaid Managed Care Provider Network.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Services Covered through CRHP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>* These services must be provided and billed in accordance with the comprehensive guidelines supported by the USPSTF and HRSA. A complete listing of all the services covered can be found at <a href="https://www.cms.gov/ccio/resources/regulations-and-guidance/">https://www.cms.gov/ccio/resources/regulations-and-guidance/</a>.</td>
<td></td>
</tr>
</tbody>
</table>

- **Preventive Health Services**
  - Under the Affordable Care Acts Federally Mandated Preventive Services guidelines, all preventative services are fully covered benefits. Preventative services and screenings, when billed appropriately, will be covered in full with no cost share (copay, deductible, etc.) taken from the member. The following services are covered benefits:
    - Well Child Visits and Immunizations*
    - Adult Annual Physical Examinations*
    - Adult Immunizations*
    - Routine Gynecological Services/Well Woman Exams*
    - Mammography Screenings*
    - Sterilization Procedures for Women*
    - Vasectomy
    - Bone Density Testing*
    - Screening for Prostate Cancer
    - All other preventive services required by USPSTF and HRSA.

- **Physician Services**
- **Nurse Practitioner Services**
- **Midwifery Services**
- **Short-term Residential Health Care Facility Services**
- **Family Planning (Participating**
### Health Care Services Covered through CRHP (cont.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>• Second Medical Surgical Opinion</td>
</tr>
<tr>
<td></td>
<td>• Laboratory Services</td>
</tr>
<tr>
<td></td>
<td>• Radiology Services</td>
</tr>
<tr>
<td></td>
<td>• Pharmaceuticals, including medical supplies and enteral formula</td>
</tr>
<tr>
<td></td>
<td>• Smoking Cessation Products</td>
</tr>
<tr>
<td></td>
<td>• Rehabilitation Services</td>
</tr>
<tr>
<td></td>
<td>• EPSDT/(Child Teen Health Program)</td>
</tr>
<tr>
<td></td>
<td>• Personal Care Services</td>
</tr>
<tr>
<td></td>
<td>• Home Health Services</td>
</tr>
<tr>
<td></td>
<td>• Private duty nursing</td>
</tr>
<tr>
<td></td>
<td>• Hospice</td>
</tr>
<tr>
<td></td>
<td>• Emergency services</td>
</tr>
<tr>
<td></td>
<td>• Foot Care Services</td>
</tr>
<tr>
<td></td>
<td>• Eye Care and Low Vision Services</td>
</tr>
<tr>
<td></td>
<td>• Durable Medical Equipment</td>
</tr>
<tr>
<td></td>
<td>• Audiology, hearing aid services and products when medically necessary</td>
</tr>
<tr>
<td></td>
<td>• Emergency transportation (See Section 7.7.6)</td>
</tr>
<tr>
<td></td>
<td>• Non-Emergency transportation (See Section 7.7.6)</td>
</tr>
<tr>
<td></td>
<td>• Dental Services</td>
</tr>
<tr>
<td></td>
<td>• Prosthetics, Orthotics</td>
</tr>
<tr>
<td></td>
<td>• Mental Health Services</td>
</tr>
<tr>
<td></td>
<td>• Inpatient substance abuse services (for non-SSI)</td>
</tr>
<tr>
<td></td>
<td>• Renal dialysis</td>
</tr>
<tr>
<td></td>
<td>• Directly observed TB therapy</td>
</tr>
<tr>
<td></td>
<td>• Adult day health care</td>
</tr>
<tr>
<td></td>
<td>• AIDS adult day health care programs</td>
</tr>
</tbody>
</table>

### Preventive Health Services
Under the Affordable Care Acts Federally Mandated Preventive Services guidelines, all preventative services are

The following three levels of care are covered:

- Primary preventive care services (i.e.,
## Service

fully covered benefits. Preventative services and screenings, when billed appropriately, will be covered in full with no cost share (copay, deductible, etc.) taken from the member. The following services are covered benefits:

- Well Child Visits and Immunizations*
- Adult Annual Physical Examinations*
- Adult Immunizations*
- Routine Gynecological Services/Well Woman Exams*
- Mammography Screenings*
- Sterilization Procedures for Women*
- Vasectomy
- Bone Density Testing*
- Screening for Prostate Cancer
- All other preventive services required by USPSTF and HRSA.

* These services must be provided and billed in accordance with the comprehensive guidelines supported by the USPSTF and HRSA. A complete listing of all the services covered can be found at [https://www.cms.gov/cciio/resources/regulations-and-guidance/](https://www.cms.gov/cciio/resources/regulations-and-guidance/).

## Coverage

- immunizations given for the purposes of preventing disease)
- Secondary preventive care services (i.e., disease screening programs provided for the purpose of detecting disease in its earliest stages)
- Tertiary preventive care services (i.e., therapy services including physical, occupation and speech, provided for the purpose of restoring maximum function)

## Inpatient Hospital Services

Inpatient hospital services cover a full range of medically necessary diagnostic and therapeutic care including medical, surgical, behavioral health (non-SSI), nursing, radiological and rehabilitative services.

Services are provided under the direction of a physician, certified nurse practitioner, or dentist.

## Alternate Level of Medical Care

Continued care in a hospital, Article 31 mental health facility, or skilled nursing facility pending placement in an alternate lower level of care.

## Ambulatory Services

Outpatient hospital services are provided through ambulatory care facilities including
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>treatment centers (diagnostic and treatment centers and/or free standing clinics), hospital outpatient departments, and emergency rooms. These facilities may provide those medically necessary medical, surgical, behavioral health and rehabilitative services and items authorized by their operating certificates.</td>
<td></td>
</tr>
<tr>
<td>Outpatient services (clinic) also include preventative, primary medical, specialty, behavioral health (non-SSI), Child/Teen Health Plan services, and ambulatory care facilities.</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>In the event of an emergency, Members will obtain transportation through 911.</td>
</tr>
<tr>
<td></td>
<td>For non-emergent transportation the Member or provider may call Medical Answering Services (MAS), the Medicaid Program’s transportation manager.</td>
</tr>
<tr>
<td></td>
<td>• Orange County - 1-855-360-3543</td>
</tr>
<tr>
<td></td>
<td>• Sullivan County - 1-855-360-3542</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Referrals/Authorizations</td>
<td>Members may self-refer to participating providers for the following benefits/services:</td>
</tr>
<tr>
<td></td>
<td>• OB/GYN Care</td>
</tr>
<tr>
<td></td>
<td>• HIV Counseling and Testing</td>
</tr>
<tr>
<td></td>
<td>• Mental Health and Substances</td>
</tr>
<tr>
<td></td>
<td>Abuse - 1st initial assessment in a calendar year</td>
</tr>
<tr>
<td></td>
<td>• Eye Care</td>
</tr>
<tr>
<td></td>
<td>For all other services members should be encouraged to speak with their PCP.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization may be required for certain services. Please refer to Section 3.6.1 for prior authorization criteria and processing.</td>
</tr>
</tbody>
</table>
### Health Care Services covered by Fee-for-Service Medicaid

- The following services are covered by Fee-for-Service (FFS) Medicaid:
- Family Planning (Non-participating providers)
- Permanent residence in a residential health care facility
- Methadone Maintenance Treatment Program (MMTP)
- Medically supervised ambulatory chemical dependence outpatient clinic programs
- Medically supervised chemical dependence outpatient rehabilitation programs
- Outpatient chemical dependence for youth programs
- Mental and behavioral health services (for SSI members)
- Intensive psychiatric rehabilitation treatment programs
- Day treatment programs
- Home and community based services waiver for SED children
- Case management
- Partial hospitalization
- Early Intervention program
- Preschool supportive health services
- School supportive health services
- Comprehensive medical case management
- HIV COBRA case management programs
- Personal emergency response services
- School-based health centers
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-covered Services</td>
<td>- Cosmetic surgery, unless medically necessary</td>
</tr>
<tr>
<td></td>
<td>- Routine hygienic foot care in the absence of a pathological condition</td>
</tr>
</tbody>
</table>
## ATTACHMENT B

### Crystal Run Health Plan

#### Child Health Plus Benefit Grid

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-child care</td>
<td>Covered in accordance with the schedule established by the American Academy of Pediatrics</td>
</tr>
<tr>
<td>Physical exams</td>
<td>Covered for care provided by child's primary care physician (PCP) or a network referral specialist with a valid referral from your child's PCP</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered in accordance with the schedule established by the American Academy of Pediatrics</td>
</tr>
<tr>
<td>X-ray and laboratory services</td>
<td>Covered</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient hospital medical or surgical care</td>
<td>Covered. Includes daily room and board, general nursing care, special diets, miscellaneous hospital services and supplies</td>
</tr>
<tr>
<td>Second surgical opinions and second medical opinions for cancer</td>
<td>Covered</td>
</tr>
<tr>
<td>Pre-surgical/pre-admission testing</td>
<td>Covered</td>
</tr>
</tbody>
</table>

### Preventive Health Services

- These services must be provided and billed in accordance with the comprehensive guidelines supported by the USPSTF and HRSA. A complete listing of all the services covered can be found at [https://www.cms.gov/ccio/resources/regulations-and-guidance/](https://www.cms.gov/ccio/resources/regulations-and-guidance/).

Under the Affordable Care Acts Federally Mandated Preventive Services guidelines, all preventative services are fully covered benefits. Preventative services and screenings, when billed appropriately, will be covered in full with no cost share (copay, deductible, etc.) taken from the member. The following services are covered benefits:

- Well Child Visits and Immunizations*
- Adult Annual Physical Examinations*
- Adult Immunizations*
- Routine Gynecological Services/Well Woman Exams*
- Mammography Screenings*
- Sterilization Procedures for Women*
- Vasectomy
- Bone Density Testing*
- Screening for Prostate Cancer
- All other preventive services required by USPSTF and HRSA.
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care</td>
<td>Covered for participating and non-participating hospitals, including emergency ambulance transportation to hospital</td>
</tr>
<tr>
<td>Prescription and non-prescription drugs</td>
<td>Covered</td>
</tr>
<tr>
<td>Short-term therapeutic outpatient services and rehabilitative therapies</td>
<td>Covered</td>
</tr>
<tr>
<td>Radiation therapies and chemotherapies</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient and outpatient treatment for alcoholism and substance abuse, and mental health</td>
<td>Covered</td>
</tr>
<tr>
<td>Dental care</td>
<td>Covered for routine dental services, periodontics, prosthodontics and orthodontics</td>
</tr>
<tr>
<td>Vision care</td>
<td>Covered. Includes eye examinations and prescription corrective lenses</td>
</tr>
<tr>
<td>Speech and hearing services</td>
<td>Covered</td>
</tr>
<tr>
<td>Blood Clotting Factor</td>
<td>Covered</td>
</tr>
<tr>
<td>Diabetic equipment, supplies and education</td>
<td>Covered</td>
</tr>
<tr>
<td>Durable medical equipment, prosthetics and orthotics</td>
<td>Covered</td>
</tr>
<tr>
<td>Hospice</td>
<td>Covered</td>
</tr>
<tr>
<td>Treatment of autism spectrum disorder</td>
<td>Covered, including 680 hours of applied behavior analysis</td>
</tr>
<tr>
<td>Home health care</td>
<td>Covered up to 40 visits per calendar year</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>Covered</td>
</tr>
</tbody>
</table>
## OFFICE VISITS
- Primary Care Office Visits (or Home Visits)
- Specialist Office Visits (or Home Visits)

## PREVENTIVE CARE
Under the Affordable Care Act's Federally Mandated Preventive Services guidelines, all preventative services are fully covered benefits. Preventative services and screenings, when billed appropriately, will be covered in full with no cost share (copay, deductible, etc.) taken from the member. The following services are covered benefits:
- Well Child Visits and Immunizations*
- Adult Annual Physical Examinations*
- Adult Immunizations*
- Routine Gynecological Services/Well Woman Exams*
- Mammography Screenings*
- Family Planning (Contraceptives)
- Sterilization Procedures for Women*
- Vasectomy
- Bone Density Testing*
- Screening for Prostate Cancer
- All other preventive services required by USPSTF and HRSA.

These services must be provided and billed in accordance with the comprehensive guidelines supported by the USPSTF and HRSA. A complete listing of all the services covered can be found at [https://www.cms.gov/cciio/resources/regulations-and-guidance/](https://www.cms.gov/cciio/resources/regulations-and-guidance/).

## EMERGENCY CARE
- Pre-Hospital Emergency Medical Services (Ambulance Services)
- Non-Emergency Ambulance Services (optional for large group coverage)
- Emergency Department
  - Copayment waived if Hospital admission
- Urgent Care Center

## PROFESSIONAL SERVICES AND OUTPATIENT CARE
- Advanced Imaging Services
  - Performed in a Freestanding Radiology Facility or Office Setting
  - Performed as Outpatient Hospital Services
- Allergy Testing & Treatment
  - Performed in a PCP Office
  - Performed in a Specialist Office
- Ambulatory Surgical Center Facility Fee
<table>
<thead>
<tr>
<th>Service Category</th>
<th>Location Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia Services (all settings)</td>
<td></td>
</tr>
<tr>
<td>Autologous Blood Banking (optional for large group coverage)</td>
<td></td>
</tr>
<tr>
<td>Cardiac &amp; Pulmonary Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td></td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td></td>
</tr>
<tr>
<td>• Performed as Inpatient Hospital Services</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>• Performed in a PCP Office</td>
<td></td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td></td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td></td>
</tr>
<tr>
<td>Clinical Trials</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td></td>
</tr>
<tr>
<td>• Performed in a PCP Office</td>
<td></td>
</tr>
<tr>
<td>• Performed in a Specialist Office</td>
<td></td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
</tr>
<tr>
<td>• Performed in a PCP Office</td>
<td></td>
</tr>
<tr>
<td>• Performed in a Freestanding Center or Specialist Office Setting</td>
<td></td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td></td>
</tr>
<tr>
<td>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td></td>
</tr>
<tr>
<td>Infertility Services</td>
<td></td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td></td>
</tr>
<tr>
<td>• Performed in a PCP Office</td>
<td></td>
</tr>
<tr>
<td>• Performed in Specialist Office</td>
<td></td>
</tr>
<tr>
<td>• Performed as Outpatient Hospital Services</td>
<td></td>
</tr>
<tr>
<td>• Home Infusion Therapy</td>
<td></td>
</tr>
<tr>
<td>Inpatient Medical Visits</td>
<td></td>
</tr>
<tr>
<td>Laboratory Procedures</td>
<td></td>
</tr>
<tr>
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<td>Outpatient Hospital Surgery Facility Charge</td>
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</table>
### Preadmission Testing

#### Diagnostic Radiology Services
- Performed in a PCP Office
- Performed in a Freestanding Radiology Facility or Specialist Office
- Performed as Outpatient Hospital Services

#### Therapeutic Radiology Services
- Performed in a Freestanding Radiology Facility or Specialist Office
- Performed as Outpatient Hospital Services

#### Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)

#### Second Opinions on the Diagnosis of Cancer, Surgery & Other

#### Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants & Interruption of Pregnancy)
- Inpatient Hospital Surgery
- Outpatient Hospital Surgery
- Surgery Performed at an Ambulatory Surgical Center
- Office Surgery

### ADDITIONAL SERVICES, EQUIPMENT & DEVICES

#### ABA Treatment for Autism Spectrum Disorder

#### Assistive Communication Devices for Autism Spectrum Disorder

#### Diabetic Equipment, Supplies & Self-Management Education
- Diabetic Equipment, Supplies and Insulin (30-Day Supply)
- Diabetic Education

#### Durable Medical Equipment & Braces (optional for large group coverage)

#### External Hearing Aids (optional for large group coverage)

#### Cochlear Implants

#### Hospice Care
- Inpatient
- Outpatient (optional for large group coverage)

#### Medical Supplies (optional for large group coverage)

#### Prosthetic Devices (optional for large group coverage)
- External
- Internal (optional for large group coverage)

### INPATIENT SERVICES & FACILITIES

#### Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)

#### Observation Stay

#### Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) (optional for large group coverage)

#### Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)
### MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mental Health Care</td>
<td>(for a continuous confinement when in a Hospital)</td>
</tr>
<tr>
<td>Outpatient Mental Health Care</td>
<td>(Including Partial Hospitalization &amp; Intensive Outpatient Program Services)</td>
</tr>
<tr>
<td>Inpatient Substance Use Services</td>
<td>(for a continuous confinement when in a Hospital)</td>
</tr>
<tr>
<td>Outpatient Substance Use Services</td>
<td></td>
</tr>
</tbody>
</table>

### PRESCRIPTION DRUGS (optional for large group coverage)

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Pharmacy</td>
<td>30 Day Supply</td>
</tr>
<tr>
<td></td>
<td>- Tier 1</td>
</tr>
<tr>
<td></td>
<td>- Tier 2</td>
</tr>
<tr>
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<td>- Tier 3</td>
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<td></td>
<td>Up to a 90 Day Supply For Maintenance Drugs</td>
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<td></td>
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<td></td>
<td>- Tier 3</td>
</tr>
<tr>
<td>Mail Order Pharmacy</td>
<td>Up to a 90 Day Supply</td>
</tr>
<tr>
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<td>- Tier 1</td>
</tr>
<tr>
<td></td>
<td>- Tier 2</td>
</tr>
<tr>
<td></td>
<td>- Tier 3</td>
</tr>
<tr>
<td></td>
<td>Enteral Formulas and modified solid food products</td>
</tr>
</tbody>
</table>

### WELLNESS BENEFITS

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gym Reimbursement</td>
<td>(optional for large group coverage)</td>
</tr>
</tbody>
</table>

### PEDIATRIC DENTAL & VISION CARE (optional for large group coverage)

<table>
<thead>
<tr>
<th>Benefit Type</th>
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<tbody>
<tr>
<td>Pediatric Dental Care</td>
<td>- Preventive/Routine Dental Care</td>
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<td>- Major Dental (Endodontics &amp; Prosthodontics)</td>
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<td>- Orthodontia</td>
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<td>Pediatric Vision Care</td>
<td>- Exams</td>
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<td></td>
<td>- Lenses &amp; Frames</td>
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<tr>
<td></td>
<td>- Contact Lenses</td>
</tr>
</tbody>
</table>

### OFFICE VISITS

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Office Visits</td>
<td>(or Home Visits)</td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>(or Home Visits)</td>
</tr>
</tbody>
</table>
## Preventive Care
- Well Child Visits and Immunizations*
- Adult Annual Physical Examinations*
- Adult Immunizations*
- Routine Gynecological Services/Well Woman Exams*
- Mammography Screenings*
- Family Planning (Contraceptives)
- Sterilization Procedures for Women*
- Vasectomy
- Bone Density Testing*
- Screening for Prostate Cancer
- All other preventive services required by USPSTF and HRSA.

*These services must be provided and billed in accordance with the comprehensive guidelines supported by the USPSTF and HRSA. A complete listing of all the services covered can be found at [https://www.cms.gov/cciio/resources/regulations-and-guidance/](https://www.cms.gov/cciio/resources/regulations-and-guidance/).

## Emergency Care
**Pre-Hospital Emergency Medical Services (Ambulance Services)**

**Non-Emergency Ambulance Services**

**Emergency Department**
Copayment waived if Hospital admission

**Urgent Care Center**

## Professional Services and Outpatient Care
**Advanced Imaging Services**
- Performed in a Freestanding Radiology Facility or Office Setting
- Performed as Outpatient Hospital Services

**Allergy Testing & Treatment**
- Performed in a PCP Office
- Performed in a Specialist Office

**Ambulatory Surgical Center Facility Fee**

**Anesthesia Services (all settings)**

**Autologous Blood Banking**

**Cardiac & Pulmonary Rehabilitation**
- Performed in a Specialist Office
- Performed as Outpatient Hospital Services
- Performed as Inpatient Hospital Services

**Chemotherapy**
- Performed in a PCP Office
- Performed in a Specialist Office
- Performed as Outpatient Hospital Services
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Setting Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Services</td>
<td></td>
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<tr>
<td>Clinical Trials</td>
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<td>Diagnostic Testing</td>
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<td>Home Health Care</td>
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<td>Infusion Therapy</td>
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