Managing Patient Care
HMO SNP

MANAGING PATIENT CARE

MEDICAL MANAGEMENT OVERVIEW

Fallon Health Weinberg's (FHW) Care and Utilization Management program reviews and evaluates the health care members receive to make sure that member care is coordinated, and that appropriate levels of services are available to members. This includes prior authorization of select services, inpatient services, integrated care management and disease management.

The Care and Utilization Management program is staffed by licensed registered nurse care specialists, nurse reviewers, independently licensed behavioral health professionals' workers and physician reviewers who are available to our network physicians. FHW Care and Utilization Management uses national, evidence-based criteria that are reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by physicians and other providers. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care.

FHW also develops in-house medical and behavioral health criteria, making use of local specialist input and current medical literature, as well as guidelines from the Centers of Medicare & Medicaid Services (CMS) and the State of New York. Criteria are available upon request. This coverage reflects benefits covered under the Medicare portion of the PLAN. MLTC Benefits are separate and guidelines can be found under that section.

The Utilization Management program provides physician support for services requiring prior authorization (see PCP referral and plan authorization process section).

FHW provides all physicians with the opportunity to discuss any denial decision with a physician reviewer or to obtain information about the status or outcome of any utilization issue or review decision from the plan by contacting Utilization Management at our toll free provider service line at 1-855-827-2003.

Fallon Health Weinberg (FHW) defines primary care providers as practitioners in Internal Medicine and Family Practice. It is recognized that physician assistants work collaboratively with these providers, but physician assistants are not considered primary care providers for the purpose of defining geographic and numerical standards for primary care services.

Geographic Distribution

The Integrated Care Organization must provide each Enrollee with the following within a 15-mile radius or 30 minutes from the Enrollee's ZIP code of residence:

- at least two PCPs;
- at least two outpatient Behavioral Health Providers;
- two hospitals (when feasible);
- two nursing facilities; and
- two community Long Term Services and Supports Providers per Covered Service

For any Covered Service for which Medicare requires a more rigorous network adequacy standard than described above (including time, distance, and/or minimum number of providers or facilities), the ICO must meet the Medicare requirements.

Cultural Needs and Preferences

FHW assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary. FHW utilizes the provider directory to notify members of any specialized services, including linguistic capabilities offered by network providers and handicap access.

Population Ratios

FHW shall continue to maintain at least one (1) adult primary care provider for every 1500 enrolled adult members. This statistic will be measured on an aggregate basis for all FHW members and all adult primary care providers.

Performance Assessment

FHW ensures that its members are satisfied with its primary care network by conducting an annual performance assessment and measuring its performance against the standards at least annually. The methodology used to review geographic and volume of primary care physicians is the GEOACCESS® survey tool, which allows for direct measurement of performance. The Service Quality Improvement Committee also examines the results from

member satisfaction surveys including the CAHPS 3.0H® (Consumer Assessment of Health plans and Providers Survey), and specific questions that include the rate of members who report no problems with obtaining access to primary care physicians. The CAHPS 3.0H survey is a rigorous methodology which includes adequate sampling, appropriate data sources and analysis.

Availability of High Volume Specialty Practitioners

FHW identifies within its network the following specialists as high volume specialty care providers: ophthalmologists, optometrists, orthopedists, obstetricians, cardiologists and licensed Behavioral Health professionals. FHW defines High Volume Specialists as those specialists that account for approximately 55% of all outpatient specialty visits. The following are standards for geographic availability for FHW network of key specialty care providers:

A. Geographic distribution of specialists

FHW shall contract with the following categories of specialists so as to maintain at least one practitioner within 15 miles or 30 minutes routine driving time, for at least 98% of enrolled members:

- Behavioral Health**
- Ophthalmologists/Optometrists
- Obstetricians/Gynecologists
- Orthopedists
- Cardiologists

** At least two outpatient Behavioral Health Providers

B. Performance Assessment

FHW Service Quality Improvement Committee analyzes data to measure its performance against the geographic standards for high volume specialists, including behavioral health practitioners at least annually. FHW formally assesses its performance using the GEOACCESS® survey tools to determine adequate number and geographic distribution for specialists. The Committee identifies opportunities for improvement and decides which opportunities to pursue, and measures the effectiveness of the interventions. In addition to the geographic assessment, the committee continually monitors member satisfaction data with the annual CAHPS results with questions specific to availability of specialists. When FHW delegates quality services to a selected vendor, the delegated entity has responsibility to conduct performance assessment and report back to FHW delegation Oversight Committee. Data analysis of availability of specialists must also be reported to the Delegation Oversight Committee using similar methodology approved by the plan to ensure performance compliance with FHW standards.

ACCESSABILITY OF SERVICES

FHW reassesses the overall distribution of specialty visits at least every other year, to determine whether the list of high volume specialists requires adjustment to include at least 50% of all outpatient specialty visits. FHW has established standards for accessibility to primary care, specialty care, and behavioral health and customer services. These standards include regular and routine care appointments, urgent care appointments and after-hours care. In addition, FHW has established standards for the response time of the various call centers to ensure that customers are able to inquire about information on how to access clinical care, how to resolve problems and billing issues, and how to make appointments. All of these standards are listed below.

In order to satisfy access measurement requirements and ensure member satisfaction, FHW collects data and conducts analyses to measure its performance against standards of accessibility on an annual basis. This is accomplished by conducting member surveys and using CAHPS® data. FHW monitors regular and routine care appointments, urgent care appointments and after-hours care and the call centers' statistics by using a methodology that allows for direct comparison of performance to the standards.

CAHPS 4.0H survey questions related to appointment access to specific practitioners and member complaints are routinely monitored for performance against the accessibility of services standards for appointment and after-hours care. FHW identifies and sets priorities for opportunities for improvement; implements intervention strategies and re-measures to determine effectiveness of corrective actions.

When FHW delegates quality services to a selected vendor, the delegated entity is responsible for monitoring accessibility of services and reporting it to FHW. The Delegation Oversight Committee has responsibility for ensuring that the accessibility standards are met by delegated vendors.

ACCESSABILITY OF SERVICES

Accessibility of Service	Standard
A. Physical Health Service	
1. Preventative and Primary Care-(Annual Physical or new patient examination)	1. Within 30 calendar days
2. Primary Care Services Routine and Regular Care (Urgent Symptomatic, Non-Urgent Symptomatic and Non- Symptomatic Office Visit)	2. Within 48 hours of member's request for urgent care; within 10 calendar days of member's request for non-urgent symptomatic care; and within 45 calendar days of member's request for non-symptomatic care
3. Specialty Care Services	3. Within 48 hours of member's request for urgent care; within 30 calendar days of member's request for non-urgent symptomatic care; and within 60 calendar days of member's request for non-symptomatic care Available 24 hours day/7 days week
4. Emergency Care*	4. Available 24 hours day/7 days week
5. After-Hours Care	5. 24 hours/day
6. After-Hours Telephone Response	6. Within 2 hours for the return call
7. General optometry care	7. Within 3 weeks for regular appointments and 48 hours for urgent care
8. Lab and X-ray	8. Within 3 weeks for regular appointments and 48 hours for urgent care
B. Behavioral Health Services	
1. Emergency Services (Including Life Threatening Emergency Needs)	1. Immediately (24 hours/days 7days/week)
2. Non-life threatening emergency	2. Within 6 Hours
3. All other behavioral health services (including routine and follow-up)	3. Within 10 business days
4. Behavioral Health URGENT Appointments	4. Within 48 hours for services that are not Emergency Services or routine services
5. Inpatient or 24-hour Diversionary Services Discharge Plan	5. Non-24-Hour Diversionary Services – within 2 calendar days of discharge; Medication Management – within 14 calendar days of discharge; Other Outpatient Services – within seven calendar days of discharge;

*Emergency care defined by the "Prudent Layperson" definition.

ACCESSABILITY OF SERVICES

Appointment Standards and After-Hours Accessibility

Type of Appointment/ Service	Appointment Access Time Frames and Expectations:
General Appointment Standards	
Routine/Non-Urgent Services	Within 14 calendar days
Urgent Care	Within 24 hours
Emergency Services	Immediately, 24 hours per day, 7 days per week
Aftercare Appointment Standards	Inpatient and 24-hour diversionary service must schedule an aftercare follow-up prior to a member's
Non-24 Hour Diversionary	Within 2 calendar days
Psychopharmacology services/Medication Management	Within 14 calendar days

Telephone Services and Office Wait Time Standards for Contracted Practitioners
Contracted practitioners are responsible for telephone coverage for the afterhours care and responsiveness of appointment telephone lines. The practitioners are responsible for arranging coverage for evenings and weekends. The plan standards for coverage are:

Physicians shall provide 24 hour physician coverage. Physicians or their designees should return patients' calls received during routine business hours for active clinical problems, on a same day basis. Routine administrative requests for completion of forms, test reports, or chronic refills should generate a telephone response within one business day.

ADMITTING FOR INPATIENT STAY OR SAME-DAY SURGERY

Admissions

Fallon Health Weinberg (FHW) UM nurses will perform concurrent reviews on all medical inpatient admissions. An FHW psychiatric nurse or behavioral health licensed professional will perform prior authorization and concurrent review on behavioral health inpatient admissions. All elective inpatient, acute hospital, acute rehabilitation and skilled nursing facility admissions must be authorized by FHW's Utilization Management Program prior to admission. Selected same-day surgeries or ambulatory care procedures must be submitted to FHW's Utilization Management Program.

Once a member is admitted, an inpatient nurse specialist or behavioral health case manager will perform concurrent review on each case, facilitating discharge planning, assisting with disqualification of continued stay and identifying members for outpatient case management. FHW uses nationally-recognized criteria for review.

Note: Some IPA/PHO provider network agreements differ from the procedure described below, depending on contract levels of risk. When applicable, please defer to your IPA/PHO procedures.

Procedure:

Elective admission

1. The admitting physician's office requests authorization for the admission by completing the appropriate section of the Request for Services form and sending it to the FHW's Utilization Management Program or by completing the request via the Online Referral Tool. The organization makes decisions within 14 days of request. The organization notifies practitioners of the decisions within one day of making the decision. Specialty physicians wishing to admit a member can call, fax, or send a Request for Prior authorization form to FHW's Care and Utilization Management Program.
2. If authorized:
   a.) Utilization Management provides the authorization number to the admitting physician indicating that the referral is authorized.
   b.) The admitting physician books the admission.
   c.) The admitting physician performs the history and physical, completes all preadmission tests and obtains the member's written consent.
   d.) The admitting physician forwards copies of the member consent and results from the history, physical and preadmission testing to the hospital prior to the admission, or otherwise complies with the hospital's admission policy.
3. If not authorized:
   a.) Utilization Management notifies the admitting physician if medical necessity criteria are not met and offers a peer to peer discussion with a physician.

b.) Utilization Management sends the original denial letter, which includes all appeal rights, to the Member and an Authorized Appeal Representative with a copy to the primary care physician.

Procedure:

Emergency or unplanned admissions

The hospital admitting department will fax the FHW Utilization Management Program to advise FHW of the admission, reporting the member's name, date of birth and facility (fax number: 716-810-1904).

FHW requires that the hospital notify us within 24 hours of an emergency or unplanned hospital admission or transfer to a different acute facility. Should a member be hospitalized from the emergency room with possible FHW eligibility, it is expected that the admitting physician's office will report admission to FHW, whether eligibility has been verified or not.

FHW will only pay for hospital days that are medically necessary, and which are called in or faxed to us within the notification time frame, 24 hours of admission. Please note: FHW members cannot be held financially liable.

ADVANCE DIRECTIVES

Our members have certain rights relating to advance directives. Advance directives are written instructions, sometimes called a living will or durable power of attorney for healthcare. Advance directives are recognized under law to ensure a person who isn't capable of making a health care decision gets health care. If a member is no longer able to make decisions about his or her health care, having an advance directive in place can help. These written instructions tell providers what to do if their patients cannot make health care decisions. We have the authority to audit FHW's patients' records for the presence of advance directives at any time pursuant to the guidelines set forth in the Medical Record Standards section of the Provider Manual.

There are different types of advance directives. They are: "Medical Orders for Life-Sustaining Treatment", "health care proxy," "living will" and "durable power of attorney for health care."

Medical Orders for Life-Sustaining Treatment (MOLST):
This is a program designed to improve the quality of care patients receive at the end of life by translating patient goals for care and preferences into medical orders. MOLST is intended for patients with serious health conditions who: want to avoid or receive any or all life-sustaining treatment, reside in a long-term care facility or require long-term care services, and/or might die within the next year."

Health Care Proxy:
Member must be at least eighteen (18) years old and of sound mind (can make decisions on their own), and can use a health care proxy to choose someone they trust to make health care decisions for them (the "agent"). This person then will make health care decisions according to the instructions if for any reason the member becomes unable to make or communicate those decisions him/herself.

Living Will:
This is a document in which a person specifies the kind of life-saving and life-sustaining care and treatment he or she does or does not wish to receive in the event the person becomes both incapacitated and terminally ill. Many states have their own titles for a living will document such as "Directive to Physicians," "Declaration Concerning Health Care," etc.

Durable Power of Attorney for Health Care:
This is a legal document through which a person appoints someone else, an "attorney-in-fact," to act on the person's behalf in making medical treatment decisions in case of future incapacitation.

If a member decides they wish to have an advance directive, there are several ways to get this type of legal form. This form can be obtained from a lawyer or from a social worker.

A member may also call FHW's Customer Service Department at 1-855-561-7247 (TTY users, please call TRS Relay 711) to request a health care proxy form.

Regardless of where the form is obtained, keep in mind that it is a very important document. One may consider having a lawyer help prepare these. It is important for the member to sign this form and keep a copy at home. They should also give a copy of the form to all of their healthcare providers and to the person named on the form as the one to make decisions if they can't.

It is also recommended that copies be given to close friends or family members. If a member knows ahead of time that they are going to be hospitalized, and have signed an advance directive, they should take a copy with them to the hospital.

If the member has not signed an advance directive form in advance but decides at the hospital that they want one, the hospital can provide the form to sign at that time. It is a member's right to fill out an advance directive at any time. According to law, no one can deny care or discriminate against a member based on whether or not they have signed an advance directive.

With advance directives, members also have the right to:

- Make decisions about their medical care
- Get the same level of care, and be free from any form of discrimination, whether or not they have an advance directive
- Get written information about their health care provider's advance directive policies
- Have in their medical record their advance directive, if they have one

For questions, please call FHW's Customer Service Department at 1-855-561-7247 (TTY users, please call TRS Relay 711), Monday through Friday, 8 a.m. to 8 p.m.

AMBULATORY CARDIAC MONITORING

Ambulatory cardiac monitoring services are covered only if ordered by a plan provider. The cardiac monitoring provider agrees to abide by the following guidelines:

1. Cardiac technician-attended monitoring must be provided 24 hours a day, seven days a week.
2. All electrocardiograph transmissions must be received on a toll-free line from anywhere in the United States.
3. Cardiac technicians must be available to assist plan providers or plan members with service questions or problems.
4. Records of any transmitted information for each plan member must be retained for a minimum of ten years.
5. For any emergency arrhythmia situation, the provider will alert plan provider via fax and/or verbal notification. In addition, the provider must alert an emergency rescue team, if needed, and fax the electrocardiograph tracing to the emergency room for advanced notification. The provider will attempt to facilitate the ambulance transportation services from a contracted provider.
6. For each plan member, the provider must produce a final report. This report, along with tracings, will be mailed to the plan provider via first class mail.

All services are subject to coverage, benefits, network, and contract policies and exclusions.

Fallon Health Weinberg

All FHW members can self-refer for mental health or substance abuse outpatient services by contacting a contracted provider. PCPs may also refer members directly to contracted providers. Members and PCPs may also contact FHW, at the number noted on member ID cards, for assistance in identifying contracted providers.

Erie County

In Erie County FHW provides 24/7 clinical coverage for member and provider calls concerning behavioral health emergent and urgent issues. Crisis Services offers a 24-hour hotline for individuals experiencing personal, emotional or mental health crisis. Crisis Services provides information about:

- Mental health services;
- Homelessness;
- Suicide Prevention; and
- Domestic Violence.

Additionally, Crisis Services serves as an Information and Resource for a range of social services.

To contact Crisis Services in Erie County, a FHW member or provider may call 716-834-3131.

Niagara County

In Niagara County, Crisis Services is available to address behavioral health emergent and urgent issues.

Crisis Services is offered to residents of Niagara County. Services provided include:

- Mobile Crisis Outreach;
- Crisis Services Coordination;
- On-site Education and Training; and
- Linkage to Trauma Specialty Services

To contact Crisis Services in Niagara County , a FHW member or provider may call 716-433-5432

Beacon PCP Behavioral Health Consultation Service

Beacon provides a PCP Behavioral Health Consultation Service available to all Fallon Health Weinberg primary care providers including family practitioners and nurse practitioners caring for Fallon Health Weinberg members.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

The PCP Behavioral Health Consultation Service gives Fallon Health Weinberg primary care providers access to one of Beacon's board certified psychiatrists for routine requests during business hours. This is not an urgent service. If a psychiatrist is not readily available to take the call then the call will be returned within 2 business days.

If you have a member, for whom you are prescribing psychiatric medications and have questions about available medications, dosing, or are considering a medication change, you can call us directly at 1-877-249-6659. This service is also available to you to provide a collaborative diagnostic discussion about a member and the management of their behavioral health issues. Physicians who have utilized it report finding it very helpful in clarifying diagnostic, treatment, and medication questions in the management treatment of routine behavioral health conditions in primary care. The service is available Monday through Thursday from 8:30a-6:00p and on Friday from 8:30a-5:00p. To access the PCP Behavioral Health Consultation Service call 1-877-249-6659.

Care Management

Fallon Health Weinberg's Model of Care emphasizes strong community-based partnerships to promote the delivery of comprehensive, fully integrated services. Integration of physical and behavioral health services is vital for assuring Enrollees' wellness, recovery and ability to experience an enhanced quality of life. FHW collaborates with all stakeholders in the member's care through an Interdisciplinary Care Team (ICT) comprised of the member, treating providers, and others involved in the member's care.

FHW's Utilization Management Program is responsible for providing integrated medical management, care coordination, complex case management and disease management services in collaboration with network providers and community agencies. UM nurses and behavioral health care managers provide regular concurrent review of an FHW member admitted to a hospital, acute rehabilitation facility or skilled nursing facility, using nationally recognized criteria to determine the appropriate level of care, and other case management services. Additional information is provided in the sections on **Hospitalization and Skilled Nursing Facility Admission** and **Observation Policy.**

FHW RN and behavioral health case managers provide complex case management, transitions in care services and other care coordination services that are delivered as part of the ICT as described below.

The focus of the ICT structure is coordination of care, which is vital to the improvement and maintenance of health among adult Dual Eligibles, who often face behavioral and medical co-morbidities or complex health issues.

All medical and behavioral health providers who are involved in the treatment of the Enrollee are included in the ICT in order to ensure care is coordinated across the continuum of care. ***The Primary Care Physician (PCP)*** is considered the lead of the ICT and is responsible for providing comprehensive annual evaluations and providing direction for the overall care plan. The lead ***Behavioral Health Provider*** is considered the co-lead when the Enrollee has an SMI diagnosis.

The ***Navigator*** (Care Coordinator) serves as the advocate for the Enrollee and coordinates all needed services. The Navigator is responsible for the initial outreach to a new Enrollee and for ensuring that all care and services are communicated to the ICT.

The ***Nurse Case Manager*** assesses the Enrollee upon enrollment and at scheduled times thereafter. The Nurse Case Manager provides consultation to the ICT about all medical conditions and care and the medical aspects of behavioral health conditions.

The ***Behavioral Health Case Manager*** may participate in the assessment of needs for new Enrollees and at scheduled times thereafter as clinically appropriate. The Behavioral Health (BH) Case Manager becomes the lead Case Manager when the Enrollee's primary

condition is behavioral.
The ***Independent Living and Long Term Services and Supports (IL-LTSS) Coordinator*** evaluates the Enrollee's needs for long term services and supports and advocates on the Enrollee's behalf through the development and implementation of an integrated Individualized Plan of Care that will appropriately meet the Enrollee's needs.

Long Term Care Residence Enrollees
Members of the ICT for Enrollees living in a Long-term Care setting include all of the same providers described above, as well as a ***Liaison*** from the facility where the Enrollee resides. For example, an Enrollee living in an assisted living facility will have an ***Assisted Living Facility Liaison***.

Disease Management

FHW has several in-house, internally developed disease management programs designed to empower members with chronic health conditions to self- manage their disease and achieve optimum control. The purpose of the FHW Disease Management program is to slow disease progression, prolong periods of health and improve quality of life by focusing on healthier living.

Disease Management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease Management supports the member-practitioner relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence based guidelines that serve as the clinical basis for these programs and member empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health.

Identification of members begins upon enrollment in FHW with member reported information including but not limited to Health Risk Assessment and medical and pharmacy claims data. Other means of identification may include Provider referral, Customer Service referral, Self- referral, Case Management referral and laboratory data.

Condition specific educational materials are provided to all members enrolled in the program. Health Educators/Nurses provide telephonic outreach to those members deemed to be "high or moderate risk." They use a "coaching" model to move members through lifestyle behavior change which addresses diet, exercise, stress management and tobacco cessation to name a few. Disease specific self- management is also addressed and includes medication adherence, biometric tracking and follow up medical care. Content for all disease management programs includes HEDIS® measures and is based on nationally recognized standards of care. There is no charge to the member for this program and membership is entirely voluntary.

Asthma

The National Heart Lung and Blood Institute (NHLBI) *Guidelines for the Diagnosis and Management of Asthma* serves as the clinical basis for the asthma management program.

The program focus is on lowering the frequency of attacks through symptom recognition, trigger identification, environmental modification and proper use of medications, as well as pathology and risk factors. Additional topics include peak flow monitoring and exercise tolerance. Smoking cessation and secondhand smoke are also discussed at length and on a regular basis.

COPD

The *Global Strategy for the Diagnosis, Management and Prevention of COPD*, *Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2014* serves as the clinical basis for the COPD Management program.

The program focus is on symptom management and improving the quality of day to day life. The Nurse or Health Educator discusses assessment and modification of the environment as well as proper use of medication/oxygen therapy. Additional topics include assessing activity level, exercising to appropriate level with physician consent and energy conservation. Smoking cessation and secondhand smoke are also discussed at length and on a regular basis.

Diabetes

The ADA Standards of Medical Care in Diabetes 2013 serves as the clinical basis for the diabetes management program.

Diabetes is one of our largest disease management programs. Health Educators coach members to help them control their diabetes through nutrition therapy, exercise and medication adherence. Additional topics include carbohydrate counting, increased activity, self-blood glucose monitoring, target blood glucose values and resulting HgbA1c, medications and how each plays a role in diabetes self-management.

Cardiac Disease

The clinical basis for the cardiac management program uses a combination of evidence based guidelines:

- The *Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure.*
- The *Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Executive Summary.*

Health Educators coach members about causes of their specific cardiac disease and lifestyle

changes needed to prevent future cardiac events. They work with members to help them to reduce modifiable risk factors such as obesity, inactivity, high blood pressure, elevated cholesterol and LDL, and smoking. Additional topics include medication adherence and cardiac disease self- management.

Heart Failure

The *2009 Focuses Update Incorporated into the ACA/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults* serves as the clinical basis for the heart failure management program.

Although the Heart Failure member population tends to be small it remains a significant chronic condition in the toll it takes on the daily lives of members if left unmanaged. The Nurse Health Educator coaches members to measure their weight, blood pressure and pulse on a daily basis and to report changes to their baseline to their primary care physician. Dietary sodium content is also discussed along with the use of a sodium log to self- monitor daily intake. Additional topics include medication adherence, smoking cessation, exercise and early symptom recognition and reporting.

Satisfaction with Disease Management

FHW annually evaluates satisfaction with the disease management program by obtaining feedback from members and analyzing member complaints and inquiries.

Providers may refer members to Disease Management Programs by calling 1-800-333-2535 ext 69898.

Integrated Care Team

FHW's Integrated Care Team provides care management services to members that have both medical and behavioral health care needs.

Members are made aware of these programs via several channels including:

FHW Outreach: FHW Navigators educate Enrollees about the available care management programs during the orientation outreach call and health needs assessment process.

Print media: the member magazine, enrollment materials and mailed program announcements.

Face to face: Providers receive education regarding FHW integrated care management team initiatives and are provided with materials to help them to facilitate members' involvement in programs. Education is provided by FHW provider relations staff. FHW staff frequently attends community based health fairs and other community events and disseminates program information as appropriate.

Telephonic: Other FHW departments receive education regarding the programs offered so that they are able to discuss pertinent programs with Members with whom they may be interacting on the telephone. These departments include customer services, enrollee services, provider relations, sales and marketing, and Utilization and Care Management. These departments receive training during their regularly scheduled departmental meetings, managers meetings and "all-employee" meetings. Entities outside of FHW also receive training as appropriate.

Chiropractic Services

Fallon Health Weinberg (FHW) partners with American Specialty Health Network (ASHN) for Chiropractic services.

Chiropractic benefit covers services for symptomatic musculoskeletal conditions requiring manual manipulation of the spine to correct subluxation. Symptomatic conditions include spinal aches, strains, sprains, nerve pains and functional mechanical disabilities of the spine. For services to be covered, a referral from the primary care provider is required.

Procedure:

For a referral to a participating chiropractor, the PCP must provide the member and/or the chiropractor with a written prescription. The script should include the following:

- Referring provider's name and address
- Member's name and identification number
- Referral issue date
- Primary diagnosis code

The chiropractor must submit a copy of the prescription to American Specialty Health Network (ASHN) when submitting the initial claim.

All services are subject to coverage, benefits, network, and contract policies and exclusions.

American Specialty Health Network contact information

- To update any existing date: 1-800-972-4226 , option 2
- Fax change request: 1-866-545-2746
- Provider applications: 1-888-511-2743, option 1
- General ASHN customer service: 1-800-848-3555

Dental Benefits

Dental Services are limited and do not include services in connection with care, treatment, filling, removal, or replacement of teeth. Non-routine dental care covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician. Prior authorization is required for these non-routine dental services.

Durable Medical Equipment (DME)

DME is defined as equipment which (a) can withstand repeated use (e.g., could normally be rented and used by successive members, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of illness or injury and (d) is appropriate for use in a member's home.

Procedure:

Most DME items require prior authorization. Prior authorization is not a guarantee of payment FHW maintains a list of inexpensive routinely purchased DME items that do not require prior authorization. The list of DME items that do not require prior authorization is available in the FHW Provider Manual.

Prior authorization for DME is coordinated through the Utilization Management Program. The Utilization Management Program will determine if the item is medically necessary for the member and will coordinate with a medical director any request that requires medical review, and will determine whether the item will be rented or purchased.

The DME supplier is responsible for obtaining prior authorization from FHW when prior authorization is required. The DME supplier is responsible for obtaining a physician's written order for any requested DME item and for maintaining the physician's written order on file and available to FHW upon request. The DME supplier calls the FHW Utilization Management Program 1-855-827-2003, or fax the Request for Prior authorization form to 716-810-1906.

DME providers will be assigned an authorization number for approved items. The authorization will include: specific timeframe, codes, and rental vs. purchase. Within 48 hours from receipt of all necessary information, FHW will communicate authorizations via fax to DME suppliers. The DME provider is responsible for ensuring that the appropriate authorization is in place prior to delivering any equipment or supplies. In instances where DME items are not authorized, the DME provider will be notified via fax of the denial decision. The PCP and member will receive a determination letter. The decision will include the denial reason(s). The member may appeal according to FHW's member appeals policy.

Orthotic/prosthetic devices

Orthotics are defined as rigid or semi-rigid devices that are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Prosthetics are defined as devices that replace all or part of an internal body organ (other than dental) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ.

Procedure:
Most orthotics/prosthetic items require prior authorization. Prior authorization is not a guarantee of payment. Please refer to the Procedure Code Look Up Tool which can be found in the Provider Tools available on www.fallonweinberg.org

Prior authorization for orthotics/prosthetics
Orthotics/prosthetics providers will be assigned an authorization number for approved items. The authorization will include: specific timeframe, codes, and rental vs. purchase. Within 48 hours from receipt of all necessary information, FHW will communicate authorizations via fax to Orthotics/prosthetics providers. The DME provider is responsible for ensuring that the appropriate authorization is in place prior to delivering any equipment or supplies.

In instances where DME items are not authorized, the DME provider will be notified via fax of the denial decision. The decision will include the denial reason(s). The member may appeal according to FHW's member appeals policy.

Directing and monitoring emergency care
The plan covers emergency care worldwide. Enrollees with an emergency medical condition should go to the nearest emergency room for care or call the local emergency communications system (e.g., police, fire department or 911) to request ambulance transportation.

An emergency health condition is a condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual (or unborn child);
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Examples of covered emergencies are stroke, unconsciousness, heart attack symptoms or severe bleeding.

Emergency services do not require prior authorization. The PCP should be notified so that arrangements can be made to coordinate any needed follow-up care. The plan will work with the PCP to assure that any follow-up continuing care that is medically necessary will be arranged for the member. Follow-up care in an emergency room often will not meet a prudent layperson definition and most emergency room follow-up care can be provided in a setting other than an emergency room.

In out-of-area emergencies the member is instructed to call the local communication system (e.g., police, fire department or 911) or go to the nearest medical facility for care. Within 48 hours after receiving emergency care the member or someone on their behalf should notify the plan and contact their PCP for follow-up assistance. It is preferred that once stabilized a member returns to the service area for follow-up care.

Urgent care
The member is instructed to call the PCP before seeking urgently needed services. Urgently needed services are those services needed immediately as a result of an unforeseen illness, injury or condition. The PCP should ensure that the member is seen in the PCP’s office or where ever appropriate. The hospital emergency department should be recommended only when the PCP determines that the office is an inappropriate place for treatment. If out-of-area and a member requires urgent care, they are instructed to call their

PCP first, if possible, before going to the nearest medical facility.

Procedure:

In-area care

If the member calls the physician prior to treatment, the physician:

- Recommends the most appropriate plan of treatment.
- Advises the member where to go for treatment.
- Calls the hospital emergency department to advise of referral, if appropriate.

If the member does not call the physician until after receiving emergency department treatment, the physician obtains information on the service and arranges follow-up care.

The physician follows the member to ensure that emergency department care and any subsequent admission is appropriate and managed properly.

Follow-up for out-of-area care

The member calls the PCP to arrange for any follow-up care. The PCP follows referral procedures in order to authorize follow-up care with any other provider. Follow-up care should be provided in the PCP's office when appropriate.

Emergency Room

Fallon Health Weinberg provides coverage of emergency room services, twenty four (24) hours a day, seven (7) days a week. If a member needs to access emergency care, any hospital listed in the Provider Directory is available for use. Members can go to any hospital for emergency care without a referral.

We want to make it easy for you to serve and provide the highest quality care possible to your FHW patients. With this goal in mind, we will keep you informed of FHW policies and procedures as well as your responsibilities as a participating FHW provider. We will send you our bimonthly newsletter as well as routinely update our Web site: www.fallonweinberg.org

AS A FHW PROVIDER YOU MUST:

- Accept and treat your FHW patients in an identical manner to all other patients in your practice. Participate in the members Integrated Care Team, discharge planning and follow-up.
- Adhere to all FHW policies and procedures as outlined in the *Provider Manual* or other appropriate channels.
- Respond to your FHW patients' linguistic, cultural, communication, access and any other unique needs.
- Accept and treat all members regardless of race/ethnicity, age, English proficiency, sexual orientation, health status or disability.
- Help your non-English speaking members get interpreter services if necessary.
    - FHW offers free translation services for non-English speaking members. If you need assistance translating any written FHW materials, contact FHWs Customer Service Department at 1-855-561-7247. All written materials are available in Spanish. FHW will translate written materials into other languages over the phone.
- Allow members to exercise their rights without worrying about adversely affecting their treatment.
- Provide Advance Directive information according to health plan requirements.
    - For more information see Advance Directives
- Provide or coordinate all age-specific Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services according to health plan requirements.
- Meet regulatory requirements.
    - Adhere to the Standard for Privacy of Individually Identifiable Health Information.
    - Use Health Insurance Portability and Accountability Act (HIPAA) compliant practices.
    - Report mandatory findings to local health departments and notify us as appropriate.

- Comply with medical record standards as outlined in Medical Record Standards section of the provider manual.
- Provide treatment consistent with professional standards and have in place systems for accurately documenting:
    - Member information
    - Clinical information
    - Clinical assessments
    - Treatment Plans, services provided and outcomes
    - Contacts with a patient's family, guardian, or partner
- Notify a patient's primary care provider (PCP) about any services and/or treatment you provide if you are not the patient's PCP.
- Make covered health services available to all members.
- Complete all required provider training annually or as required according to Federal and State requirements and mandates.
- Discuss all treatment options with your patients, regardless of cost or benefit coverage.
- Keep your information current with us.
- You cannot charge a FHW member for any service that is not medically necessary or not a covered service if you did not explain this, or explain that other services may meet the member's needs. You also need to explain to the member that he/she would have to pay for such services. You will need to document that you have notified the member.

Each Fallon Health Weinberg member selects a primary care provider (internal medicine, family practice) from the list of FHW providers. The personal or primary care provider has the primary responsibility for managing and monitoring overall care and for providing the continuity of care for each member in his/her panel. The primary care provider's role includes the following responsibilities:

- Provide primary care, including preventive care, diagnosis and treatment of illness and injury, and office laboratory and diagnostic services, as available.
- Perform a comprehensive physical exam within 90 days of a community dwelling members' enrollment and within 10 business days of an institutional dwelling member's enrollment
- Participate in the members Integrated Care Team, discharge planning and follow-up

- Provide medical care in the hospital or skilled nursing facility as appropriate, following procedures for “Admitting for Inpatient Stay or Same-Day Surgery.”

- Refer member for specialty care when appropriate, following procedures for “PCP Referral and Plan Prior authorization Processes.”
- Assist with case management by referring members and by participating in multidisciplinary case management teams.

- Provide coverage on 24-hour basis, direct member to appropriate place of treatment and monitor initial and follow-up treatment for member emergent/urgent conditions. Advise emergency room care as appropriate according to procedures.

CERTIFIED HOME HEALTH SERVICES

Certified Home Health Services

A Fallon Health Weinberg Nurse Care Specialist will perform concurrent review on all certified home health services (skilled home health care and home infusion) admissions. Once a member is admitted, the nurse care specialist will perform concurrent review on each case, facilitating discharge planning, assisting with disqualification of continued stay and identifying members for outpatient case management. FHW uses nationally recognized criteria for review.

Procedure

1. All in-home services must be ordered by a plan physician.

2. Skilled home health care is defined as nursing, physical therapy, occupational therapy, speech therapy, home health aide, and/or medical social work provided by a Medicare Certified Home Health Care Agency.

    a) The following applies to SKILLED HOME HEALTH CARE SERVICES **Medicare skilled home health care requirements must be met (i.e. members must be homebound and skilled needs must be present based upon Medicare criteria).**

    b) If the request is approved, FHW will provide a 30-day authorization beginning on the "start of care" date. An Agency doesn't need to send a request for an evaluation first, and then a subsequent request when the plan of care is known. All requests must be submitted on the Universal Health Plan/Home Health Authorization Form – March 1, 2006 version.

    c) If a member needs additional skilled home health Care Services following the initial 30-day period, FHW will consider authorizing subsequent services for up to a 30-day period.

    d) Upon completion of all home health services, the Agency must notify FHW in writing of the discharge utilizing the appropriate discharge section of the Universal Health Plan/Home Health Authorization Form. FHW must be notified of the Agency discharge prior to, or on the day of, the last skilled discipline visit.

    e) In addition, for **all Fallon Health Weinberg Enrollees,** a copy of the Notice of Medicare Non-Coverage letter must be faxed to FHW at the time of discharge and include a discharge summary of services provided.

5. FHW will not authorize any requests for visits which have already been provided and not previously authorized.

6. FHW notification to members of prior authorization concurrent authorization, reduction of services, termination of services and the appeals/grievance process will meet the requirements of Medicare, the Managed Care Act and the Plan.
7. For prompt payment, the Agency must indicate the correct “start of care date” on the request form.

Hospital admissions

When a Fallon Health Weinberg (FHW) member is admitted to an acute care hospital, the hospital must notify the FHW Care and Utilization Management Program by faxing the admission face sheet to 716-810-1904 within 24 business hours of admission. Once the notification is received, the FHW inpatient UM nurse will conduct an admission review to determine the medical necessity of the admission. All clinical should be faxed to 716-810-1904. All other reviews (in-area and out-of-area) will be conducted telephonically or may be submitted to FHW Inpatient Utilization Management by fax at 716-810-1904. Written documentation from the medical record will be requested when verbal and faxed information is inadequate. Reviews must include the following information:

- The date and time of admission
- Type of admission (emergent or elective, inpatient/observation)
- Service the member was admitted to
- Admitting diagnosis
- Co-morbid diagnoses
- Clinical status
- Functional status
- Prescribed medical treatment
- Residence of the member (their own home, long-term care facility, assistive living, etc.)
- Name, address and phone number of the responsible party or legal guardian
- Estimated length of stay

Admission and length of stay are based on medical necessity and the appropriateness of the level of care. FHW physician medical review is available to consult with the inpatient UM nurse and physician regarding medical necessity and level of care issues as they arise. The UM nurse works collaboratively with the physician and hospital staff to assist with and promote a timely discharge.

FHW Standard Response Times Acute inpatient and Outpatient

	Type of Request	Response Time
	Concurrent (Inpatient Approval	Decision is made in 1 business day of obtaining all necessary information Oral notification of decision is given to provider in1 business day of decision being made Written/electronic notification given to provider within 1 day after oral notice
	Concurrent Intensive Outpatient	Notice to include number of days, services, etc. extended Decision is made in 1 business day of obtaining all necessary information Oral notification is given to provider in 1 business day of decision being made Written/electronic notification given to provider within 1 day after oral notice Notice to include number of days, service, etc extended
	Concurrent (Inpatient Denial)	Decision is made in 1 business day of obtaining all necessary information Oral notification given to provider in 1 business day of decision Written / electronic notification given provider in 1 day after oral notice Advised of expedited appeal process if request is denied Continue service until member notified of termination or reduction in coverage
	Concurrent (Outpatient Denial)	Notice is sent to member in sufficient time for member to appeal and get decision on appeal before the benefit is reduced or terminated. Decision is made in 1 business day of obtaining all necessary information. Oral notification given to provider in on business day of decision Written/electronic notification given to provider and member 1 day of oral notification

	Reconsideration	Provider can request reconsideration at notification of denial with decision made within 1business day. Oral notification given within 1 business day.
	Post-Service Review Process	Decision is made in 30 calendar days from receipt of request. Electronic or written notification of the decision given to member/practitioner in 30 calendar days from receipt of request.

Retrospective reviews for hospital and skilled nursing facility admissions

Medical admissions and discharges that occur over holidays and weekends will require a retrospective review until a concurrent review can be conducted. BH admissions and discharges can be discussed 24 hours a day 7 days a week.

The UM nurse may conduct a telephonic or electronic review. A retrospective review may take up to 30 days for a determination. The UM nurse or designated staff representative will notify the billing department of the hospital or skilled nursing facility of the determination.

Admission to a skilled nursing facility

All admissions to a skilled nursing facility (SNF) must be approved by the FHW UM nurse prior to admission.

For FHW Enrollees, the level of service and number of covered days that the enrollee is admitted to the facility of admission will be based upon the medical necessity of the condition as determined by your plan physician and the plan.

Care in an SNF will be covered if all of the following three factors are met:

1. The member requires skilled nursing or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel.
2. The member requires these skilled services on a daily basis.
3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in an SNF. Services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of the member's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, his/her particular medical needs and accepted

standards of medical practice. The services must also be reasonable in terms of duration and quantity.

If the member does not meet skilled care criteria or care can be provided in a less restrictive setting (including the home), the request for admission will be reviewed with the medical director and the member will be notified of the decision. If admission is denied, the member will be issued a notice of non-coverage letter. If a member requests admission to a non-contracted facility, the request will be reviewed and the member will be notified of the decision. (It is at the sole discretion of the plan to authorize a non-contracted SNF admission for FHW Enrollees). In addition, FHW Enrollees are entitled to a home SNF benefit as described in Title VI, Section 621 of BIPA. Under this SNF home benefit, a member may elect to receive post-hospital services through the following facilities:

- The SNF in which the enrollee resided at the time of admission.
- The SNF that provided services through a continuing care retirement community that provided residence to the enrollee at the time of admission to a hospital.
- The SNF in which the spouse of the enrollee is residing at the time an enrollee is discharged from the hospital.

An enrollee may elect to receive services through one of these facilities only if the facility has agreed to be treated in a substantially similar manner as an FHW contracted SNF.

Prior to admission to a SNF, the physician or transferring hospital must notify the assigned UM nurse or contact the FHW Utilization Management Program—Skilled Nursing Facility Team at the designated SNF fax line 716-810-1905

Upon admission to a skilled nursing facility, it is the responsibility of the designated staff at the facility to contact the FHW UM nurse of the admission as soon as possible on the day of admission, and no later than within 24 hours of admission.

Once a member is admitted to a skilled nursing facility, the UM nurse conducts a concurrent review and collaborates with the treatment team and FHW outpatient case manager for discharge planning if the member returns to a non-institutional setting.

Length of stay in a skilled nursing facility will be based on the member meeting skilled care criteria. The skilled nursing facility shall designate a case management contact that will be responsible for providing the FHW UM nurse with weekly updates on the member's clinical and functional status. The SNF must contact the assigned FHW UM nurse within two business days after admission. Information must include the member's functional status, skilled qualifiers, types and frequency of the therapies, discharge planning, information regarding the discharge site, family involvement and education required, discharge dates, and changes in the member's level of care.

At a minimum, the FHW UM nurse will conduct weekly updates telephonically or via fax 716-810-1905. The UM nurse may request medical records to review clinical

information in addition to the information requested by fax. The skilled nursing facility is responsible for providing medical records upon request by the FHW UM nurse.

When the member's status changes from skilled to custodial, the facility case manager must notify the FHW UM nurse as soon as this level of care change is anticipated. The member's medical record must be sent via fax to the UM nurse for review by the medical director. If the decision is made to deny further skilled services, the member will be provided with a notice of non-coverage letter. We require that all contracted SNFs provide the notice of non-coverage letter to the member upon request. Length of stay in the skilled nursing facility will be based on the existence of skilled criteria, the ability of the member to achieve realistic goals and the progress of the member. Skilled nursing facilities are responsible for proactive discharge planning, following through on discharge plans, education of the patient/family and facilitating application for financial assistance based upon member needs and future plans.

The skilled nursing facility shall be responsible for notifying the FHW UM nurse within one week prior to a planned discharge to prevent fragmentation of health care delivery and to ensure follow through on the discharge plan. The skilled nursing facility is responsible for notifying the FHW UM nurse when the member's condition requires a change in the level of care, within 24 hours of the change.

Lack of notification by the skilled nursing facility to the FHW UM nurse when the member's level of care changes or the member no longer requires skilled services will become the facility's financial responsibility until the FHW UM nurse is notified.

INTERPRETER SERVICES

FHW offers free translation services for non-English speaking members. If you need assistance translating any written FHW materials, contact FHW's Customer Service Department at 1-855-561-7247.

All written materials are available in Spanish, large print and other alternate formats like Braille. FHW will translate written materials into other languages over the phone.

If you need an interpreter to be present during your healthcare visit, let your healthcare provider's office know at the time you schedule your healthcare appointment.

Please call FHW's Customer Service Department at 1-855-561-7247. (TTY users please call TRS Relay 711), Monday through Friday, 8 a.m. to 8 p.m.

LOCATING A NETWORK PROVIDER

At FHW we make finding a network provider easy.

FHW members will need to pick a primary care provider (PCP) who is affiliated with FHW and is within their network. If they do not pick a PCP, FHW will choose one for them. Members can contact FHW customer service at any time to assist with this process.

Whenever possible, a PCP should refer to a specialist who is in the member's network. In some cases, such as when the type of specialty that a condition requires is not available from an FHW network provider, the PCP will need to request an authorization from FHW for the member to see a provider outside of their FHW network. See PCP referrals and plan prior authorization process to learn more about services that require a referral or prior authorization.

To assist members with choosing a network provider, please refer to the online provider Look Up tool found at: www.fallonweinberg.org.

You will be able to search by product network, provider name, location, specialty or language. You do not need a username of password to use this online tool.

You may also call FHW's Customer Service Department at 1-855-561-7247 (TTY USERS, PLEASE CALL TRS RELAY 711), Monday through Friday, 8 a.m. to 8 p.m. to assist with this process.

NURSE CONNECT

FHW offers all FHW members access to registered nurses and other health care professionals who serve as health coaches 24 hours a day, seven days a week, 365 days a year. A health coach can provide:

- Personal education and support
- Information to help your patients make health decisions
- Educational materials relevant to a diagnosis or condition (mailed right to their home)
- Assistance with finding additional health information online

Your patients can reach a Nurse Connect health coach by calling FHW's Customer Service Department at 1-855-561-7247 (TTY USERS, PLEASE CALL TRS RELAY 711),

Observation policy

An observation stay is an alternative to an inpatient admission where short-term, intensive outpatient care is believed to be medically appropriate to manage and improve a member's condition and expedite the return home. Examples of diagnoses amenable to outpatient observation status are: dehydration requiring fluid administration, R/O appendicitis and renal calculi. Candidates for observation status should be identified as early as possible and orders should be written that indicate assessment or observation days.

Any member admitted up to 48 hours may be considered on observation status and considered outpatient. Members who require hospitalization more than 48 hours will be considered inpatient admissions, or per the contractual provision.

Members admitted for same-day surgery and discharged within 48 hours will be considered observation status under the same-day surgery umbrella, if applicable to the provider's contract.

The FHW UM nurse reviews all admissions. If the member meets the observation status criteria, the UM nurse will document the hospital stay as outpatient status and inform the hospital of the determination.

Observation policy defined

Observation is an alternative to an inpatient admission that will allow a reasonable and necessary time to evaluate and render medical services to:

- Those members with unstable conditions whose diagnosis and treatment is not expected to exceed 48 hours.
- Those members whose need for an inpatient admission can be determined within that specified time.
- Those members with conditions that may be responsive to aggressive, timely and expeditious outpatient treatment extending up to 48 hours.
- Those members undergoing post ambulatory surgical procedures requiring additional observation beyond midnight (e.g., pain control, hydration, etc.).
- Those members with post-diagnostic procedures with an untoward complication requiring additional observation and/or treatment (e.g., allergic reaction - IVP, etc.) beyond normal recovery period for that procedure.

The 48-hour time frame should remain a benchmark. Cases that need to remain in observation more than 48 hours should be evaluated on an individual basis and should be the exception rather than the rule. Observation may not exceed 48 hours.

Observation is **not** to be used:

- As a convenience for the member or the physician.
- As a routine preparation or routine recovery from diagnostic or surgical procedures.
- For the administration of blood, chemotherapy or sleep studies.
- For socioeconomic issues or custodial care.
- In place of recovery room or an extension to surgical day care if discharge is appropriate before midnight the day of the procedure.
- For cases routinely and appropriately cared for in the emergency or outpatient department.

Physician and hospital responsibilities:
The physician assumes the following responsibilities for an observation stay:

- The physician order should clearly indicate an admission to observation status including time and date.
- The physician may assign a member to observation directly from the office, through the emergency department, and following same-day surgery and diagnostic procedures.
- The physician is encouraged to inform a member of their observation status.
- The attending physician is responsible for evaluating the member at least once in the 24-hour time period, and more often as dictated by the clinical circumstances.
- The decision to discharge from observation, admit as an inpatient or continue in observation must by made by the 47^{th} hour or earlier.

The hospital assumes the following responsibilities for an Observation Stay:

- Care for Observation Status may be received on an observation unit, entirely within the emergency department (up to 48 hours) or in an inpatient bed.
- The member treated in observation must receive appropriate inpatient care, including reasonable and necessary periodic monitoring by the nursing staff.
- The hospital must obtain an authorization for all members placed in observation status.
- The hospital must provide a census to Fallon Health Weinberg for those members placed in and/or discharged from observation during the previous 48 hours.

- Plan nurse care specialist may concurrently or retrospectively reclassify inpatient admissions to observation status, or vice-versa, if deemed medically necessary upon review.

Fallon Health Weinberg observation diagnoses

Observation diagnoses may include, but are not limited to:

- Abdominal pain
- Angina, R/O MI
- Asthma
- Back Pain (musculoskeletal)
- Biliary colic
- Bronchiolitis/bronchitis
- Cellulitis and other skin infections
- Change in mental status
- Chest pain
- Chronic obstructive pulmonary disease
- Closed fractures
- Concussion
- Congestive heart failure
- Croup
- Dehydration
- R/O ectopic pregnancy
- Diabetes (without ketoacidosis)
- Epistaxis
- False/premature labor
- Fever of unknown origin (FUO)
- Gastroenteritis
- Grand mal status and other epileptic convulsions
- Headache or migraine
- Hyperemesis gravidarum
- Hypoglycemia
- Immunization-related reactions
- Kidney and urinary infections
- Lumbar puncture reaction
- Parenteral pain management
- Pelvic inflammatory disease
- Preeclampsia
- R/O CVA transient ischemic attack (TIA)
- Renal colic
- Sinusitis/pharyngitis
- Smoke inhalation
- Syncope

Oral surgery

Policy

Fallon Health Weinberg (FHW) covers the following oral surgery services. All services must be provided by a plan-contracted oral surgeon. This does not include plan dentists.

FHW provides for emergency related dental care and oral surgery performed in an outpatient hospital or ambulatory surgery setting which is medically necessary to treat an underlying medical condition.

Please note:
All members may self-refer to an FHW plan-contracted oral surgeon for the removal of impacted teeth and emergency dental care. For any other oral surgery procedure, plan authorization is required. The provider should verify eligibility prior to performing the procedure by calling FHW at 1-855-827-2003

Oral surgery services:

1. Oral examination and subsequent extraction of teeth for the following:
    a. Suspected infection in those at risk for developing bacterial endocarditis
    b. Preparation for radiation treatment of the head or neck

2. Removal or exposure of impacted teeth, including both hard and soft tissue impactions

3. Surgical removal of benign or malignant lesions (includes cysts) affecting the intraoral cavity.
    a. Reconstruction of a ridge is covered when performed as a result of and at the same time as the surgical removal of a tumor.

4. Surgery related to the jaw or any structure connected to the jaw, including structures of the facial area below the eyes. This includes:
    a. Reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances if used for this purpose.
    b. Wiring of teeth when performed in connection with the reduction of a jaw fracture.

c. Removal of a torus palatinus (a bony protuberance of the hard palate) if the procedure is not performed to prepare the mouth for dentures.

d. Lingual frenectomy

e. Insertion of metallic implants if the implants are used to assist in or enhance the retention of a dental prosthetic as a result of a covered procedure.

5. Emergency dental care such as to relieve pain and stop bleeding as a result of accidental injury to sound natural teeth or tissues when provided as soon as medically possible after the injury. This does not include restorative or other dental services.

6. Oral examination to detect infection prior to kidney transplantation.

Procedure for referring to oral surgeons:
The primary care provider (PCP) should contact the oral surgeon by telephone, fax or mail and provide the PCP's name, NPI number, and the reason for the initial consultation. There is no referral required for extraction of impacted teeth by a plan-contracted provider.

All subsequent visits for these services require prior authorization by the servicing

provider.

The oral surgeon must submit a *Request for Prior authorization Form* for all subsequent oral surgery services and treatment to the FHW Utilization Management Program at 1-855-827-2003.

The form must have the following sections completed:

Form section #	**Complete:**
I.	Member information
II.	Referring physician
III.	Prior authorization request
V.	Signature

All services are subject to coverage, benefit, network and contract policies and exclusions.

Out-of-area care

Members are covered for emergency services, post-stabilization services and urgent care services, such as injuries and sudden illnesses, wherever they travel, even when outside of FHW's service area. If a member becomes seriously sick or hurt while out of area, they should be instructed to go to the nearest doctor or emergency room or call 911. Members are instructed to call their PCP within 48 hours of receiving health care while traveling.

Routine health care is not covered outside of FHW's service area. The following are examples of care that is NOT covered while a member is traveling:

- Tests or treatment that a PCP requested before the member traveled
- Routine care or care that can wait until the member returns home (for example, physical exams or immunizations)
- Routine care that can be anticipated as a need before traveling (for example, routine prenatal care)

PCP Referral and Plan Prior Authorization Process

Fallon Health Weinberg's (FHW's) referral and prior authorization process is outlined in the following pages. A grid is provided to describe the PCP referral and prior authorization, and notification policies and procedures. The type of service, services included and referral process are outlined within the grid. FHW's PCP referral and prior authorization process applies to all FHW products.

The following are important reminders about FHW's referral and prior authorization process:

- PCP coordination of care is the foundation for care delivery.
- All specialty visits, initial and follow up, must be coordinated by the PCP. Specialists cannot refer to other specialists.
- Specialty visits that occur without PCP coordination will not be reimbursed. Any exceptions to this rule, e.g., member self-referrals, are specifically noted below.
- Office-based procedures: FHW has a designated list of procedure codes available in the Procedure Code Look Up Tool, which can be found in the Provider Tools available on www.fallonweinberg.org, that require plan prior authorization by the performing physician.
- PCPs are allowed to direct for specific types of specialty services for eligible health plan members who are being referred within the members' network option.
    - If the PCP refers a member for **non-covered benefits**, **or to non-contracted provider**s, the **PCP's referral becomes void**, as these situations require plan prior authorization.
    - Please note that if these non-covered or out-of-network services are not specifically preauthorized by the plan, reimbursement to these providers will not occur, and either the member or referring physician will be financially liable for the services.
- A pre-service denial box has been added to the Request for Prior Authorization form. If a FHW Enrollee disagrees with his/her physician or clinician regarding a request for service, the member has the right to appeal this decision. FHW must then issue a written determination notice to the member and include the member's right to appeal. Our physician reviewers must have the clinical rationale in order to exercise an independent clinical judgment. Should FHW agree with the decision to decline or deny a referral for medical services or supplies, a formal denial will be issued to the FHW Enrollee, which, per regulatory requirements, may be subsequently appealed

by the member.

PCP referrals

Referrals for specialty care are required for FHW members.

1. The PCP refers the member to a specialist within the member's product for medically necessary care.
2. PCP contacts the specialist by telephone, fax, mail, or script and provides the PCP's name, their NPI number, the reason for the referral and number of visits approved.
3. Referral should be documented in member's medical records for both PCP & specialist. FHW reserves the right to audit medical records to ensure specialty referral was obtained. Lack of proof of referral may result in claims retractions.
4. The specialist verifies member's eligibility through the FHW online eligibility tool, POS device or by contacting FHW Customer Service at 1-855-561-7247.
5. The specialist treats the member according to the PCP's request and exchanges clinical information with the member's PCP.

All services are subject to network, coverage, benefit and contract policies and exclusions.

PCP referral and Prior Authorization grid

Type of service	Services	Referral process/Prior Authorization
Primary care	Family practice Internal medicine	Member self-referral
Specialty services	Specialty visits—all non-contracted, tertiary	Plan prior authorization requested by PCP.
	Specialty visits—all FHW contracted providers within member's	PCP referral
	Annual GYN (one visit)	Member self-referral within product Option
	Other GYN	Member self-referral within product option (Pursuant to Chapter 141)
	Chiropractors	For a referral to a participating chiropractor, the PCP must provide the member and/or the chiropractor with a written prescription each calendar year. The chiropractor needs to submit a copy of the prescription to American Specialty Health Network when submitting the initial claim.
	Obstetrics (prenatal and maternity)	Member self-referral within product Option
	Oral surgery (impacted teeth)	Member self-referral within product option NOTE: FHW members- FHW provides for emergency related dental care and oral surgery performed in an outpatient hospital or ambulatory surgery setting which is medically necessary to treat an underlying medical condition.

PCP referral and prior authorization grid

Type of service	Services	Referral process/Prior Authorization
	Oral surgeon consultation * See benefit coverage for FHW members above	PCP referral within product option. For additional information, please refer to the oral surgery section in this document.
	Oral surgery services and treatment * See benefit coverage for FHW members above	Plan prior authorization requested by specialty (for office or facility-based services) for procedures specified on the Procedure Code Look Up Tool
	Plastic reconstructive surgeon consultation	PCP referral
	Plastic reconstructive surgery and treatment	Plan prior authorization requested by specialist (for office or facility-based services) for procedures specified on the Procedure Code Look Up Tool
	Podiatry services	Plan prior authorization is no longer required for most services; although some procedures may still require a plan prior authorization. For additional information, please refer to the podiatry section in this manual.
Specialty services	Transplant evaluation	Plan prior authorization requested by PCP or specialist.
Office-based procedures	For all office-based procedures identified on the List of Procedure Codes Requiring Prior Authorization, the PCP or specialist must obtain plan prior authorization.	
Other professional services	Abortion	Member self-referral (Coverage based on member's benefit)
	Neuropsychological testing	Plan prior authorization requested by PCP or specialist
	Nutrition	PCP referral
	Pain clinic	PCP referral

All services are subject to network, coverage, benefit and contract policies and exclusions.

PCP referral and prior authorization grid

Type of service	Services	Referral process/Prior Authorization
	Routine eye exam	Member self-referral
	Physical, occupational or speech therapy	Covered physical therapy and occupational therapy do not require a PCP referral or prior authorization by the plan. A physician prescription is required and therapists must be contracted by FHW. Members will be covered up to their benefit maximum. Speech therapy requires plan prior authorization by the plan.
	All unlisted CPT-4 codes and all unspecified HCPCS	Plan prior authorization requested by PCP or specialist.
	Genetic testing	PCP referral to specialist required for initial consultation. Plan prior authorization requested by PCP or specialist needed for subsequent testing.
Outpatient diagnostic tests	PET scans	Plan prior authorization requested by PCP or specialist to the NIA program
	All noncontracted, tertiary	Plan prior authorization requested by PCP or specialist.
Hospital/facility	Elective hospital/facility same-day surgery and ambulatory procedures	For all facility-based services identified on the Procedure Code Look Up Tool requiring prior authorization, the PCP or specialist must obtain plan prior authorization and the facility must provide notification to FHW.
	All elective inpatient admissions	Plan prior authorization requested by PCP or specialist

All services are subject to network, coverage, benefit and contract policies and exclusions.

PCP referral and prior authorization grid

Type of service	Services	Referral process/Prior Authorization
DME	DME	Plan prior authorization is required for certain DME services. For additional information, see the DME section in this document.
Nutritional supplements	Nutritional supplements for which coverage is mandated by law are supplied through contracted pharmacies	Plan prior authorization is required. Provider writes a prescription for the nutritional supplement; member fills the prescription at a contracted retail pharmacy. NOTE: For FHW members refer to the Special formula (enteral-nutrition products) process located in the FHW Products section. A specific form for special formulas must be completed and submitted for review.
Hospice	Hospice	Plan prior authorization is required.
Oxygen	Oxygen	Plan prior authorization is required.
Prosthetics and orthotics	Prosthetics and orthotics	Plan prior authorization is required.
Nonemergency ambulance	Nonemergency ambulance	Plan prior authorization is required

All services are subject to network, coverage, benefit and contract policies and exclusions.

PCP REFERRAL AND PLAN PRIOR AUTHORIZATION PROCESS

PCP referral and prior authorization grid

Type of service	Services	Referral process/Prior Authorization
Transportation non-emergent, to in-state location or location within 50 miles of the border	FHW or the member can coordinate this service.	PT-1 Form Required.
Behavioral Health	Outpatient mental health and outpatient substance abuse	Member self-referral by calling FHW at 1-877-249-6659 TTY users, please call TRS Relay 711)
Please note this is not a comprehensive list of all FHW Covered Services.		

FHW Standard Response Times

Type of Request	FHW will respond within:
• **Pre-Service Non-urgent (Routine) Approval**	• Decision is made in 2 business days of obtaining all necessary information FHW may extend the 14 calendar day time frame by up to 14 additional calendar days if the member, authorized appeal representative, if any, or provider requests the extension, or if FHW can justify a need for additional information, there is a reasonable likelihood that such information would lead to approval of the request, if received, and such information is reasonably expected to be received within 14 calendar days. If FHW takes an extension, the member and authorized appeal representative, if any, must be given written notice of the reason for the extension and inform the member and authorized appeal representative, if any, of the right to file a grievance if the member or authorized appeal representative, if any, disagrees with the extension. • Oral notice is given to the provider in 24 hours of decision • Written / electronic notice is given to the member, authorized appeal representative, if any, and provider in 2 business days after oral notice

PCP REFERRAL AND PLAN PRIOR AUTHORIZATION PROCESS

Type of Request	FHW will respond within:
• **Pre-Service Non-urgent (Routine) Approval**	• Decision is made in 2 business days, not to exceed 14 Calendar Days, of obtaining all necessary information . • Decision is made within 14 calendar days of receiving request for service • Oral notice is given to the provider in 24 hours
• **Pre-Service Non-urgent (Routine) Denial**	Decision is made in 2 business days, not to exceed 14 Calendar Days, of obtaining all necessary information . All prior authorization requests expedited by the requesting physician (FHW determines whether to expedite a request if taking the time for a standard authorization decision would seriously jeopardize the member's health) are processed (and written determination notice to the member, authorized appeal representative, if any, and provider is made) as expeditiously as the member's health requires, but not to exceed 48 hours after the receipt of the expedited request for service. FHW will address any extensions for expedited authorizations as well as grievance rights if the member disagrees with the Plan requested extension.
	Oral notice is given to the provider in 24 hours of decision Written / electronic notice is given to the member, authorized appeal representative, if any, and
• **Pre-Service Non-urgent (Routine) Denial**	Decision is made within 14 business days of receiving request for service Oral notice is given to the provider in 24 hours of decision Written / electronic notice is given to the member and provider in 1 business day after oral notice
• **Pre-Service Urgent/Expedited Approval**	Decision is made in 72 hours from receipt of request Oral and written notice given to member, authorized appeal representative, if any, or practitioner in 72 hours of request.
• **Pre-Service Urgent/Expedited Denial**	Decision is made in 72 hours from receipt of request Oral and written notice given to member, authorized appeal representative, if any or practitioner in 72 hours of request

PCP REFERRAL AND PLAN PRIOR AUTHORIZATION PROCESS

Type of Request	FHW will respond within:
• **Pre-Service Urgent/Expedited Extension**	Decision time frame is extended once up to 48 hours if unable to make decision due to lack of necessary information FHW may extend the 14 calendar day time frame by up to 14 additional calendar days if the member or provider requests the extension, or if FHW can justify a need for additional information, there is a reasonable likelihood that such information would lead to approval of the request, if received, and such information is reasonably expected to be received within 14 days. If FHW takes an extension, the member must be given written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with the extension. Decision must be made within 48 hours of receiving the information, or by the end of 48-hour period given the member to supply the information, whichever is earlier Decision must be made even if information is incomplete or was not received within this period Notification must be sent to member within 24 hours of the request to extend the decision time frame regarding specific information to make the decision Member has 48 hours to provide the specified information
Peer to Peer Reconsideration	Provider can request reconsideration at notification of denial with decision made within 1 business day. Oral notification given within 1 business day.
Post-Service Review Process	Decision is made in 30 calendar days from receipt of request. Electronic or written notification of the decision given to member/practitioner in 30 calendar days from receipt of request.

The following services do not require an additional PCP referral or plan prior authorization when provided by a contracted, in-network provider and within the member network option:

- Allergy injections
- Cardiac nuclear medicine testing
- Cardiac rehabilitation outpatient

- Chemotherapy outpatient
- Diabetes education
- Dialysis
- EMG/NCV
- Interventional cardiology (cardiac catheterization, angiography, PTCA, electronic pacing study)
- Pacemaker/defibrillator check
- Pulmonary rehabilitation outpatient
- PUVA
- Radiation therapy outpatient
- Sleep Studies

FALLON HEALTH WEINBERG

Fallon Health Weinberg has a formulary drug list that includes medications from every drug class except for certain medications excluded by Medicare. These excluded medications are the member's responsibility and include the following:

- Agents when used for anorexia, weight loss, or weight gain
- Agents when used to promote fertility.
- Agents when used for cosmetic purposes or hair growth
- Agents when used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Nonprescription drugs
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.
- Drugs not registered in the FDA Drug Directory
- Brand drugs (i.e. drugs with an FDA application type "NDA" or "BLA") that are not under a manufacturer discount agreement.

The FHW formulary can be found on the FHW Web site, www.fallonweinberg.org in the Physicians and providers area, in the "Pharmacy" section. Any medication requiring prior authorization will be designated with "PA" in the requirements column. FHW will notify practitioners whenever there is a change in the formulary. These notifications are by direct mailings, through the provider newsletter, and by email.

New to market policy

FHW follows a new-to-market medication evaluation policy and usage determination for medications newly approved by the FDA. FHW has a waiting period of up to 180 days for all new medications, in order to ensure enough time to determine true dosing parameters, side-effect profiles, drug-drug interactions, drug-disease state interactions, and age-related issues. Medications or new indications of medications that fall within one of the following classes of clinical concern, antidepressants, anti-psychotics, anticonvulsants, anti-cancer, immunosuppressive or HIV/AIDS, will be subject to the expedited review process. This process involves evaluation and usage determination for the preceding medication classes within 90 days of approval by the FDA. During this period, a physician can request the medication via the prior authorization process.

Quantity, duration limits and Step Therapy

To further ensure patient safety, ensure appropriate dosing and control costs, Fallon Health Weinberg has established quantity, duration of use limits and Step Therapy for a specific list of medications. The limits and duration will appear in the quantity limits column and Step Therapy on the note column in the online drug formulary. If a physician would like an exception to this rule for a specific member, he/she can submit a completed prior authorization request form to the Department of Pharmacy Services. This form must state the medical reason why **the management tool would be inappropriate for the member**.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe medications. These reviews are conducted each time a prescription is filled by a member and on a regular basis by reviewing our records. During these reviews we look for the following:

- Possible medication errors
- Duplicate drugs treating same condition
- Age-gender related issues
- Drug-drug interactions
- Drug-disease state interactions
- Drug allergies
- Drug dosage errors
- Over-usage of narcotic drugs

Prescription process

Pharmacies should process member prescriptions through the claims adjudication system at the point of service. When there is a generic version of a brand-named drug available, the pharmacies will automatically give the member the generic version unless the prescribing physician states that the member must have the brand-named drug only (Generic Drug Law St.1976, C.470, Sec.13).

Prescriptions written for Fallon Health Weinberg members must conform to the FHW formulary. If the prescribed drug is not a preferred formulary drug, the pharmacist may call the provider to discuss a substitution or send notification by fax that the prescribed drug requires prior authorization. The pharmacist will not provide a substitution without the physician's approval. If the physician feels that there is no clinically appropriate substitution, he/she should follow the prior authorization request procedure described below to request approval for the medication. It is recommended that every effort be made

to utilize formulary medications before requesting non-formulary products. FHW provides prior authorization approval criteria for most medications listed on the formulary that require prior authorization.

The following information is necessary and mandatory by law when documenting prescriptions (written and oral).

1. Correct spelling of name and address of member
2. Name and address of physician
3. Physician registration number (DEA)
4. Date of writing the prescription
5. Name, dosage and strength of medication
6. Directions of usage
7. Number of refills allowed

Other information that ensures a speedier processing of prescriptions includes the member's date of birth and home telephone number.

FHW encourages practitioners to write or to transmit prescriptions electronically. Prescriptions should be called in to the pharmacy only when it is not possible to give a written prescription, e.g., physician is on-call.

Prior authorization request policy

Prior authorization is required for any medication noted with a "PA" on the FHW formulary, regardless of the quantity being prescribed. Prior authorization is also required for any medication not specifically included on the formulary list.

Prior authorization request procedure

Fallon Health Weinberg partners with CVS health (Fallon Health Weinberg's Pharmacy Benefit Manager) for pharmacy prior authorization. **CVS health reviews pharmacy benefit drugs** (patient self-administered drugs, including oral medications), and **Fallon Health Weinberg reviews medical benefit drugs** (physician-administered drugs, including home infusion).

Ou prior authorization process **offers you two ways to submit a prior authorization** request for patient self-administered drugs:

Patient-administered drugs (pharmacy benefit)

Electronic prior authorization tool (ePA)

You can use the ePA tool to submit prior authorizations securely and electronically. **With the ePA tool, you'll be able to see immediately if an authorization has been granted** or if more information is needed. It's quick and easy! Download the ePA Training Guide (pdf).

You'll get an immediate response—approval, denial, or request for more information—based on the criteria you enter. If your request isn't approved immediately, you'll get a response through the ePA tool after the PA submission is reviewed by a clinician. **You'll also get a fax notice** so that you can easily update your patient's chart. There's no cost to use the ePA tool.

Learn more about the ePA tool
Visit caremark.com/epa to learn more and to register to use the ePA tool. You'll need your NPI and DEA numbers to register.

Call or fax
You can also call in your prior authorization to 1-866-412-5394, or fax it to 1-855-633-7673 . Please use the CVS health prior authorization form if submitting your request by fax.

Physician-administered drugs (medical benefit)

For physician-administered drugs that require prior authorization, fax a completed Prior authorization form for medical benefit drugs to us at 716-810-1909

Please note: To facilitate the process, we recommend reviewing the criteria documents that are available on the FHW website. The criteria and PA Forms can be found on the Providers area of the FHW Web site, www.fallonweinberg.org, in the "Pharmacy" section. Clinical review criteria are also available to all practitioners upon request.

Routine requests are processed within three days from the date the request is received. Urgent/emergency requests are processed within one day of the date the request is received.

The provider will be notified of the decision by fax. If the prior authorization is not approved, the provider will be notified by fax citing denial reasons, alternative medications if indicated, a reference to the guideline, protocol or other similar criterion on which the denial decision is based, and information on the appeal process.

In accordance with federal regulations, members of Fallon Health Weinberg Plan with Medicare Part D prescription coverage are covered, with a required co-payment, for the following mandated medications:

Note: The following Medicare mandated medications are not applied to the Medicare Part D accumulators. A Prior Authorization is required to determine whether the below conditions are met.

- Epoetin (EPO), even when self-administered, when indicated in the treatment of

anemia in connection with the drug AZT or chronic renal failure, with appropriate lab values

- Immunosuppressive medications:
    - o Immunosuppressive drugs are prescribed following a corneal, kidney, heart, liver, bone marrow/stem cell, lung, or heart/lung transplant, whole organ pancreas transplant performed concurrent with or subsequent to a kidney transplant because of a diabetic nephropathy (performed on or after July 1,1999), or intestinal and multi-visceral transplant (performed on or after April 1, 2001).
    - o The transplant met Medicare coverage criteria in effect at the time (e.g., approved transplant facility for heart, kidney, liver, lung, heart/lung or intestinal/multi-visceral transplants; national and/or local medical necessity criteria).
    - o The member was enrolled in Medicare Part A at the time of the transplant and is enrolled in Part B at the time immunosuppressive drugs are dispensed.
    - o The drugs are medically necessary to prevent or treat rejection of an organ transplant in the particular members.
    - o The drugs are furnished on or after the date of discharge from the hospital following a covered organ transplant.
    - o There is no time limit for immunosuppressive drug coverage for Medicare-approved transplants.
- Oral drugs prescribed for anticancer chemotherapy if (a.) the drugs have the same active ingredient(s) as anticancer drugs covered by Medicare, which are not injectable; (b.) the drugs have the same active ingredients in the body.
- Intravenous or oral antiemetic drugs as part of an anticancer chemotherapeutic regimen, limited to 72 hours post cancer treatment.
- Injectable drugs required by Medicare (such as blood clotting factors, calcitonin, influenza vaccine).
- Drugs that are administered through durable medical equipment, for example injectable drugs used in an insulin pump or inhalation medications administered via a nebulizer if Medicare criteria are met.

Diabetic supplies

Fallon Health Weinberg	
Insulin	Prescription copayment per 30 day supply
Insulin syringes (includes needles)	Prescription copayment per 30 day supply
Blood glucose meter	Covered in full
Blood glucose test strips	Covered in full
Blood ketone test strips	Covered in full
Spring-powered lancet device	Covered in full
Lancets	Covered in full
Urine glucose test strips	Covered in full
Urine ketone test strips	Covered in full
Insulin pens (includes pre-filled insulin pen cartridges; needles sold separately)	Prescription copayment per 30 day supply
Insulin pen needles	Prescription copayment per 30 day supply
Prescribed oral medications that influence blood sugar levels	Prescription copayment per 30 day supply

The following diabetic supplies require prior authorization through Pharmacy Services:

- Quantities of blood glucose test strips in excess of 150 per 30-day supply, non-preferred blood glucose test strips
- Non-preferred Blood glucose meters, meters with adaptive features, such as an integrated voice synthesizer or integrated lancing device
- Some Insulin pens and insulin pen needles

Diabetic supply procedure

1. The physician writes a prescription for the diabetic supply.
2. The member fills the prescription at an FHW-contracted pharmacy. The pharmacy collects any applicable copayment.

Injectables

Injectables are defined as sterile medications given with the aid of a needle/syringe and administered parenterally. Certain medications may be supplied by an FHW contracted pharmacy for patient self use. Other medications are obtained by the contracted health care provider or from the specialty injectable pharmacy for in-office use. Many injections require prior authorization. For Fallon Health Weinberg members with Medicare Part D prescription coverage, some injectable medications are covered under the members Medicare Part B benefits.

Note: Call the Pharmacy Services Department Line (1-855-827-2003) for any questions regarding whether a medication can be self-administered or must be administered in the office.

Injectable supply procedure
The following procedure can be followed for injectable medications*

A. Injectable medication to be self-administered (or by a family member) at home:

   a. Provider writes prescription.
   b. The member fills the prescription at an FHW-contracted pharmacy.

B. Injectable medication to be administered in the physician office:

   a. Provider supplies the medication from their own stock and bills FHW directly for both the medication and the administration of the medication, or

   b. Provider calls one of FHW's contracted suppliers. The contracted supplier will bill FHW directly for the medication. Provider may bill FHW for the administration of the medication only.

*For medications that require prior authorizations, providers must obtain authorization prior to administration of the medication.

Note: CVS/CAREMARK Specialty Pharmacy is Fallon Health Weinberg's Pharmacy Benefits Manager and contracted supplier for many of the drugs that are classified by FHW as medical benefits. Medical benefit drugs are items that are administered by a health care professional in an office setting.

A prescription form for CVS/CAREMARK Specialty Pharmacy is included in this manual (see "Forms" section). To obtain services from CVS/CAREMARK Specialty Pharmacy,

please fax the completed enrollment form to the number provided on the form or call CVS/CAREMARK Specialty Pharmacy at 1-800-238-7828.

Transition medication process

The transitional process is for Fallon Health Weinberg members who are new to FHW or new to Medicare. This process is designed to provide temporary medication coverage for FHW non-formulary medications until a prior authorization can be obtained by the prescriber. The qualifying member can obtain up to 30-day temporary supply (unless the prescription is written for less), within the first 90 days of their enrollment. Members will receive a letter within 3 business days of a Transition fill to inform them of the nature of the fill and instructions on how to obtain a prior authorization.

Medication therapy management program

As a Medicare Part D plan sponsor, FHW is required to offer a medication therapy management program (MTMP) to our Medicare-eligible members who are considered high-risk. FHW's medication therapy management program is for FHW members who are managing at least 8 prescriptions, have three or more chronic conditions* and are spending more than $3,144.00 on prescriptions each year. The program is free and voluntary. Once members meet the criteria, they are contacted and if they are interested in joining this program, their primary care provider will be notified.

To better assist members who enroll, a clinical pharmacist will work with the member's PCP to address any significant clinical changes—to help monitor drug-drug and drug-disease interactions, adverse drug effects and over- or under-utilization of drugs or resources. The pharmacist can also help educate the enrolled members on proper use of their prescriptions or over-the-counter medications, all with the goal of improving drug regimen adherence. The MTMP Pharmacist will also be available to answer any medication-related questions that you may have regarding these members.

* Targeted disease conditions are: COPD, Diabetes, Hypertension, Hyperlipidemia, and asthma.

PODIATARY SERVICES

Podiatry services

A PCP referral is required for Podiatry services. Fallon Health Weinberg (FHW) is responsible for determining whether a member is entitled to covered services.

FHW coverage

FHW members are covered for some non-routine foot Utilization Management based on medical criteria. Routine foot Utilization Management such as trimming of corns and calluses, treatment of flat feet or partial dislocations of the feet are not covered.

Covered items

1. Office visit with a plan affiliated podiatrist or orthopedist.
2. Office based procedures (subject to the medical criteria defined below).
3. Inpatient or facility based procedures (subject to the medical criteria defined below) provided within the provider's legal scope of practice.

Foot Care Policy Overview:

This policy relates to both routine (e.g., trimming of corns and calluses) and non-routine (e.g., treatment of foot ulcers) foot care.

Policy & Criteria

Referral:

Covered podiatry services require a PCP referral. Some procedures may still require a plan prior authorization. For a list of procedures requiring prior authorization, please see the Procedure Code Look Up Tool which can be found in the Provider Tools available on www.fallonweinberg.org

Policy:

Routine foot Utilization Management must be provided by a contracted podiatrist whether in an office setting or in a facility that is providing the patient skilled level of care (e.g., skilled nursing facility). Routine foot care (subject to the routine foot care criteria defined below) is limited to the following services once in each 60-day period.

1. Cutting or removal of corns and calluses
2. Trimming, cutting clipping or debriding of nails
3. Other hygienic and preventive maintenance care considered self-care (i.e., cleaning and soaking the feet and the use of skin creams to maintain skin tone of both ambulatory and bedridden patents), and
4. Any services performed in the absence of localized illness, injury or symptoms involving the foot.

PODIATARY SERVICES

Please note that:

1. Attending physician must submit documentation satisfying the routine foot care clinical criteria (below)
2. Authorization for routine foot care is provided once in each 60-day period. More frequent treatment requires supporting documentation indicating the medical necessity for this service.
3. In all cases, the medical record must support the medical necessity and frequency of this treatment including specific evidence that all requirements for coverage are met.
4. The patient must be seen by the physician (MD or DO) treating the systemic illness at least every six (6) months to be considered active care.

Non-routine foot care coverage is limited to:

1. Office visit with a plan contracted podiatrist or orthopedist
2. Office based procedures (subject to the non-routine foot care clinical criteria defined below)
3. Inpatient or facility based procedures (subject to the non-routine foot care clinical criteria defined below) provided within the providers' legal scope of practice.

Routine foot care clinical criteria:

The patient has a complicating systemic disease indicated by a diagnosis of any of the following criteria:

1. Diabetes mellitus** with complications, including:
    a. Diabetes with renal manifestations (ICD-9-CM 250.40 to 250.43)
    b. Diabetes with ophthalmic manifestations (ICD-9-CM 250.50 to 250.53)
    c. Diabetes with neurological manifestations*** (ICD-9-CM 250.60 to 250.63)
    d. Diabetes with peripheral vascular disorders (ICD-9-CM 250.70 to 250.73)
2. Arteriosclerosis obliterans (ASO) of lower extremities with manifestation as indicated by ICD-9-CM 440.20 to 440.24 (intermittent claudication, rest pain, ulceration, gangrene)
3. Buerger’s disease (ICD-9-CM 443.1)
4. Chronic thrombophlebitis** (ICD-9-CM 451.11, 451.19)
5. Peripheral neuropathies involving feet associated with:
    a. Malnutrition and vitamin deficiency,** such as:
        i. Malnutrition (general, pellagra) (ICD-9-CM 265.2, 357.4)

ii. Alcoholism (ICD-9-CM 357.5)

iii. Malabsorption (celiac disease, tropical sprue)

iv. (ICD-9-CM 579.0, 579.1, 357.4)

v. Pernicious anemia (ICD-9-CM 281.0)

b. Carcinoma** (ICD-9-CM 357.3)

c. Diabetes mellitus** (ICD-9-CM 357.2)

d. Drugs and toxins** (ICD-9-CM 357.6, 357.7)

e. Multiple sclerosis** (ICD-9-CM 340)

f. Uremia** (chronic renal disease) (ICD-9-CM 585, 357.4)

g. Traumatic injury (ICD-9-CM 956.0 to 956.9)

h. Leprosy or neurosyphilis (ICD-9-CM 030.1, 094.0 to 094.9, 357.4)

i. Hereditary disorders, including hereditary sensory radicular neuropathy (ICD-9-CM 356.2); Fabry's disease (ICD-9-CM 272.7, 357.4); amyloid neuropathy (ICD-9-CM 277.3, 357.4)

** For diagnoses marked with two asterisks (**), routine foot care is covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition.

*** Diabetes with neurological manifestations (ICD-9-CM 250.60 to 250.63) does not require Class Findings (see below).

Class findings:

Signs and symptoms fall into three (3) classes: A, B and C. To fulfill the coverage requirement for routine foot care, there must be:

- One Class A Finding, or
- Two Class B Findings, or
- One Class A and Two Class C findings.

<table>
<tr><th>Class Findings A</th><th>Class Findings B</th><th>Class Findings C</th></tr>
<tr><td rowspan="5">• Non-traumatic amputation of foot or integral skeleton portion</td><td>• Absent posterior tibial pulse</td><td>• Claudation</td></tr>
<tr><td>• Absent dorsalis pedis Pulse</td><td>• Temperature changes (e.g., cold feet)</td></tr>
<tr><td>• *Advanced trophic changes such as:</td><td>• Edema</td></tr>
<tr><td rowspan="2">1. Hair Growth
2. Nail changes (thickening)
3. Pigmentation changes (discoloration)
4. Skin texture (thin, shiny)
5. Skin color (rubor or redness)</td><td>• Paresthesia (abnormal spontaneous sensations in the feet)</td></tr>
<tr><td>• Burning</td></tr>
</table>

Three (3) trophic changes are required to meet one (1) Class Finding

Non-routine foot care clinical criteria:

The following conditions / diagnoses satisfy criteria for services (note that the list is not all-inclusive and that other acute podiatry conditions may apply):

1. Bunions (bunionectomy)
2. Bursitis and capsulitis
3. Diabetic foot ulcers
4. Ganglion
5. Release of hammer toes
6. Heel spurs and plantar fasciitis
7. Ischemic ulcers
8. Neuroma and neuralgia
9. Osteoarthritis
10. Osteomyelitis
11. Sprains and ligamentous injuries
12. Tendentious and synovitis
13. Treatment of fractures and dislocations of the feet or ankles

14. Skin and selected soft tissue trauma
15. Infected callosities
16. Plantar warts
17. Treatment of ingrown toenails with paronychia or subungual abscess
18. Treatment of painful mycotic toenails (including fungal cultures of toenail clippings) with:
    a. Marked limitation of ambulation; or
    b. Causing pain in non-ambulatory patients.
19. Avulsion or excision of toenail plate
20. Cellulitis and or abscess of the foot
21. Treatment of symptomatic or painful onychauxis or onychogryposis

What is not covered:

The following items are not covered:

1. Routine foot care such as cutting or removal of corns, calluses or trimming of toenails for individuals not meeting the above criteria.
2. Routine foot care meeting the above criteria within 60 days of the previously covered office visit unless medically necessary and approved by the plan.
3. Orthopedic shoes unless permanently attached to a brace.
4. Other support devices for the foot (e.g., arch supports, UCB's & orthotics* see note below regarding FHW members, except Essential members, who are not covered for orthotics) unless for the treatment of severe diabetic foot disease.

NOTE: For FHW coverage types orthotics are covered as follows: braces (non dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body. For individuals over age 21, certain limitations apply.

Treatment options

Fallon Health Weinberg (FHW) supports providers, acting within the lawful scope of practice, to advise and advocate on behalf of an individual who is a member of FHW regarding the following:

- The medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future decisions
- The member's health status

FHW contracted providers are required to provide information regarding treatment options, including the option of no treatment, to FHW members, including those with limited English proficiency or reading skills, diverse cultural backgrounds and physical or mental disabilities, in a culturally competent manner. The provider shall ensure that individuals with disabilities have effective communication with participants through the plan in making decisions regarding treatment options. The provider shall educate patients regarding their health needs, share findings of history and physical examinations, side effects of treatment, management of symptoms and recognize the patient has the final course of action among clinically acceptable choices.

UTILIZATION STATEMENT

Utilization decision-making is based on appropriateness of care and service and existence of coverage. Fallon Health Weinberg does not specifically reward practitioners or other individuals for issuing denials of coverage for service or care. The plan does not provide financial incentives for utilization decision makers that encourage decisions that result in underutilization.