

SECTION 8- Medical Management

8.1- Program Overview

The VNSNY CHOICE Medical Management Department has been designed to maximize the quality care delivered to VNSNY CHOICE members. The program focuses on assisting providers in planning for, organizing, and managing the healthcare services provided to VNSNY CHOICE members to promote member health and well-being. Information and data collected through medical management procedures are used by the Medical Management department to properly allocate resources and to foster efficient and effective care delivery.

The Medical Management department emphasizes collaboration with network providers, contracted vendor organizations, and other VNSNY CHOICE staff to ensure that high-quality healthcare is provided at the most appropriate level by the most qualified panel of providers.

The Medical Management department is responsible for the following areas:

- Care Management and Coordination
- Authorization and Notification Processes
- Continuity of Care

8.2- PCP Directed Care

VNSNY CHOICE endorses the philosophy that clinical care is best rendered when a member's PCP is given the authority and responsibility for coordinating the overall healthcare of a member.

Providers of VNSNY CHOICE Medicare and MLTC members do not need to submit referrals to CHOICE for approval when referring to participating specialist in the VNSNY CHOICE network.

Please be sure that you are referring members to VNSNY CHOICE network physicians, ancillary facilities, and providers. If a required specialty is not represented in VNSNY CHOICE's Provider Directory or Directory Addendum, call VNSNY CHOICE Medicare's Provider Services Department at the telephone number listed in the Introduction of the provider manual. However, there are no non-emergent, out-of-network benefits for any plan, and the provider must obtain approval from VNSNY CHOICE's Medical Management department if the provider wishes to refer a member to a non-participating provider.

General Guidelines

The following guidelines may assist in ensuring referrals are appropriately managed:

Members should be referred to specialists who can best communicate with the member in accordance with the principles of cultural competence. This is to ensure optimal communication between providers and members of various racial, ethnic, and religious backgrounds, as well as disabled individuals. For example, members should be referred to specialists who speak the member's language when the member does not speak or understand English. The Provider Directories provide data on languages spoken by the provider, as well as other relevant information.

If possible, the PCP, OB/GYN, or the office staff should assist the member in making appointments with specialists and should provide directions to the specialist's office. This is important for ensuring member compliance with specialty referrals and for obtaining prompt access to specialty services for members requiring urgent care. MLTC members and certain Medicare members are entitled to transportation assistance.

8.3- Referrals

VNSNY CHOICE Medicare Plans

No referral is required for a VNSNY member to see a specialist in our network. Please be sure that you are referring members to VNSNY CHOICE network physicians, ancillary facilities, and providers.

SelectHealth Special Needs Plan

Upon determination that specialty care is required, a PCP or appropriate staff, may use VNSNY CHOICE's Provider Directory to identify a network specialty provider and directly schedule an appointment. Alternatively, PCPs or appropriate staff, may contact VNSNY CHOICE to coordinate and schedule the visit. VNSNY CHOICE will schedule the referral on behalf of the PCP/office and communicate the appointment information to the member. Generally, this service is restricted to use with private specialty providers, as referrals to hospital based specialty clinics are most efficiently processed by HIV clinic based administrative staff.

Referring providers should ensure that all necessary clinical information is forwarded to the consulting specialist in advance of the member's scheduled appointment.

Referrals to Specialty Care Centers

Members with a life-threatening, a degenerative or disabling disease, or condition which requires prolonged specialized medical care, may be referred to an accredited or designated specialty care center. Every effort should be made to refer the member within VNSNY CHOICE's

provider network. These referrals are made pursuant to a treatment plan developed by the specialty care center and approved by VNSNY CHOICE in consultation with the PCP (or specialist provider approved by VNSNY CHOICE to coordinate a member's primary and specialty care) and the member or the member's designee.

Specialist as Coordinator of Primary Care

Members with a life-threatening, degenerative, and disabling disease, or condition which requires prolonged specialized medical care, may receive a referral to a specialist who will then function as the coordinator of primary and specialty care for that member. These referrals are made in consultation with the PCP or specialist provider approved by VNSNY CHOICE to coordinate a member's primary and specialty care, and the member or the member's designee.

If the specialist does not meet the qualifications of an HIV Specialist, a co-management model will be employed in which an HIV Specialist assists the PCP in an ongoing consultative relationship as part of routine care and continues with primary responsibility for decisions related to HIV-specific clinical management in coordinating with the other specialist.

Direct Access for OB/Gyn Care

Female members have direct access to primary and preventive obstetrics, gynecology services and follow-up care as a result of a primary and preventive visit and any care related to pregnancy from VNSNY CHOICE OB/Gyn network providers without a referral from the PCP.

Self-Referrals

Members may self-refer for the following services:

- Unlimited self-referrals to an in-network provider for an initial evaluation for outpatient behavioral health and substance use. A treatment plan is developed during the initial evaluation and shared with SelectHealth.
- Routine refraction for vision services.
- Diagnosis and treatment of tuberculosis by public health agency facilities.

Family planning and reproductive health services.

Family planning services include but are not limited to emergency contraception and follow up, sterilization and abortion. Members may receive HIV counseling, HIV testing, referral, and partner notification services as part of the family planning visit. Other HIV pre- and post-test counseling may be performed regardless of whether the provider participates in the VNSNY CHOICE network. Enrollees may receive family planning services from any qualified Medicaid provider regardless of whether the provider is a participating or a non-participating provider without a referral from the member's PCP and without approval from VNSNY CHOICE.

Managed Long Term Care (MLTC) Plan

Upon enrollment, every member is assigned to a VNSNY CHOICE Care Manager (a nurse or social worker). The Care Manager works closely with the member, his/her family, and physician to develop a plan of care, which include all required covered services and medical services. The Care Manger helps members obtain these services from network providers, including making appointments and arranging for transportation.

Specialty Care

VNSNY CHOICE MLTC coordinates the member's medical, home- and community-based services. The plan of care is developed in collaboration with the member, providers, and an interdisciplinary team.

Physician and hospital services are not part of the MLTC covered services and members may continue to utilize their existing providers under the Medicare and/or Medicaid programs.

For those services that are MLTC covered benefits, VNSNY CHOICE will help members obtain these services from network providers, including making appointments and arranging transportation.

Self-Referral Services

Members may self-refer for the following services:

- Dental: Up to 2 routine dental check-up examinations per year.
- Vision Care: Routine eye exam once a year and eyeglasses every 2 years.

As with all covered services, it is important that members inform their CHOICE Care Manager of self-referred services.

8.4- Authorization of Services

Other than for emergency care, providers must obtain prior authorization from Medical Management for all VNSNY CHOICE plans for acute inpatient admissions; selected outpatient procedures and services, including certain ancillary services; and all out-of-network care. Prior authorization may be requested by the member's PCP or by the specialist who has received a referral from the PCP who is caring for this member.

The following information must be supplied when requesting prior authorization of services:

- Member's name and VNSNY CHOICE ID number
- Attending/requesting provider's name and telephone number
- PCP's name (if not the attending/requesting provider)

- Diagnosis and ICD-10 Code
- Procedure(s) and CPT-4 Code(s) and procedure date(s)
- Services requested and proposed treatment plan
- Medical documentation to demonstrate medical necessity
- For inpatient admissions: hospital/facility name, expected date of service, and expected length of stay

Please be sure that ALL of the listed information above is included when you fax a prior authorization request. If you are calling in the request, please have the information available when you call Medical Management.

Services Requiring Prior Authorization

- All elective and urgent inpatient admissions
- All Skilled Nursing Facility (SNF) admissions
- All Rehabilitation facility admissions
- All subacute admissions
- All mental health and substance abuse admissions
- All out-of-network services
- All cosmetic procedures
- All procedures considered experimental /investigational that are required by Medicare to be covered services
- All transplants and all transplant evaluations
- All rentals and DME over \$250
- Home Infusion Procedures/services

Concurrent and Retrospective Authorizations

VNSNY CHOICE processes Concurrent Review Requests for home health care services following an inpatient admission, for inpatient Substance Use Disorder treatment or for continued, extended or more of an authorized service than what is currently authorized. Retrospective reviews are used to authorize health care services already provided, that could not be reviewed in the usual preauthorization process. SelectHealth makes a utilization review determination involving health care services which were already delivered within thirty (30) days of receipt of the necessary information.

A standard decision will generally be rendered within 14 days of being requested. The plan is allowed a 14-day extension if the time is needed review additional documentation.

For CHOICE MLTC Members

Prior Authorization and Concurrent Reviews – Expedited and Standard

A. Service Authorization Requests

The plan makes a service authorization determination as fast as the member's condition requires and no more than:

- Expedited: 72 hours after receipt of the Service Authorization Request, subject to extension
- Standard: Three business days after receipt of the necessary information, but not greater than 14 days after receipt of the Service Authorization Request, subject to extension.

B. Concurrent Review Service Authorization Requests

The plan makes a concurrent review service authorization determination as fast as the member's condition requires and no more than:

- Expedited: One business day after receipt of necessary information, but no more than 72 hours after receipt of the service authorization request, subject to extension.
- Standard: One business day after receipt of necessary information, but no more than 14 days of receipt of the service authorization request, subject to extension

C. Service Authorization Extensions

The plan extends a service authorization request's timeframe up to 14 calendar days when requested by the member or provider (written or verbal), or the plan requires additional time to determine medical necessity and can demonstrate how the

extension is in the member's best interest.

In the case of a request for Medicaid covered home health care services following an inpatient admission, one business day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday, 72 hours after receipt of necessary information; but in any event, no more than three business days after receipt of the request for services.

Up to 14 calendar day extension: Extension may be requested by Enrollee or provider on enrollee's behalf (written or verbal).

The plan also may initiate an extension if it can justify need for additional information and if the extension is in the enrollee's interest. In all cases, the extension reason must be well documented.

Home Health Care Services

Following an inpatient admission, a determination is made within one business day after receipt of necessary information, except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, where a determination is made within 72 hours after receipt of necessary information, and in any event, not more than three business days after receipt of the request Service Authorization.

For CHOICE Total Members

Standard requests are processed as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for Standard Organization Determination. Medicare Part B drugs are processed no later than 72 hours after the date the organization receives the request.

Expedited Determinations may be requested when the enrollee or his/her physician believes that waiting for a decision under standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. The health plan must automatically provide an expedited determination if a physician indicates, orally or in writing that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee.

Expedited determinations must be made as expeditiously as the enrollee's health requires, but no later than 72 hours after receiving the request or twenty-four (24) hours for Medicare Part B drugs.

The Medicare health plan may extend the time frame up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in



the interest of the enrollee. Medicare Part B drug requests are not subject to extensions.

For SelectHealth Members

A request for an expedited review of a service can be made when SelectHealth or the service provider indicates that a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The member can also request an expedited review. The decision on whether or not to expedite is made within 1 business day of receipt of the request for an expedited review and the member and service provider are notified by phone and in writing.

If the request for an expedited review is denied, SelectHealth handles the request under the standard review timeframe.

Please be sure that ALL of the information at the beginning of this subsection (8.4) is included when you fax a prior authorization request. If you are calling in the request, please have the information available when you call Medical Management.

Please note timeframes below for SelectHealth are as follows:

Prior authorization requests:

- Expedited within 72 hours
- Standard three business days after all information received but not more than 14 days
- Certified court ordered mental health of substance abuse services within 72 hours
- Pharmacy 24 hours; immediate auth for 72-hour emergency supply; immediate access to 5-day supply for SUD treatment medication; immediate auth of 7-day supply for opioid withdrawal/ stabilization

Concurrent Review

- Expedited 1 business day after all info but no more than 72 hours
- Standard one business day after all info but more than 14 day
- Home care after inpatient stay within 72 hours
- Inpatient SUD requested 24 hours prior to discharge from inpatient within 24 hours of request

Retrospective Review within 30 days of all information. Notice is mailed to member on date of decision.

If SelectHealth fails to make a decision within the timeframes advised above, the decision will be deemed an adverse determination which is automatically subject to appeal.

A written notice of an adverse determination (initial adverse determination) will be sent to the member and provider and will include:

- The reasons for the determination including the clinical rationale if any
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals
- Notice of the availability, upon request of the enrollee or the enrollee’s designee of the clinical review criteria relied upon to make such determination

The notice will also specify:

- What, if any, additional information must be provided to, or obtained by, the managed care organization (MCO) in order to render a decision about the appeal
- A description of action to be taken
- A statement that the MCO will not retaliate or take discriminatory action if appeal is filed

A process and timeframe for filing/reviewing appeals, including enrollee right to request expedited review

- Notice of the enrollee’s right to contact NYSDOH, with a 1-800 number, regarding their complaint
- Fair Hearing notice, including right to aid continuing
- A statement that the notice is available in other languages and formats for special needs and how to access these formats.

SelectHealth may reverse a pre-authorized treatment, service, or procedure on retrospective review under the following conditions:

- Relevant medical information presented to the MCO or utilization review (UR) agent upon retrospective review is materially different from the information that was presented during the pre-authorization review.

- The information existed at the time of the pre-authorization review but was withheld or not made available.
- The MCO or UR agent was not aware of the existence of the information at the time of the pre-authorization review.
- Had the MCO or UR agent been aware of the information, the treatment, service or procedure being requested would not have been authorized

For adverse determinations rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one business day of receipt of the request and shall be conducted by the member’s health care provider and the clinical peer reviewer making the initial determination.

For Delegated Vendor Services

Beacon Health Options:

- General provider handbook: beaconhealthoptions.com/providers/beacon/handbook/

(Utilization Management starts on page 48)

- HARP program specific provider handbook: beaconhealthoptions.com/pdf/network/nyc_health_plans/NY-HARP-Provider-Manual.pdf

Medimpact:

- mp.medimpact.com/mp/public/Login.jsp

Healthplex:

- healthplex.com/doc/no/HEALTHPLEX_PROVIDER_MANUAL

8.5- Out-of-Network-Services

VNSNY CHOICE MLTC

VNSNY CHOICE MLTC has a network of providers available to meet its members’ needs. It is recognized, however, that under defined circumstances, members may need to utilize out-of-network providers for covered services.

Members may not elect to use a non-participating provider unless no such provider exists in the network or the network providers are unable to provide the service. In all such cases, when

VNSNY CHOICE is the primary payer, the member must get prior approval before accessing out-of-network services. The member should consult with his/her Care Manager who will coordinate the referral with the non-participating provider, health plan, and member's physician (if appropriate), incorporate it into the approved treatment plan and document appropriately to ensure proper follow-up and payment.

When an approved referral to an out-of-network provider for covered services is made, VNSNY CHOICE will enter into a member-specific letter of agreement (LOA) with the provider to specify payment terms, period of coverage, and quality assurance measures.

VNSNY CHOICE has an established policy and procedure that specifies those instances in which a referral to an out-of-network provider for covered services may be made, including:

- Continuation of care
- Emergent/urgent care
- Clear and compelling medical service need that can only be met by an out-of-network provider.
- Provider in the process of being contracted
- Additional service capacity needed
- Covered services which are also covered by Medicare

VNSNY CHOICE Medicare

VNSNY CHOICE Total has a network of providers available to meet its members' needs. It is recognized, however, that under defined circumstances, members may need to utilize out-of-network providers for covered services.

Members of CHOICE Medicare may not elect to use a non-participating provider unless no such provider exists in the network or those in the network are unable to provide the service. In all such cases, when VNSNY CHOICE is the primary payer, the member must get prior approval before accessing out-of-network services. The member should consult with his/her Coordinated Care Manager who will coordinate the referral with the non-participating provider, health plan, and member's physician (if appropriate), incorporate it into the approved treatment plan and document appropriately to ensure proper follow-up and payment.

When an approved referral to an out-of-network provider for covered services is made, VNSNY CHOICE will enter into a member-specific letter of agreement (LOA) with the provider to specify payment terms, period of coverage, and quality assurance measures.

VNSNY CHOICE Medicare has an established policy and procedure that specifies those instances in which a referral to an out-of-network provider for covered services may be made, including:

- Continuation of care
- Emergent/urgent care
- Clear and compelling medical service need that can only be met by an out-of-network provider
- Provider in the process of being contracted
- Additional service capacity needed

SelectHealth

In the event that a PCP determines, in conjunction with VNSNY CHOICE's Medical Management Department, that a specific physician resource is either not available within the network, or that the most appropriate choice of a specialist exists out-of-network, the PCP and/or VNSNY CHOICE will make a referral to an appropriate non-participating provider. The resulting treatment plan will be reviewed and approved by VNSNY CHOICE in consultation with the PCP, the non-participating provider and the member or the member's designee. Approval from VNSNY CHOICE is required for all out-of-network referrals.

8.6- Continuation of Care

VNSNY CHOICE MLTC

Upon enrollment, a member may be under care for audiology, dental services, optometry, or podiatry services with a provider who is not included in the VNSNY CHOICE network. The member will be given the option of completing this course of treatment with the current out-of-network provider for a maximum of sixty (60) days, or transitioning at the time of enrollment to a VNSNY CHOICE provider.

The member will be informed of the need to transfer to a network provider upon completion of the current course of treatment, even if there is a medical need for additional services. This transition will take place within sixty (60) days after the enrollment date.

VNSNY CHOICE will ensure that all required services are available for its members. When a provider leaves the network (either voluntarily or through the termination of a subcontractor) the program will assist members in changing to another service provider.

Members who are in the process of a course of treatment with a provider who is terminating participation in the network may continue to receive care from this provider until the course of treatment is completed, or 90 days, whichever is sooner.

VNSNY CHOICE will notify members of providers who terminate their participation in the plan within 15 days of learning of the termination.

VNSNY CHOICE Total

Continuation of Care is the process used to review and evaluate authorizations to non-participating providers during a transitional period.

Continuation of Care will be considered in either of these circumstances:

- When a newly enrolled VNSNY CHOICE member is under active treatment at the time of enrollment with a provider who does not participate in the VNSNY CHOICE network
- When a current member's healthcare provider has left the VNSNY CHOICE network (except when the provider was terminated from participation under circumstances involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governing agency that impairs the health care professional's ability to practice).

The out-of-network provider must agree to accept VNSNY CHOICE reimbursement as payment in full and agrees to comply with all of VNSNY CHOICE UM/QI policies and procedures.

A request for continuity of care may be made utilizing our *"Transitional Care Request Form"* and must be submitted to our Medical Management Department.

SelectHealth

Members Whose Healthcare Provider Leaves the Network

VNSNY CHOICE permits members whose provider leaves the plan's network, for reasons other than imminent harm to patient care, or a determination of fraud or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, to continue an ongoing course of treatment with that provide during a transitional period.

The transitional period may continue up to 90 days and begins on the date the provider's contractual obligation to provide services to Select Health members terminates or if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery through 60 days post-partum.

During this transitional period, the non-participating provider agrees to:

- Accept reimbursement from VNSNY CHOICE at rates established as payment in full.
- Adhere to VNSNY CHOICE's quality assurance requirements and agrees to provide to VNSNY CHOICE necessary medical information related to such care.
- Otherwise adhere to VNSNY CHOICE policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by VNSNY CHOICE.

New Members

If a new member has an existing relationship with a health care provider who is not a member of the VNSNY CHOICE network, VNSNY CHOICE permits the member to continue an ongoing course of treatment by the non-participating provider during a transitional period of 60 days from the member's effective date of enrollment if:

- (1) the member has a life-threatening disease or condition or a degenerative and disabling disease or condition.
- (2) the member has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period shall be extended to include the provision of post-partum care directly related to the delivery.

The non-participating provider must agree to adhere to the conditions outlined in the paragraph "*Members Whose Health Care Provider Leaves the Network*" above in order for VNSNY CHOICE to authorize continuation of care for a new member whose current provider does not participate in the VNSNY CHOICE network.

8.7- Hospital Services & Emergency Services

Hospital Transfer from Out-of-Network Providers

VNSNY CHOICE will attempt to coordinate all out-of-network care both locally and out of the service area, including informing the network practitioner. Call the Medical Management Department at the telephone number located in Introduction of this provider manual if you become aware that one of your patients is receiving out-of-network care. If you are called upon to facilitate transfer to an in-network facility for one of your patients, you must provide the necessary medical guidance for a safe transfer. You must notify us of an admission to an out-of-network hospital or to request our assistance with a transfer into our network. To do so, call Medical Management at the telephone number listed in Introduction of this provider manual.

Second Opinions

VNSNY CHOICE may require that your patient see a physician, determined by VNSNY CHOICE, for a second opinion. VNSNY CHOICE reserves the right to require a second opinion for any surgical procedure or healthcare service. There is no formal list of procedures requiring second opinions.

Procedures or services requiring a second opinion will be decided on a case-by-case basis.

Members may request a second opinion relating to the need for surgery or for a major non-surgical diagnostic and therapeutic procedure. Members may obtain a second opinion from a participating provider within the VNSNY CHOICE network. In the event that the recommendation of the first and second physician differs regarding the need for the surgery or other major procedure, a third opinion from a participating provider shall also be covered.

Notification Requirements for Hospitals

Hospitals are required to provide VNSNY CHOICE with notification within twenty-four (24) hours of each admission in order to verify eligibility, confirm authorization, including level of care.

For emergency admissions, notification should occur once the member has been stabilized in the emergency department or, for members who are not stabilized, within one business day when reasonably feasible based on the member's medical condition and information available. Proper timely notification is required in order to facilitate communication between VNSNY CHOICE Medical Management and insure timely and accurate payment of hospital claims upon receipt. Notification requirements apply whether the emergency and treatment occurred in or out of VNSNY CHOICE's service area. This notification allows VNSNY CHOICE's

Medical Management Department to assure information is shared as part of transitional care, assure medical necessity and appropriate care setting and help facilitate the implementation of a transition plan to next level of care in collaboration with the facility designated staff.

Participating hospitals are required to notify VNSNY CHOICE of updates in status, and the anticipated discharge date at least 48 hours prior. The facility is expected to provide confirmation of member's discharge on the actual day.

Emergency Room Services

An emergency is the sudden or unexpected onset of a condition requiring medical or surgical care, without which a patient could reasonably be expected to suffer serious physical impairment or death using the prudent layperson standard. In an emergency, a member should seek care as soon as possible; there is no requirement for the member to obtain an authorization from his/her physician or from VNSNY CHOICE. VNSNY CHOICE distinguishes emergency services from urgently needed services.

Below is a list of urgently needed services and procedures to follow:

When to Use the Emergency Room

It is appropriate for a member to use a hospital emergency room when an emergency condition exists, such as:

- Heart attack or severe chest pain, in adults
- Stroke
- Severe shortness of breath or difficulty breathing
- Cyanosis
- Hemorrhaging
- Poisonings
- Major burns
- Spinal injuries
- Shock
- Allergic reaction accompanied by swelling of the face or lips, or wheezing in the chest

- Severe or prolonged bleeding from anywhere on the body
- Loss of consciousness
- Severe or multiple injuries
- Sudden change in mental status
- Convulsive seizures
- Other acute conditions that are determined to be emergencies

In-Area Versus Out-Of-Area Emergency Services

In-Area: No authorization is required, however, at the PCP's discretion, the member may be at the hospital, directed to the nearest emergency room, or recommended to be seen in the treating physician's office. In the event the member cannot notify the PCP before seeking care in the Emergency Room, the member should call the PCP as soon as possible after the encounter to advise the PCP of the encounter and to facilitate follow up care.

Out-of-Area: Out-of-area coverage is limited to care for accidental injury, unanticipated emergency illness, or other emergency conditions. VNSNY CHOICE will cover out-of-area emergency room services and urgent care services when they are medically necessary, using a prudent layperson standard.

Notifying VNSNY CHOICE

Regardless of whether your patient is in or out of the VNSNY CHOICE service area when the emergency condition begins, the PCP or the member should contact VNSNY CHOICE as soon as possible, but no more than 48 hours after the onset of the emergency so that we may facilitate any care needed after the emergency room encounter. If the patient is unable to contact us within 48 hours as a result of a medical condition, she/he should do so at the earliest possible time.

Coverage

In most cases, hospital emergency room services are covered by VNSNY CHOICE without an authorization. Additional care after the doctor says it was not a medical emergency will only be covered at the usual coverage if an in-network provider provides the additional care. Follow-up emergency room visits, within VNSNY CHOICE's service area, are not covered. Follow-up services are covered when they take place in the PCP's office.

Urgently Needed Services

Urgently needed care is medical care for a condition that needs immediate attention for an unforeseen illness or injury, and it is not reasonable, given the situation, for the member to get medical care from their PCP or other plan provider regardless of whether the member is in the VNSNY CHOICE service area at the time of service. In these cases, the patient's health is not in serious danger or life threatening.

Members should call their PCP if they think they need urgently needed services. If a member is hospitalized after having received urgently needed services, the member (or someone on their behalf) must contact VNSNY CHOICE within one business day of the hospital admission.

If a member needs urgent care while outside the plan's service area, we request that he/she call their PCP first, whenever possible. However, urgently needed services will be covered by the plan when the member is away. In addition, VNSNY CHOICE will cover follow-up care that is provided by non-plan providers outside the plan's service area as long as the care still meets the definition of "urgently needed care".