EmblemHealth

Chapter 15: SNF IRF LTAC

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Return to Provider Manual

Search the Provider Manual

Overview

This program applies to post-acute care (PAC) services and direct admissions from the community for EmblemHealth members (see the section below for Excluded Members). EmblemHealth manages most PAC preauthorizations and utilization management of requested community referral services.

Preauthorization may be needed before certain services can be rendered or equipment supplied. Depending on which networks members access and who has financial risk for their care, preauthorization requests are evaluated by EmblemHealth, or the member's assigned Managing Entity. For the list of Healthcare Common Procedure Coding System (HCPCS) codes requiring preauthorization, refer to **Clinical Corner**.

Preauthorizations do not guarantee claims payment. Services must be covered by the member's health plan and the member must be eligible at the time services are rendered. Claims submitted may be subject to benefit denial. Prior to rendering services, all providers must verify member eligibility and benefits by signing in to our secure portal at **emblemhealth.com/providers** and using the Eligibility drop-down under the Member Management tab.

Excluded Members

The following members are excluded from the EmblemHealth PAC preauthorization process:

- City of New York Employees with EmblemHealth Plan, Inc. (formerly GHI) benefit plans – requests should be made to Anthem Blue Cross and Blue Shield (formerly known as Empire BCBS); (refer to **Who to Contact for Preauthorizations**)
- Members whose ID card indicates a primary care provider (PCP) from HealthCare Partners (HCP).

Excluded members are medically managed by the assigned Managing Entity in the same way as they are for other services. To determine the Managing Entity, check the member's ID card or eligibility information by signing in to the secure portal at **emblemhealth.com/providers** and using the Eligibility drop-down under the Member Management tab. You may also use the Preauthorization **Lookup Tool** on the provider portal to determine if a preauthorization is required and who is responsible for conducting the review. See the **Utilization and Care Management** chapter of the Provider Manual for applicable rules and preauthorization processes.

Preauthorization Process

Services Requiring Preauthorization

EmblemHealth performs preauthorization review for PAC and direct admissions for the following:

- Skilled nursing facilities (SNF)
- Inpatient rehabilitation facilities (IRF)
- Long-term acute care facilities (LTAC)

Members should not be transferred from an inpatient hospital setting to an SNF, IRF, or LTAC setting without an EmblemHealth preauthorization number. SNF, IRF, or LTAC facilities receiving program members without preauthorization should contact EmblemHealth to verify approval before admission. Servicing facilities may obtain SNF, IRF, or LTAC preauthorization details online or by phone. See the **Who to Contact for Preauthorization** section of the Directory chapter.

Who Requests Preauthorization

- Hospitals are responsible for submitting the initial PAC preauthorization requests for members being discharged to an SNF, IRF, or LTAC.
- SNF, IRF, and LTAC providers are responsible for submitting:
  - Concurrent review requests for existing admissions.
  - Initial preauthorization requests for community referrals.
  - Initial HHC service requests for members discharging from their facility with home health services.

How to Obtain a Preauthorization

Below is the information and process you need for submitting preauthorization requests.

The requesting provider should be prepared to submit:

- Patient’s medical records
- Details such as:
  - Admitting diagnosis
  - History and physical
  - Progress notes
  - Medicine list
  - Wound or incision/location
  - Physical therapy or physiatrist notes as necessary

EmblemHealth offers two (2) convenient methods to request preauthorization - online (fastest option), and by phone. See the **Who to Contact for Preauthorization** section of the Directory chapter.:

Preauthorization Time Frames

Regulatory time frames are followed for all member requests. EmblemHealth is dedicated to transitioning members to the next appropriate level of care as quickly as possible, and decisions will be made within one (1) business day of receipt of complete information. Therefore, we encourage early discharge planning and requests so that determinations are in place prior to the discharge date.

Once the determination is made, EmblemHealth provides verbal notification to the requesting provider. A copy of the determination letter is also faxed or mailed to the provider.

The initial preauthorization is valid for seven (7) days. During that time, inpatient hospitals must transfer the member to an

SNF, IRF, or LTAC facility. If the member is not discharged within the seven (7) day approval period, a new preauthorization is required.

SNF/IRF/LTAC Prior Approval Criteria

Criteria used by EmblemHealth includes, but are not limited to:

- MCG Health (fka Milliman Care Guidelines)
- Medicare Benefit Policy Manuals & Clinical Findings

Concurrent Review

Facilities that fail to provide clinical updates and/or progress notes to the Managing Entity or EmblemHealth concurrent review nurse are not reimbursed for unauthorized days.

Hospital Transfers

If an emergency occurs, the SNF, IRF, or LTAC facility should take all medically appropriate actions to safely transport the member to the nearest hospital, including the use of an ambulance, if necessary. EmblemHealth must be notified when a member temporarily leaves and returns to an SNF, such as when the member is readmitted to the hospital.

Discharge Planning

The discharge planning process from all facility settings should begin as early as possible. This allows time to arrange appropriate resources for the member's care.

Hospitals are responsible for submitting the initial preauthorization requests directly to EmblemHealth for members being discharged to an SNF, IRF, or LTAC. For PAC services after an inpatient hospital stay (acute rehabilitation, skilled nursing facility stay, and home care) , the EmblemHealth concurrent review nurse facilitates preauthorization of medically necessary treatments if the member's benefit plan includes these services.

For members in an SNF, IRF, or LTAC, the discharging facility is responsible for submitting the initial home health care service requests to EmblemHealth. See the **Who to Contact for Preauthorization** section of the Directory chapter.

For members who need durable medical equipment upon discharge, refer to the Durable Medical Equipment **chapter**.

Notice of Medicare Non-Coverage (NOMNC) for Medicare Members

Important: For date extension (concurrent review) requests, SNFs should submit clinical information 72 hours prior to the last covered day. This allows time to issue the Notice of Medicare Non-Coverage (NOMNC). The provider is responsible for completing and issuing the NOMNC to the member, having it signed and returning it to EmblemHealth.

In accordance with Centers for Medicare & Medicaid Services (CMS) guidelines, the servicing provider issues the NOMNC no later than two (2) calendar days prior to the discontinuation of coverage or the second to last day of service, if care is not being provided daily.

The servicing provider is responsible for informing the end-of-service dates and the appeal rights for members who are cognitively impaired. If the proxy is unable to sign and date the NOMNC, the staff member and witness who informed the proxy of the end date and appeal rights should document according to CMS regulation, sign and date the form, and return it to EmblemHealth.

Denial and Appeal Process

Denial of Preauthorization

Cases that do not meet medical necessity on initial nurse review are sent to a physician for second-level review and determination. If the EmblemHealth physician makes an adverse determination, the requesting facility is contacted.

The physician reviewer may suggest an alternate level of care and/or the appeals process. Once a service is denied, members and providers must file an appeal to have the request reviewed again.

Denial of Extended Services

Cases that do not meet medical necessity on concurrent nurse review are sent to a physician for second-level review and determination. If the EmblemHealth physician makes an adverse determination, the requesting facility is contacted.

SNF Date Extensions (concurrent review requests) for Medicare Members: The NOMNC is issued no later than two (2) calendar days prior to the discontinuation of coverage. The third (3^{rd}) calendar day is not covered unless the decision is overturned or the NOMNC is withdrawn.

If a member appeals the end-of-stay decision through a Medicare-contracted Quality Improvement Organization (QIO), the SNF is responsible for sending the medical records to the QIO by the time indicated on the request for records. QIO is open seven (7) days a week to take appeal information.

Appeals Process

Refer to the applicable Dispute Resolution chapters for **Commercial/CHP plans**, **Medicaid plans**, and **Medicare plans**.