

Membership Handbook



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Guiding Principles

Independence Care System (ICS) is a nonprofit organization committed to assisting people with disabilities to live independently. Using the vehicle of a managed long-term care program, ICS develops a comprehensive range of services and integrates them into a specialized system of care which can be used in a flexible manner.

At its core, ICS is a community of people — consumers with a variety of different disabilities, providers of care, staff and friends — who share a common vision and a commitment to participate in our own governance.

Based on our values and beliefs we:

- Support consumer-members as the primary managers of their own care
- Create quality jobs, especially for front-line workers, as a prerequisite for quality care
- Treat everyone with respect and honesty — and especially listen and respond to each other
- Value individual diversity
- Develop people
- Reflect about our work and learn from both our mistakes and successes
- Treat the work seriously but have fun doing it
- Focus on creativity, clarity and simplicity
- Foster quality employment opportunities for people with disabilities, including at ICS
- Share information and knowledge
- Promote high levels of involvement from everyone and cultivate many leaders, not just one

As we practice what we believe, Independence Care System will be a vibrant place with a wonderful spirit. It will be large in size, but feel small in scale.

**ICS WILL DO A VARIETY OF ORDINARY THINGS
TO SUPPORT OUR MEMBERS EXTRAORDINARILY WELL.**

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Introduction

Welcome to Independence Care System

The members, staff and Board of Directors of Independence Care System (ICS) welcome you to our managed long-term care plan for people at least 18 years old with physical disabilities and chronic illnesses.

ICS is a nonprofit organization committed to assisting people with disabilities and with chronic illnesses to live independently. When we use the words “managed care,” we mean something very specific about service and service delivery. At ICS “managed care” is about coordinating — with you — to be sure you receive the services you medically qualify for in order to live independently. If you decide to join ICS, you will be enrolling in a **managed long-term care plan**. ICS will provide covered benefits through our network of providers or assist you in arranging for non-covered benefits (that is, benefits that are still covered directly by Medicare and Medicaid on a fee for service basis) to meet all of your health and long-term care service needs. By enrolling in ICS, you will be agreeing to allow us to coordinate Medicare and non-covered Medicaid benefits on your behalf.

ICS is located at 257 Park Avenue South. ICS membership is voluntary, and requires Medicaid eligibility. We serve the boroughs of the Bronx, Manhattan, and Brooklyn. Our member services center telephone number is **1-877-ICS-2525**. Consumers with hearing and speech impairments can reach ICS at **TDD/TTY 1-877-ICS-2525**.

Understanding ICS: We’re Different

It can be difficult for people with disabilities and with chronic illness to find the medical and other services needed to live independently. ICS was created to make this process easier, more focused on your needs, and more satisfying to you. Our goal is to work with you to build a specialized system of care to support your full participation in community life. As a member, you plan and manage your own health care and social supports working with care managers and service providers. You also have the opportunity to work with us and participate in determining how our organization works.

Our History

ICS was started jointly by Cooperative Home Care Associates (CHCA) and the Paraprofessional Healthcare Institute (PHI). Cooperative Home Care is a worker-owned licensed home care service agency that is widely recognized as a model for providing high quality paraprofessional jobs and high quality paraprofessional services to its disabled and elderly clients. The Paraprofessional Healthcare Institute is a nonprofit organization, created by CHCA, to develop new programs and conduct policy analysis based on its “quality jobs/quality care” approach.

New York State has authorized ICS to operate a managed long-term care plan. ICS is responsible to provide the medically necessary covered services described in its contract with the New York State Department of Health. ICS is accountable to the New York State Department of Health for the quality of services delivered to its members.

How To Use This Handbook

This handbook is an important guide to the ICS plan. It contains the information you need to understand how ICS works, our enrollment policies, the services we provide, and the role you play in our work *together*. **If you need information in another language or on audio cassette, please let the ICS representative know.**

The handbook is organized in sections, and is designed to be easy to read and understand. Section 1 of this handbook provides you with a brief overview of who we are, and the unique “managed care” plan we provide for people with disabilities and chronic illnesses. The following sections of the handbook describe our enrollment policies and procedures, your rights and responsibilities as a member of ICS, and a detailed list and description of our services. We are very pleased to be working with you, and welcome your thoughts and ideas as our relationship develops over time.

We encourage you to review this material carefully, refer to it when you have a question, and to call our Member Services Center at 1-877-ICS-2525 if anything is not clear.

The ICS Plan: Comprehensive and Specialized

This Section describes the ICS Plan in greater detail. Please read it carefully, and let us know if you have any questions or concerns.

At ICS, “managed long-term care” is the way we describe the full range of services that we integrate into a system of care that is also *flexible*. Our goal is to work **with** you to support your full participation in community life. When you enroll, a care manager will be assigned to work with you and help make this goal a reality.

This System Has 4 Key Elements:

- 1. Our focus is on you with emphasis on linking you to home and community-based services.** ICS emphasizes a consumer’s-eye view of the service network. Our whole approach is to begin with *you*: *your* needs and *your* goals. We focus on the services you need: home care, medical equipment and supplies, transportation, and the other community based services. ICS also coordinates the primary medical care and other community-based services that will meet your needs, and help you reach your goals. If needed, nursing home care is also covered.
- 2. Our long-term care services are comprehensive.** Independence Care System offers you a full range of home and

community-based support services. Many of these services may be obvious, such as home care, non-emergency transportation, and specialized medical equipment. But many other services are also available, such as wheelchair repair and nursing home care, if needed. ICS works with you to coordinate these services, and make you aware of other services that you may not know about.

- 3. Member Participation.** Members participate in the care planning process. This means that you can be present at team meetings whether they are held in your home or the ICS office.
- 4. An integrated network of care...over time.** Independence Care System understands that your needs may change over time. We will always work with you to adjust services that continue to maximize your independence and comfort. For as long as you remain a member of ICS, we will be there for you — whether you are at home, in a hospital, or in a nursing home. We will spend time with you, listen and learn from you, and work with you to get the services and resources you need.

We recognize the importance of services you may already have in place, and that you may value the relationships you have developed with your current service

providers. If you are already receiving health services from a medical provider (e.g. your doctor), with whom you are satisfied, we can talk with them about working with ICS. Working with ICS means that your current medical providers agree to collaborate with the ICS care manager to coordinate all of your health and social service needs (even though they will continue to bill regular Medicare, Medicaid or other commercial insurances for their payment). Since hospital care, medical providers, and drug coverage are not part of ICS covered services, members may want to keep their commercial private pay insurances in force even though enrolled in ICS. If your current medical providers do not wish to collaborate with ICS, you will not be able to enroll unless you choose to change to providers who have agreed to work with ICS. Your care manager can help you find an experienced and accessible physician, if necessary.

Choosing Your Service Providers

For covered services paid for by ICS, the provider must be in the ICS network. For example:

- **Home Care Services:** If you are already receiving home care services with which you are satisfied, we may be able to work out an arrangement that lets you

keep your current home care worker (if they work for an agency that we contract with, for example) or you can choose to receive home care services from carefully selected and trained home care workers within our network.

- **Other Services:** Other services such as podiatry, dentistry, optometry, durable medical equipment, home delivered meals, and home modifications to promote independent functioning, will be provided from carefully selected provider agencies within our network.

ICS Services...

Using the Provider Network

One of the primary challenges faced by many people with disabilities and chronic illness is finding providers with expertise and sensitivity that meet *your* specific needs. For ICS covered services, ICS has developed a provider network of health and social service providers who are fully accessible for people with disabilities. When medically necessary, ICS will link you to these providers who can meet your individualized needs. If you want to change providers, call your ICS care manager at 1-877-ICS-2525 and we will review with you the list of providers in our network from which you can choose.

A member can be referred for a covered service to a health care provider outside the ICS network when ICS does not have a provider with training and experience to meet a special need. Your ICS care manager will help you to obtain that “out-of-network” referral, if needed.

Transitional Care

If you are a new enrollee in ICS and receiving a covered service from a provider who is not in our network, you may complete the course of an ongoing treatment for a transitional period of up to ninety (90) days if your provider agrees to accept payment at the plan’s rate, follows the ICS quality assurance requirements, and provides ICS with a treatment plan and medical information related to the services as needed.

If a provider leaves the ICS network while you are receiving services from them, the same 90-day transitional period also goes into effect, so that you can complete the treatment plan. It is your choice to either remain with that provider until your treatment is completed or choose a network provider with whom to complete the treatment. Your ICS care manager can help you choose another provider from our network for your future needs.

Accessibility

For all services, ICS will gather specific information on each provider site regarding factors that affect access to services and will make that information available to you. This information includes, but is not limited to such data as:

- bathrooms or handicapped stalls large enough to accommodate not only someone in a wheelchair, but his/her home care worker as well;
- hydraulic lifts and staff trained in using hydraulic lifts;
- availability of examination tables that move to a lower height; and
- vans equipped with tie-downs for electric wheelchairs.

Your satisfaction with the services you receive is important — for us, for you, and others in our community. We will be asking your opinion about the services you receive from providers, and provide regular, confidential feedback to your service providers so that our services can continue to improve.

Care Coordination is Key... Your Plan of Care

Prior to enrollment, you and the ICS intake nurse or social worker will develop your initial care plan. The initial care plan

is a written description of all the services you need. It is based on an assessment of your health care needs, the recommendation of your doctors and your personal preferences. You will receive a copy of your care plan which will list the services that are authorized to begin on your first day of enrollment.

Once your enrollment is official, your ICS care manager will arrange for the services on your care plan to begin. Within the first two months of enrollment, you and your care manager will meet to review and update your care plan, as needed. This meeting can happen in your home or the ICS office, whichever you prefer. If you need transportation to come to the office, we will arrange it. Your family or others close to you can also attend.

Our care management staff will arrange for the services on your care plan to begin on the first day that your enrollment is effective. You can call the member services center toll free at **1-877-ICS-2525** to arrange for any of your support service needs that vary, such as transportation to medical appointments or delivery of durable medical equipment. For any equipment which needs to be individually fitted to your specifications, your care manager will arrange for a Physical or

Occupational Therapy consultation for you prior to ordering the equipment. This will ensure that you get what works best for you. **Remember, as your needs change, so will your care plan. We will work with you to develop a new care plan that addresses your current needs twice a year (every six months). You will keep a written copy of your current plan, so that you will know what services will be provided.**

Your care manager is available to meet with you in your home, or to talk with you by telephone if you have any questions (Toll free **1-877-ICS-2525**). He/she will work with you to arrange for and coordinate your care with all your service providers, including your medical providers. If you are hospitalized, your care manager will work with you and the hospital staff to make sure that your needs are met during your hospital stay, and that your discharge planning needs are identified and arranged.

In order to make sure that ICS is meeting your needs on an ongoing basis an ICS nurse will assess your needs at least twice a year. Every 6 months, we will work with you to develop a new care plan that addresses your current needs. As your needs change, this will require that your care plan changes — you may require different services, or the same services more or less frequently.

Requesting Additional Services or Changes to the Care Plan

You can request changes in your care plan at any time. It is important for you to let us know what you need — talk with your care manager if you have a need for any service you are not currently receiving or wish to make changes in your care plan. ICS will respond to your request for additional or changed services as soon as possible. (See Service Authorization section.) If you are not satisfied with the response to your request, there are other steps you can take. (See Grievance and Appeal section.)

You Continue To Receive Your Medicaid/Medicare Benefits...

When you enroll in ICS, you continue to receive all of your Medicaid and Medicare benefits. Services not included on the ICS covered services list — such as physicians and hospitals — are coordinated by ICS, but are paid directly by Medicare and Medicaid on a fee-for-service basis, or by commercial insurance if you have it.

Covered Services

ICS will pay for the following long-term care and other medically necessary services if they are a part of your approved care plan:

- Care Coordination — ICS is responsible for the coordination and management

of all your health and social support needs, including medical social services.

- Home Care Aide Services (includes home health aides, personal care aides, home attendants, housekeeping, and personal assistants)
- Home Health Nursing, Physical, Occupational, and Speech Therapies
- Nutrition Services
- Medical Equipment, including prosthetics and orthotics
- Medical Supplies (gauze pads, bandages, diapers and nutritional supplements similar to Ensure)
- Non-emergency Transportation
- Podiatry Services (Foot Care)
- Dental Care
- Optometry (Eye Exams, Glasses, and Other Vision Services)
- Audiology and hearing aids (services and equipment for people with hearing impairment, including hearing aid batteries)
- Adult Day Health Care
- Social Day Care
- Respiratory Therapy
- Social and Environmental Supports such as home modifications, linkage to vocational training, and referrals to Independent Living Services for skills training, help in setting up an apartment, using accessible transportation, check writing, etc.

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- Home Delivery of Meals
 - Personal Emergency Response System (PERS)
 - Outpatient Rehabilitation Services (such as physical, speech, occupational therapies)
 - Nursing Home Care (including post acute and/or short-term rehabilitation, long-term stays and respite care).

Please refer to the ICS Benefit Guide (Section 7) which describes what is covered by ICS for each benefit.

Access to Nursing Home Care

While our services are focused on maintaining your independence in your home and community, ICS also covers nursing home care, if this is the service you need. Your care manager will help you choose a nursing home that meets your needs. ICS has contracts with several nursing homes in our service area. If you should need nursing home care and prefer a facility not already under contract with ICS, we will try to make arrangements for your care with the facility you prefer. If we are unable to contract with the facility you prefer, you must either use a facility in ICS' network or disenroll from ICS so that you can enter the facility of your choice.

Members who have Community Medicaid coverage only (usually because of asset

transfers in the three years prior to needing nursing home care) will not meet the Medicaid financial eligibility criteria for nursing home coverage (known as institutional eligibility). Members who need nursing home care may be subject to disenrollment under these circumstances (See Section 4: Your Rights and Responsibilities). Your care manager will assist you to make appropriate plans for care.

Services That ICS Helps You Obtain And Coordinate That Are Still Paid For Directly By Medicare And Medicaid...

You are free to select the providers of your choice for the services covered directly by Medicare and Medicaid fee-for-service, and commercial insurers, if you have it. Although these services are not paid for by ICS, if you need assistance, your care manager can help you identify appropriate providers, arrange appointments, referrals, and transportation to services that continue to be covered directly by Medicare and Medicaid fee for service and commercial insurers such as:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Physician Services
- Laboratory Services
- Radiology and Radioisotope Services

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- Emergency Transportation
 - Prescription and Non-Prescription Drugs, including compound prescriptions
 - Medical/Surgical Supplies
 - Enteral and Parenteral Therapy
 - Hearing Aid Batteries
 - Chronic Renal Dialysis
 - Mental Health Services
 - Alcohol and Substance Abuse Services
 - Office of Mental Retardation and Developmental Disabilities (OMRDD) Services
 - Family Planning Services

If you have any difficulty getting these services because the provider misunderstands the Medicaid code on your card or for other reasons, call ICS immediately so we can explain to your provider that ICS membership does not affect their billing to Medicare or Medicaid fee for service, or a commercial insurance for services not covered by ICS.

Emergency Care: Call 911

An emergency is an accidental injury or an acute illness which occurs without warning and which has the potential to cause immediate disability or death, or which, if not treated immediately, could cause severe pain or discomfort. The complete definition of an emergency is “a medical or behavioral condition which occurs suddenly and manifests itself by symptoms of sufficient

variety, including severe pain that a prudent layperson who possesses an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such a condition in serious jeopardy or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or (2) serious impairment to such bodily functions; or, (3) serious dysfunction of any bodily organ or part of such person; or, (4) serious disfigurement of such person.”

Some signs of an emergency are:

- Dislodging of an indwelling catheter;
- Severe chest pain;
- Severe shortness of breath;
- Loss of consciousness (fainting);
- Sudden change in mental status (disorientation);
- Convulsive seizures (fits);
- Severe or multiple injuries, including fractures;
- Bluish color of skin or lips;
- Allergic reactions accompanied by swelling of the face or lips, or wheezing in the chest;
- Bleeding that cannot be stopped.

If your symptoms require emergency care, you may not have the time to get help from Member Services or the care manager to

arrange your transportation or an appointment. **In case of an emergency, call 911.**

You can get emergency care **at any hospital emergency room either in or out of the service area.** As soon as you or a family member or friend is able (within 24 hours), please call your care manager toll free at **1-877-ICS-2525** to let them know what happened and for assistance in coordinating your needs.

Urgent Care: Call Your Physician or ICS, 24 Hours a Day

When you need urgent care for symptoms (for example, for bruises, sprains, minor burns, upper respiratory infections) that need attention sooner than a routine medical visit can be scheduled, call your physician or the care manager. Your care manager can assist you by:

- Recommending treatment,
- Scheduling a home or office visit for you, or
- Sending you to a hospital emergency room.

ICS has around-the-clock, 24-hour phone system (Toll free **1-877-ICS-2525**), so care management staff are always available to answer your questions.

If you need either emergency or urgent care, you can get these services in or out

of the service area without approval. This includes urgent dental care, as well.

How to Obtain Services During and After Hours

ICS has a 24 hours a day, seven days a week “on call” system. It is usually best to ask your care manager your questions during regular business hours (Monday through Friday, 9 am and 5 pm) toll free at **1-877-ICS-2525**. If you have an urgent need for assistance or have questions about your care or services that cannot wait until business hours, call the toll free (**1-877-ICS-2525**) number at any time and your call will be directed to the ICS on call staff.

- To access TDD/TTY during business hours, call ICS directly at **1-877-ICS-2525**. After business hours, call the New York TDD/TTY Relay Service at **1-800-662-1220** (teletype to voice) or **1-800-421-1220** (voice to teletype) and ask to be connected to the ICS toll free line (**1-877-ICS-2525**).
- If you speak another language besides English and Spanish and do not have (or do not wish to use) a friend or family member to interpret for you, please call our toll free number **1-877-ICS-2525** and you will be connected to the AT&T Language Line. This service can translate your questions from your primary

language so that your needs or concerns are clearly communicated. ICS can connect to the AT&T line 24 hours a day, 7 days a week.

Out of Area Care: Call ICS Care Management

If you plan to travel out of the ICS service area (Bronx, Brooklyn or Manhattan), call your ICS care manager so they can assist you to arrange for any needed services or care.

ICS cannot be financially responsible for unapproved out of area services. Unapproved services are those covered services you do not arrange through your care manager.

Consequences of Obtaining Any Covered Services Without ICS Approval

Receiving unapproved services may mean that the provider will not be paid. Whether you are at home or traveling outside the ICS service area, if you receive covered services without the approval of your care manager, the services may not be paid for. **(Please read the Benefit Guide which explains when you can go to an ICS provider for covered benefits without a prior referral.)**

Please make every effort to call us before you receive services from any provider. This is both a courtesy, and an important responsibility of your ICS membership.

See Section 4 for additional responsibilities of your membership in ICS.

Service Authorizations

Your care manager must approve the medically necessary covered services important to your health and well-being. Medical necessity is defined as services needed to prevent, diagnose, correct or cure conditions in a member that cause acute suffering, endanger life, result in illness or infirmity, or interfere with capacity for normal activity.

ICS care managers use the above definition of medical necessity when reviewing requests for services. At a minimum, the ICS benefit will cover no less than that which is covered in the Medicaid fee-for-service system. In addition, certain health services must be ordered by a physician and will require that ICS coordinate and arrange access to the service provider. These services are:

- Skilled Home Care, such as nursing;
- Home Care Aide Services, such as home health aides, personal care aides and personal assistants*;
- Physical, Speech, Occupational and Respiratory Therapies;
- Durable medical equipment, including prosthetics and orthotics;
- Adult day health care; and
- Nursing home care
- Medical Supplies

* HOME CARE AIDE SERVICES — A physician’s order is required to start personal care services; however, the decision as to frequency and amount of hours is the decision of an ICS nurse care manager based on the home care hours assessment tool. If you are dissatisfied about whether or not your physician has ordered home care aide services for you, or with the decision of your nurse care manager regarding the number of hours or frequency of the aide services, you can file an appeal of our decision with ICS through the Grievance and Appeal process outlined in Section 4.

All ICS members who have both Medicare and Medicaid coverage, will choose or be assigned to a Medicare Part D Plan to pay for prescription drugs ordered by a physician, except for drugs which are not covered Medicare; in that case they will be paid through Medicaid fee-for service. ICS members with Medicaid only will have prescription drugs paid for by Medicaid fee-for-service.

Some services do not require a physician’s order to obtain approval. Although all services must be authorized by your care manager, ICS members can make their own appointment for preventive health services or an initial evaluation in the

following areas, as long as those services are provided by a network provider:

- Optometry (vision services)
- Dental
- Podiatry (foot care)
- Audiology (hearing services)
- Nutrition

The network provider will then submit a request for service authorizations within the scope of the Medicaid fee-for-service guidelines. Please read the benefit descriptions in the ICS Benefit Guide.

These covered services do require the authorization of your care manager before you start the services:

- Personal Emergency Response Systems (PERS)
- Social day care
- Environmental and social supports
- Home delivered meals
- Non-emergency transportation

When you need any of the above services, you or your medical provider should call your ICS care manager to arrange for these services. Your care manager will discuss with your provider the best means for meeting your needs and fulfilling the requested service.

Service authorization requirements apply to all services that you request from ICS. This means that ICS must notify you and/or your designee within certain timeframes of its decision to either approve or not approve the requested service and you have certain rights for requesting an appeal of ICS' decisions. When you request a change or adjustment to a service you are already receiving, our approval process is called concurrent review. Concurrent review means that your care manager must decide and notify you of our decision by phone and in writing as per the following guidelines:

Concurrent Review

- **Expedited concurrent review** — within 1 business day of receipt of all necessary information, but no more than 3 business days of receipt of request for services from member or provider on behalf of member.
- **Standard concurrent review** — within 1 business day of receipt of necessary information, but no more than 14 days of receipt of request for services from member or provider on behalf of member

When you request a new service, our approval process is called prior authorization. Your care manager must decide and

notify you of our decision by phone and in writing as fast as your condition requires as per the following guidelines:

Prior Authorization

- **Expedited prior authorization** — 3 business days from request of service from member or provider on behalf of member.
- **Standard prior authorization** — within 3 business days of receipt of all necessary information, but no more than 14 days of receiving the request for service from member or provider on behalf of member.

Extensions can be granted if either you, as a member, your provider, or ICS needs more time to get information to make a decision that is in your best interests.

Up to 14 calendar days extension

- An extension may be requested by the member or provider on the member's behalf.
- ICS may also initiate an extension if it can justify the need for additional information and if the extension is in the member's interest.

Members or providers on behalf of member may appeal ICS' service authorizations decisions (see Appeal section.)

Enrollment Information

This Section describes the specifics of the enrollment process, eligibility requirements, and the steps to becoming a member of ICS. We encourage you to read both this Section and Section 4 (Your Rights and Responsibilities) carefully before you enroll, and talk with us if you have any questions about the ICS plan, your eligibility, and/or the enrollment process.

Eligibility: Who Can Become A Member Of ICS?

ICS members are people with physical disabilities or chronic illnesses who are able to remain in their homes and communities. Your membership is voluntary.

You are eligible for membership in ICS if you are:

- Living in the ICS service area (currently Bronx, Brooklyn or Manhattan);
- Eligible for Medicaid with or without spend-down;
- Physically disabled and/or chronically ill and are at least 18 years old;
- Functionally impaired as defined by New York State Department of Health assessment measures (Semi Annual Assessment of Members (SAAM)) that could qualify you for nursing home level care;

- Able to return to or remain safely in the community without risking your health and safety, as defined by New York State Department of Health criteria;
- Expected to need at least one of the following services and care management for at least 120 days from your date of enrollment:
 1. Nursing services in your home
 2. Therapies in the home
 3. Home health aide services
 4. Personal care services
 5. Adult day health services
 6. Social day care if used as a substitute for in-home personal care services.

If you are interested in joining ICS, but do not meet eligibility criteria, the reasons for non-enrollment and your rights to challenge this decision will be explained to you by the enrollment staff who will document it in writing to make sure you understand.

All interested consumers who meet the functional and financial eligibility criteria can enroll regardless of service related cost factors, race, ethnicity, religious beliefs, or sexual preferences.

If you start the enrollment process and change your mind about joining ICS, just let the enrollment staff know and we will

confirm your withdrawal request in writing and delete your application.

Enrollment Specifics

Enrollment in ICS is voluntary. If you are interested in joining ICS, a telephone call from you (or someone who can make the call for you) is how you begin the enrollment process. The enrollment process takes place over one or two interviews to make sure that you are fully informed of ICS' benefits and so that a complete assessment of your needs, goals and preferences can be conducted.

Meeting You. Meeting Us.

When you call us, we will ask you a few questions to get information about your disability and give you information about ICS and our eligibility requirements. We will arrange a convenient time to meet with you either in your home, hospital or nursing home. At this first meeting, you will have the opportunity to ask questions and our enrollment team will fully explain the ICS plan of services.

The enrollment staff will also ask you about any preferences you may have regarding your current service providers, and check your financial eligibility for Medicaid. If you need help to apply for

Medicaid or recertify your Medicaid eligibility, an ICS Medicaid Eligibility Specialist is available to assist you.

An ICS intake nurse will meet with you to assess your capabilities and discuss your goals and preferences for care. The ICS intake nurse will determine if you meet the criteria for nursing home level of care by completing a variety of assessment forms, so we can better understand your service needs. The nurse will discuss with you your current abilities and need for supports and consult your physician for recommendations and orders. Together, you will develop an initial care plan that is submitted to the New York City Human Resources Administration (HRA) as part of the enrollment package.

Paperwork

Once you have all the information you need and have decided to enroll, the enrollment package described above is completed. You will be asked to sign an enrollment agreement and an initial care plan. If additional information is needed from your medical or mental health provider, the enrollment staff will ask you to arrange for your medical records to be sent to ICS.

The completed enrollment package must then be sent to the New York City Human Resources Administration (HRA) for processing. Enrollments in ICS must be approved by HRA. If HRA finds that you are not eligible and you disagree, your rights will be explained to you. Enrollments for persons being discharged from hospitals, or Office of Mental Health, Mental Retardation/Developmental Disabilities or Alcohol and Substance Abuse facilities become effective on the first day of the month following discharge. Nursing home residents who are planning to return to community living can be enrolled in ICS with the effective date of enrollment timed to coincide with their month of discharge.

Welcome!

When HRA approves your application for enrollment, ICS is notified prior to the effective date of enrollment. Your care manager will contact you to arrange a home visit to assess whether your care plan still adequately meets your needs. Your care manager will then work with you to make any needed adjustments to your care plan (which will be written on your copy of the care plan) and arrange to start services on the first day of your enrollment month.

You will also receive through the mail, prior to the first day of your enrollment, an ICS identification card with your name and number on it. (Remember, you need to carry your regular Medicare and Medicaid fee for service cards, as well as any commercial health insurance cards that you choose to keep, to get services not covered by ICS but still covered by Medicare and Medicaid fee for service and commercial insurance.)

You will also be contacted by the ICS staff for an initial orientation within two months of enrolling. The ICS staff is responsible for educating members and providers about ICS. The purpose of orientation is to make sure you understand how to use the benefits provided by membership in ICS and to help you know the best way to communicate your questions, concerns, suggestions, and recommendations to ICS. The staff is responsible for listening to your concerns and complaints in order to be responsive to your suggestions on how we can better work with you.

Your Rights and Responsibilities

This Section describes your rights and responsibilities as an ICS member, and includes information about how you can most effectively communicate with us if you have a question, concern, or are not satisfied with ICS services at any time.

This Section also describes certain conditions under which your membership in ICS could be cancelled by ICS. It is very important that you understand both your rights and your responsibilities as a member, and ask questions if you do not understand any of the information we give you.

As An ICS Member, You Have The Right To:

- Receive medically necessary care.
- Timely access to care and services.
- Privacy about your medical record and when you get treatment.
- Get information on available treatment options and alternatives presented in a manner and language you understand.
- Get information in a language you understand; you can get oral translation services free of charge.
- Get information necessary to give informed consent before the start of treatment.
- Be treated with respect and dignity.
- Prepare an “Advance Directive” and health care proxy, to clearly state your preferences for care and treatment in the event you cannot make your own wishes known (See Section 6: Member Communications).
- Appoint someone to speak for you about your care and treatment.
- Get a copy of your medical records and ask that the records be amended or corrected.
- Take part in decisions about your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status, or religion.
- Be told where, when and how to get the services you need from ICS, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- Complain to the New York State Department of Health or your local Department of Social Services (HRA), the right to use the New York State Fair Hearing System, or in some instances, request a NYS External Appeal through the New York State Insurance Department.

As An ICS Member, It Will Be Your Responsibility To:

- Use the ICS network of providers for covered services unless previous arrangements have been made with your care manager.
- Get approval from your care manager before receiving covered services, other than in-network preventive health services described on pp. 15-16.
- Tell your ICS care manager about your care needs and concerns.
- Notify ICS when you go away or out of town.
- Pay or arrange to pay your cost share if a spend-down amount was determined by HRA.

Payment of Spend-down

If a spend-down amount was determined by HRA, you are required to pay the specified amount to ICS by the 15th of each month. If you have any problem meeting this responsibility, please discuss it with your care manager, who will discuss your options for payment. Your continued eligibility for Medicaid services depends on your meeting your surplus payment responsibility. New York State allows ICS to disenroll members who do not pay their spend down amount within 30 days of being due.

If You Are Not Satisfied...

ICS will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. We encourage you to discuss your concerns directly with your care manager first as your care team is best equipped to help you resolve any problems you may have. If your concern or problem is not addressed to your satisfaction, you may use our grievance and appeal process.

We maintain a toll free Member Services line (1-877-ICS-2525), so that you can call us at any time with problems or suggestions. You can also file a complaint anytime with the New York State Department of Health by calling toll free 1-866-712-7917.

There will be no change in your services or the way you are treated by ICS staff or a health care provider because you file a grievance or appeal. We will maintain your privacy. We will give you any help you may need to file a grievance or appeal. This includes providing you with interpreter services or help if you have vision, hearing, and/or speech problems. (Remember, ICS can be reached at TDD/TTY 1-877-ICS-2525.) You may choose someone (like a relative, friend, or provider) to act for you.

To file a grievance or to appeal a plan action, please call 1-877-ICS-2525 or fax us at 1-212-584-2555. You can also write to us at: 257 Park Ave. South, New York, New York, 10010. When you contact us, please give us your name, address, current telephone number and the details of the problem.

What is a Grievance?

A grievance is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a grievance with us.

The Grievance Process

You may file a grievance orally or in writing to us. The person who receives your grievance will record it, and appropriate ICS staff will oversee the review of the grievance. We will send you a letter telling you we received your grievance and a description of our review process. We will review your grievance and give you a written answer within one of two timeframes:

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after the receipt of necessary information,

2. For all other types of grievances, we will notify you of our decision within 45 days of receipt of necessary information, and the entire process must be completed within 60 days of receipt of the grievance. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your grievance and our decision about your grievance.

How to Appeal a Grievance Decision

If you are not satisfied with the decision we make concerning your grievance, you may request a second review of your issue by filing a grievance appeal. **You must file a grievance appeal in writing. It must be filed within 60 business days** of receipt of our initial decision about your grievance. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address, and telephone number of the individual we have designated to respond to your appeal. All grievance appeals will be conducted by appropriate professionals, including health care professionals (who were not involved in the initial decision) for grievances involving clinical matters.

For **standard appeals**, we will make the appeal decision **within 30 business days** after we receive all necessary information to make our decision. We will expedite the appeal if a delay would significantly increase the risk to your health. For **expedited grievance appeals**, a decision will be made **within 2 business days** of receipt of necessary information. For both standard and expedited grievance appeals, you will receive written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical reasons for our decision.

What is an Action?

When ICS limits or denies services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; reduces, suspends or terminates services we already authorized; denies payment for services; doesn't provide timely services; or doesn't make grievance or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See **How to File an Appeal of an Action** on page 24 for more information.)

Timing of Notice of Action

If ICS decides to deny or limit services you requested or decides not to pay for all or

part of a covered service, we will send you a notice when we make our decision. If we are proposing to reduce, suspend, or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Explain the reasons for the action, including the clinical reasons, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria that ICS used to make the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for ICS to make a decision on the appeal.

If ICS is reducing, suspending, or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstance under which you might have to pay for services if they are continued while we were reviewing your appeal.

How To File an Appeal of an Action

If you do not agree with an action that ICS has taken, you may appeal. When you file an appeal, ICS will review the reasons for our action to decide if we were correct. You can file an appeal of an action with ICS by calling the Member Advocacy staff at 1-877-ICS-2525 or writing to us. When ICS sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you have 45 calendar days (from the date on our notice to you) to file your appeal request. You can call us to file your request for an appeal, but you must also send a written request unless you ask for an expedited review.

How to Contact ICS to File an Appeal

ICS staff can be reached by calling 1-877-ICS-2525. Ask to speak to the Director of Advocacy. If you are putting

your appeal in writing, please mail it to:

**Director of Advocacy
Independence Care System
257 Park Ave. South, 2nd floor
New York, N.Y. 10010**

Your appeal will be tracked and appropriate staff will review the reasons behind the decision. We will send you a letter telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable staff who were not involved in the plan's initial decision or action that you are appealing.

How to Request that Services Continue During the Appeal Process

If you are appealing a reduction, suspension, or termination of services you are currently authorized to receive, you may request to continue to receive these services while ICS is deciding on your appeal. ICS must continue your service if you make your request no later than 10 days from the mailing of the notice to you about our intent to reduce, terminate, or suspend your services, and the intended effective date of our action, and the original period covered by the service authorization has not expired. Your services will continue until you withdraw the appeal, the original authorization period for your services has

been met, or until 10 days after we mail your notice about our appeal decision, if the decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section on page 26.)

Although you may request a continuation of services while your appeal is under review, if your appeal is not decided in your favor, ICS may require you to pay for these services if they were provided only because you asked to continue to receive them while your appeal was being reviewed.

How Long Will It Take ICS to Decide My Appeal of An Action?

Unless you ask for an expedited review, ICS will review your appeal of the action as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the date we received your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision. If we reverse our decision to deny or limit requested services, or reduce, suspend, or terminate services, and services were not provided while your appeal was pending, we will provide you with the services as quickly as your health condition requires. In some cases, you may request an “expedited” appeal. (See Expedited Appeal section below.)

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. ICS will respond to you within two business days after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a

standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

If ICS Denies Your Appeal, What are Your Options?

If ICS' decision about your appeal is not totally in your favor, you will receive a notice explaining your right to a Medicaid Fair Hearing from New York State.

The notice will explain how to get a Fair Hearing (call toll free 1-800-342-3334), who can appear at the Fair Hearing on your behalf, and, for some appeals, your right to request to receive services while the hearing is pending and how to make that request. If ICS denies your appeal because of issues of medical necessity or because the service in question is experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of the ICS decision.

State Fair Hearings

If ICS did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State *within 60 days* of the date we sent you the notice of the ICS decision on your appeal.

If your appeal involved the reduction, suspension, or termination of authorized

services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services in question to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent to you by ICS or by the intended date of our action to reduce, suspend, or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period ends, or the State Fair Hearing Officer issues a decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, ICS must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you receive the disputed services while your appeal is pending, ICS is responsible for the payment of the covered services ordered by the Fair Hearing Officer.

State External Appeals

If ICS denies your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an **external appeal** from

New York State. The external appeal is decided by reviewers who do not work for ICS or New York State. These reviewers are qualified professionals approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Insurance within 45 days from the date ICS denied your appeal.

Your external appeal will be decided within 30 days. An additional 5 business days may be needed if the external appeal reviewer needs more information. The reviewer will tell you and ICS of the final decision within 2 business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell

you and ICS the decision right away by phone or fax. You will also receive the decision in writing as soon as practicable.

You may ask for both a Fair Hearing and an external appeal. If you ask for both, the decision of the Fair Hearing officer is the one that counts.

Ending Your Membership

If you are not satisfied with the services provided by or through ICS, or believe that it is in your best interest to end your membership in ICS, you have the right to disenroll.

If you want to disenroll, you can let us know orally or in writing. You can either sign the ICS Disenrollment Form or we will put your request in writing to confirm your wishes and forward your request to HRA for processing so that you can be fully reinstated on fee-for-service Medicaid or in another managed care plan. Your care manager will also help you to link up with the service arrangements you may need. It can take from 15 - 60 days to be reinstated on fee-for-service Medicaid or enroll in another managed care plan, during which time ICS will continue to meet your needs, as described in your care plan. *If you disenroll from ICS, you do not lose your Medicare or Medicaid coverage.*

ICS encourages you to call your care manager or the ICS Advocacy staff toll free (1-877-ICS-2525), to discuss any problems you have that are related to your decision to end your membership. We hope to be able to address your needs to your satisfaction; but, disenrollment is your choice and you are not required to go through the Advocacy staff if you would like to disenroll.

Conditions That May Lead To Membership Cancellation By ICS

ICS values your membership; but, in the situations listed below, ICS *must* disenroll you from the program:

- You are no longer eligible for Medicaid.
- You move out of the ICS service area (Bronx, Manhattan, and Brooklyn).
- You leave the ICS' service area (Bronx, Manhattan, Brooklyn) for more than 60 days.
- You are hospitalized or are an inpatient in an Office of Mental Health, Mental Retardation and Developmental Disabilities or Alcohol and Substance Abuse facility for more than 45 days.
- You need nursing home placement, but are not eligible for such care under the Medicaid program's institutional rules.
- Your annual reassessment indicates that you no longer need a nursing home level of care based on the New York State

Department of Health assessment measures, and you are not expected to need this level of care for six months, unless the discontinuance of ICS services puts you at risk of nursing home placement.

ICS may disenroll you if:

- You fail to make efforts to pay any spend-down costs you agreed to pay within 30 days of the due date, provided that reasonable efforts have been made to collect the amount due, including a written demand for payment, and explanation that you are at risk of disenrollment.
- You or your family knowingly fails to complete or submit any consent form or other document needed to obtain services or payment from Medicare or Medicaid
- You knowingly provide false information, engage in fraudulent conduct, or otherwise deceive ICS or engage in fraudulent conduct with respect to any substantive aspect of membership in ICS.
- You are engaged in conduct or behavior that seriously impairs ICS' ability to provide services, provided that ICS has documented the reasonable efforts to resolve the problems presented by you.
- Your physician refuses to collaborate with ICS in the development and implementation of your care plan. Collaboration by the physician means a willingness to

refer to network providers and write orders for covered services.

Safeguarding Your Rights

ICS cannot request disenrollment because of adverse changes in health status, utilization of health services, diminished mental capacity, or uncooperative, disruptive behaviors that result from special needs.

To safeguard your rights, all recommendations for involuntary disenrollment are reviewed by the Director Advocacy.

Members who are at risk of being involuntarily disenrolled will receive a written notification of that risk from the ICS care manager and will be reminded that he/she can have their point of view heard at a case conference meeting. If a member does not respond to the **ICS Notice of Possible Disenrollment** or does not wish to participate in a case conference to address the problem, ICS will submit the involuntary disenrollment request with the necessary justifications to HRA for their review and a decision. Members will be notified in writing when ICS submits an involuntary disenrollment request to HRA. HRA will notify the member directly of their decision and the member will receive a notice from HRA advising of the right to a fair hearing if they agree with the involuntary disenrollment. The ICS care manager will

also contact the member to discuss HRA's decision and finalize planning for the member's needs through fee-for-service Medicaid or another managed care plan.

Covered services are provided until the effective date of disenrollment, all applicable Fair Hearing rights are exhausted, and the member is linked back to fee-for-service Medicaid, another managed care plan, or any needed services. If a member requests a fair hearing from the New York State Office of Temporary and Disability Assistance (OTADA) in a timely way, services (i.e. aid continuing) will remain in place until a fair hearing decision is reached.

If HRA disagrees with ICS' request to involuntarily disenroll the member, ICS can ask for further review of the case situation by the local social service district (HRA) Medical Director. ICS will notify the member of the HRA Medical Director's decision and plan to continue services if the member remains in the ICS Plan.

Members who are disenrolled can be re-enrolled if requested by the member, assuming that the original reason for disenrollment has been resolved.

Information Provided Upon Request

ICS will make available at your request the following information about the plan's operations:

- A list of the names, business addresses and official positions of the membership of the Board of Directors and Officers of ICS;
- A copy of the most recent certified financial statement of the plan including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;
- Information relating to consumer complaints and aggregated information pertaining to grievances and appeals;
- A description of the procedures followed by the plan in making decisions about medical devices;
- Individual health practitioner affiliations with participating hospitals and other facilities, if any;
- Licensure, certification and accreditation status of network providers;
- Specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which ICS might consider in its utilization review and

how it will be used in the utilization review process for the purpose of assisting enrollees and prospective enrollees to evaluate the covered services provided by ICS;

- Written application procedures and minimum qualification requirements for health care providers to be considered by ICS;
- Comparative information about the plan including quality and performance indicators, and other descriptive and statistical information which has been disclosed to the NYS Department of Health and the Center for Medicare and Medicaid Services.
- Procedures for protecting the confidentiality of medical records and other enrollee information.

In addition, health care professionals licensed, registered, or certified pursuant to Article 8 of the State Education Law must provide enrollees or prospective enrollees with information concerning education, training, experience, facility affiliation, and participation in clinical performance reviews conducted by the New York State Department of Health, if requested.

Member Participation

We believe that as a “member” you should have the opportunity to actively participate in the governance of our organization. During your formal orientation (within the first 60 days of membership), the ICS Advocacy orientation staff will explain that members, in addition to developing their own care plans with the care manager, have consumer representatives on the Board of Directors. By having a voice in care management and the Board, you can shape the policies and programs that ICS has to offer.

The Board of Directors — The ICS Board of Directors has two consumer representatives to present your point of view on issues such as the purpose of ICS and its progress based on ICS’ mission and vision. As part of the Board of Directors, the consumer representatives meet regularly with the other seven Board members. The other Board members include: the President of ICS, the Presidents of

Cooperative Home Care Associates and the Paraprofessional Health Care Institute, as the sponsoring organizations, and the professional provider, public policy and financial community. Together, they are responsible to govern and lead ICS. (The names and phone numbers of the Board of Directors are available upon request.)

Performance Improvement Committee — The purpose of the ICS Performance Improvement (PI) Program is to provide a systematic method to monitor and continuously improve the quality of services delivered to ICS members. ICS will seek your opinions on *all* our interactions with you from the enrollment process, to the services provided, to the responsiveness of our staff and provider network. You will be asked to participate in member satisfaction surveys and ICS will listen to your recommendations and adjust our services as appropriate.

Member Communications

Independence Care System is committed to keeping you informed about our service network and to use the information provided by you to develop and improve how we serve you.

During the first quarter of each calendar year, your ICS care manager will deliver an updated ICS provider network list and copies of updated policies and procedures which should be kept with your Member Handbook.

Important Phone Numbers

Keep these phone numbers handy:

ICS Member Services — 1-877-ICS-2525

ICS TDD/TTY (during business hours) — 1-877-ICS-2525

New York TDD/TTY Relay Service (after business hours) — 1-800-662-1220
(for teletype to voice), 1-800-421-1220 (for voice to teletype)

AT&T Language Line — call ICS toll free 1-877-ICS-2525 to connect

New York State Department of Health — 1-866-712-7917

Advance Directives

All members have the right to an advance directive, that is, making your wishes for critical care or end-of-life treatment clearly known in case you are unable to speak on your own behalf. This includes the right to appoint a health care proxy to speak on your behalf if you are unable to do so. Members who already have an advance directive and health care proxy in place will

be asked to make a copy available to ICS for use with appropriate health care providers. Members interested in further information about advance directives and appointing a health care proxy can request Advance Directives and Health Care Proxy forms from their care manager who is ready to answer additional questions or concerns.

Adult Day Health Care

What is Covered?

Adult Day Health Care (ADHC) provides skilled services such as nursing, physical, speech, and occupational therapies in a day program setting offered by a residential health care facility or approved extension site. Other services available in ADHC are: nutritional counseling, socialization activities, dentistry, podiatry, and administration of medications. Transportation to and from the facility may be included in the daily rate.

Ordering Guidelines

- Adult Day Health Care (ADHC) should be considered for members who need **one or more** skilled services **and** can benefit from the socialization provided in this group setting
- ADHC services may be used instead of personal care
- Care manager should arrange for member to visit the ADHC and get recommendation for scheduling from the center
- ADHC obtains order from MD
- Upon receipt of MD order, care management authorization is documented in care plan

Exclusions

Should not be used for socialization reasons only (see Social Day Care options).

Approval Needed

MD order required

Audiology

What is Covered?

1. Hearing exam
2. Hearing aid evaluation
3. Selecting, fitting, dispensing of hearing aids
4. Hearing aid repair
5. Replacement of accessories (batteries) when necessary to maintain the hearing aid in functional order

Ordering Guidelines

- Members can self-refer for a hearing exam from a network provider when medically necessary to alleviate disability caused by the loss or impairment of hearing
- If other goods and services are needed, the network provider will request an authorization based on professional, clinical judgment and standards addressing the specific clinical needs of the member
- When ordering hearing aid(s) make sure the warranty information is completed
- One set of hearing aids may be ordered every three (3) years
- Repairs or replacements due to documented damage or loss may be made at any time
- Care manager should include need for service in the Care Plan based on member reports of hearing difficulty

Exclusions

In the canal (ITC) hearing aides that are

digital or programmable are not covered.

MD Order Required?

No

Approval Needed

Members can directly access a hearing exam through a network provider. Care managers can authorize hearing aids and items under \$500 in cost that meet the ordering guideline criteria referenced above. If a care manager is unsure of the item, it should be reviewed by the care management supervisor or clinical peer reviewer.

Items costing greater than \$500 require supervisory review to determine cost effectiveness and medical necessity.

Supervisors will consult with clinical peer reviewer before a determination is made.

Dental Care

What is Covered?

- Routine, preventive dental examination and treatment once every six months such as:
Examinations Cleaning
Gum scaling X-rays
- Restorative care such as:
Filings Bridgework Dentures
- Dentures lost or damaged due to loss, fire, or theft can be replaced with appropriate documentation

Ordering Guidelines

- Members may self-refer for dental care

within the dental provider network

- Members may choose any dentist from the provider network; the dentist will obtain the authorization for payment from ICS
- When dental treatment plan costs more than \$2,000, the dental provider will send the treatment plan and the x-rays to the Care Manager for review by the dental peer reviewer who will evaluate the plan based on professional, clinical judgment and generally accepted professional guidelines (e.g. American Dental Association)
- Care manager should include need for dental care in the care plan

Exclusions

Dental implants

MD Order Required?

No

Approval Needed

Member can self-refer to a network provider for routine bi-annual examination and emergent care. Provider will request authorization for payment of any treatment (routine or non-routine) to be provided resulting from the examination. Care managers can authorize the cost of the treatment plan when it is less than \$2,000 following the Medicaid fee-for-service coverage guidelines. If the treatment plan cost is greater than \$2,000, the plan must

be reviewed by a licensed dental consultant (prospective peer review) prior to authorization. The dental consultant will use his professional, clinical judgment and base his/her decision on generally accepted professional guidelines.

Durable Medical Equipment

What is Covered?

Devices and equipment needed in the treatment of a specific medical condition or used to support functioning in activities of daily living. These include, but are not limited to:

- Mobility devices including wheelchairs, walkers, canes, and scooters.
- Beds
- Bathroom equipment
- Adaptive aids such as reachers
- Repair of the above equipment

Ordering Guidelines

- Care managers will prior authorize medically necessary durable medical equipment as part of care plan
- When ordering a wheelchair or scooter, Care Manager must follow the ICS process with the ICS Rehab coordinator
- Repairs should be directed to the ICS repair clinic process
- Beds and mattresses have a separate approval process to follow (reference: ICS Hospital Bed Guide)

- Items that are covered by Medicare are purchased or rented under Medicare payment guidelines
- Small items such as: crutches, walkers, canes are usually purchased
- Larger mechanical items (hospital beds, hoist lifts, etc.) are leased so they can be serviced if needed
- Servicing of equipment is usually covered by the vendor during a leasing period
- ICS will cover repairs on purchased equipment if it is more financially feasible to repair than replace

Exclusions

Refer to ICS Wheelchair Ordering and Hospital Bed Ordering Guidelines.

MD Order Required?

Yes

Approval Needed

The process for specialty items that need professional assessment by physical and occupational therapists to assure appropriate fit is described in Wheelchair and Hospital Bed Ordering Guides.

Home Care Aide Services

What is covered?

- Home Health Aides (HHAs) provided as part of a treatment plan administered by a Certified Home Health Agency (CHHA)
 - Personal Care Aides (PCAs)
- Housekeepers

Ordering Guidelines

RN care manager completes ICS Home Care Assessment tool and reviews the Department of Health Home Health Aide/Personal Care Aide scope of practice guidelines to determine appropriate type and number of hours of home care assistance needed, considering role of informal supports and member's living arrangements.

Exclusions

Home care aide hours should not be approved for time member spends in adult day health program or dialysis treatment.

MD Order Required?

Yes. Physician certifies the need for service, but does not determine the number of hours, but may make a recommendation. No MD orders are needed for housekeeping services.

Approval Needed

Care manager includes the need for home care aide services on care plan and authorizes the type and number of hours.

Home Delivery of Meals

What is Covered?

- Home delivered meals are provided consistent with a member's plan of care
- Members who need assistance with meal preparation (i.e. cannot cook, are not safe cooking, have no cooking

facilities) and have less than 4 hours per day of home care service are eligible for one meal per day to be delivered

- Under special circumstances (e.g. PCA is unable to prepare special dietary requirements to address nutritional changes), a member may receive two (2) meals daily for a limited time

Ordering Guidelines

- Care manager should assess member's functionality and any special nutritional needs based on diagnosis (e.g. wound healing support, weight management, diabetes management)
- Meal can be frozen to be re-heated or delivered hot
- Care manager should specify dietary restrictions, allergies, and member food preferences on the authorization
- Care manager authorization as part of care plan

Exclusions

None

MD Order Required?

No

Approval Needed

As long as member needs meets ordering guidelines referenced above, service will be authorized.

Medical Supplies

What is Covered?

Medical supplies and items for health use other than medications, prosthetic and orthotic devices and durable medical equipment that are used in the treatment of a specific medical condition and which are consumable, non-reusable, disposable. These include but are not limited to:

- Diabetic Supplies, if not provided by a pharmacy plan
- Dressing and other wound care supplies
- Urinary Catheters
- Incontinence Supplies (e.g, disposable underwear/briefs/underpads)
- Nutritional Supplements such as Ensure

Ordering Guidelines

Care managers will authorize medically necessary supplies. The following information is necessary in order for the care manager to order medical supplies:

- Determination of Medical necessity
- Specific information about the supplies requested

MD Order Required?

Yes

Approval Needed

As long there is a medical necessity for ordering the supplies referenced these will be ordered.

Nursing Home Care

What is Covered?

Post acute care, short-term rehabilitation, respite care, and long-term custodial care in a skilled nursing facility, licensed by the New York State Department of Health.

Nursing Home per diem rates cover:

- Semi-private room & board
- Nursing and personal care services, including assistance with all activities of daily living
- Rehabilitation services
- Recreational and socialization activities
- Maintenance of the member's room
- Other facility related services

Ordering Guidelines

There are two points of entry for members to possibly need nursing home care:

1. Post-acute care hospitalization
2. From the community when a member's needs cannot be safely or adequately provided in the homes (e.g. specialized wound care, round the clock RN care, etc.)

Post-acute Care:

- Coordinate the discharge plan with the hospital discharge planning staff
- Provide list of network nursing facilities to the discharge planner. Nursing homes within the ICS provider network should be the location of choice; but if

there are no beds available or the member has Medicare and this is a post-acute Medicare coverable stay, a short-term agreement can be made by Provider Relations to authorize payment in a non-network nursing facility

From the community:

- Arrange completion of the Patient Review Instrument (PRI) by a qualified RN
- Forward PRI to network nursing facilities

Exclusions

Members who express a preference to be placed in a non-network nursing facility for a long-term care placement with no intent to return to community living.

MD Order Required?

Yes — the nursing home will usually get the MD order directly.

Approval Needed

Care manager authorization required.

Nutrition Services

What is Covered?

- Assessment by a qualified nutritionist of the nutritional status, food preferences, and need for therapeutic diets
- Nutritional education as part of a treatment plan

Ordering Guidelines

- Nutrition services are indicated for the purpose of assessing a member’s risk for and/or treatment of malnutrition, eating disorders, weight management or dietary restrictions. Nutrition services are also considered for the promotion of healing and to complement treatment of clinical conditions
- Should be considered for members with diagnoses such as obesity (BMI greater than 25), diabetes, End Stage Renal Disease (ESRD), cardiovascular disease, cancer, loss of appetite, underweight, swallowing issues
- Nutritionist will determine appropriate number of follow-up visits needed based on his/her assessment and will submit a treatment plan for authorization. Care manager will review for authorization based on professional, clinical judgment and standards addressing the specific clinical needs of the member (e.g. American Diabetes Association, American Heart Association, etc.)
- Care manager will note the need for service in the care plan

Exclusions

None

MD Order Required?

No

Approval Needed

Members can self refer for one wellness evaluation per year within the provider network.

Recommended treatment plans submitted by the qualified nutritionist will be authorized by care manager for members meeting clinical and diagnostic criteria referenced above.

Optometry Services

What is Covered?

Optometry services (eye exams, eyeglasses, contacts) are covered.

This includes:

- Annual eye exams to detect visual defects and eye disease
- Prescription lenses and up to \$100 for eyeglass frames every two (2) years
- Replacement of lost, stolen or damaged glasses with documentation
- Low vision aids
- Low vision services

Ordering Guidelines

ICS members can self-refer for annual eye exam through a network provider.

Network provider will follow payment rules requesting service authorization for all prescribed items, including but not limited to:

- Medically necessary contact lenses and polycarbonate lenses (reimbursed at the

Medicaid rate for corrective lenses)

- Replacement of lost, damaged, or destroyed eyeglasses with documentation
- Two pairs of eyeglasses instead of bifocals for members who cannot adjust to bifocals
- Tinted lenses with documentation of medical necessity
- Low vision aids

Exclusions

Members with neurological problems, acute vision loss, elevated IOP, suspicious optic nerves, diabetic retinopathy, cataract, should be referred to an ophthalmologist.

Contact lenses and tinted lenses are not covered when prescribed for **cosmetic reasons** only.

MD Order Required?

No

Approval Needed

Members can self-refer for exam from a network provider.

Items and services under \$500 in cost are authorized following Medicaid fee for service guidelines. Items greater than \$500 require supervisors to review and any recommendation to deny is reviewed by a clinical peer reviewer utilizing professional, clinical judgment and low vision standards of care.

Personal Emergency Response System (PERS)

What is Covered?

An electronic device worn by a member to secure help in the event of a physical, emotional, or environmental emergency.

This includes:

- Installation of equipment
- Monitoring of equipment
- Console unit, two personal care activators, and a smoke detector

Ordering Guidelines

Authorization for Personal Emergency Response System (PRES) is based on care manager's comprehensive assessment including evaluation of member's physical disability, the degree to which they would be at risk of an emergency due to medical or functional impairments or disability and the degree of their social isolation.

Exclusions

- Member is no longer living at home (e.g. nursing home, transitional housing)
- Members who receive 24-hour care or have a reliable caregiver present in home
- Members who have shown significant improvement in condition and no longer need PERS

MD Order Required?

Yes

Approval Needed

Care manager authorization as part of care plan.

Podiatry

What is Covered?

- Routine Foot Care, such as treatment of corns and calluses, trimming of nails, hygienic care such as soaking or cleaning feet
- Non-routine Care such as:
 1. Diagnosis and treatment of any illness or injury in the foot, such as infection or fungus
 2. Incisions
 3. Excisions
 4. Removal of foreign objects
 5. Repair or suture of tendons, foot, flexor
 6. Treatment of dislocations

Ordering Guidelines

- Members can self-refer to a network podiatrist
- Network podiatrist will follow payment rule guidelines to request authorization for treatment plan from care manager
- Members with Diabetes, ulcers, infections should be evaluated at least yearly by a network podiatrist
- Care manager should list need for service in care plan

Exclusions

None

MD Order Required?

No

Approval Needed

If a treatment plan is questionable, care manager will refer any recommendation to deny services to a clinical peer reviewer who will base decision utilizing professional clinical judgment and standards set by American Podiatry Association and/or American Diabetic Association.

Rehabilitation Services

What is Covered?

Rehabilitation services include physical, occupational, and speech therapies provided in a licensed rehabilitation facility or through a certified home health agency.

- Physical therapy services include examination, diagnosis, and treatment of musculoskeletal and neuromuscular problems
- Occupational therapy includes evaluation of performance, skills assessment, treatment customized to improve ability to perform activities of daily living
- Speech therapy includes evaluation and treatment of slurred speech, breath control, voice issues, aphasia, stuttering, swallowing difficulties

Ordering Guidelines

- Members newly diagnosed with strokes, fractures, spinal cord injuries
- Members with a recent decline in functioning who have potential to regain functionality
- Members with recent exacerbations of existing conditions, such as MS, onset of weakness
- Members at risk of falling — evaluate home for safety and possible adaptations
- Members needing new equipment or assistive devices
- Care manager must include need for therapy as part of care plan

Maintenance therapy should be considered for members who without intervention would experience loss of range of motion or cardiac conditioning, or increase in spasticity, any or all of which would result in loss of functional capability.

Determination of setting for rehab services (i.e. home-based or site-based) should consider member's functionality (homebound or not), accessibility of apartment, need for therapeutic equipment, and member's therapeutic goals.

Exclusions

None

MD Order Required?

Yes

Approval Needed

Network therapists will submit recommended treatment plans for care management

authorization. Care manager will forward any recommendation to deny authorization to a clinical peer reviewer for a decision based on professional, clinical judgment and professional standards of care.

Respiratory Services

What is Covered?

The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures.

Includes:

- Application of medical gases
- Humidity and aerosols
- Intermittent positive pressure
- Continuous artificial ventilation
- Administration of drugs through inhalation and related airway management
- Patient Care
- Patient Teaching

Ordering Guidelines

- Therapy provided through DME provider network
- Respiratory therapist accompanies supplies

Exclusions

None

MD Order Required?

Yes

Approval Needed

All MD orders for respiratory services are followed and implemented. Care manager authorization of equipment as part of care plan; service component is part of contractual agreement with equipment provider.

Skilled Home Health Care Services (Skilled RN, LPN, MSW Services)

What is Covered?

Home health care includes skilled services which are of a preventive, therapeutic, and health teaching nature.

This includes:

- Skilled nursing services
- Medical social services
- Home infusion (chemotherapy, intravenous feedings)

This section describes the skilled nursing and social work services benefit. Skilled nursing includes both registered (RN) and licensed practical nursing (LPN) care arranged (by contract) through certified home health agencies, licensed agencies, or nursing registries.

Medical social services describes the psychosocial assessment and treatment planning offered by qualified social workers and social work assistants.

Ordering Guidelines

Skilled RN care is arranged for members who need clinical oversight, treatment of a medical condition. Examples of skilled nursing needs include:

- Newly diagnosed members who need monitoring and education about their diagnosis and treatment
- Members with exacerbations of their diagnosis (e.g. Multiple Sclerosis)
- Monitoring of vital signs (e.g. pulse, blood pressure, and glucose levels)
- Wound care
- Ostomy care
- Gastrointestinal/Genitourinary Care
- Medication administration (includes prepouring, injectable and infused drugs)
- Supervision of home health aides

For members with Medicare who meet the homebound criteria, care manager should authorize an evaluation visit within 5 days of referral and request a treatment plan that includes planned treatments, visit frequency, and number of visits for each discipline.

LPN care should be considered when member has health-related tasks that are outside the scope of practice for home health aids to perform (e.g. tube feeding) and there are no family/significant others who can be trained to perform the task.

Social Work Services — All ICS members get medical social services through the social worker/social work assistant in their unit.

Exclusions

None

MD Order Required?

Yes. Certified Home Health Agency will obtain MD orders separately

Approval Needed

Care manager must authorize RN or LPN services as part of care plan.

Social and Environmental Services

What is Covered?

Services and items which support the medical needs of the member and are part of the member's care plan.

This includes, but is not limited to:

- Home improvements and modifications which support more independent functioning
- Appliances and assistive devices
- Independent Living Skills training (how to use public transportation, balance a checkbook, pay bills, etc.)

Ordering Guidelines

Service or item is essential to prevent the medical condition from getting worse, help member function more independently, or will reduce/substitute for need for personal care workers.

Exclusions

Items solely needed for convenience or recreation.

MD Order Required?

No

Approval Needed

Care manager authorization as part of care plan. Care management authorization of items over \$500 in cost require supervisory review.

Social Day Care

What is Covered?

Social Day Programs provide special recreational and therapeutic activities designed to provide socialization. These are usually held in group settings under the auspice of a specialty program (e.g. United Cerebral Palsy) or nursing facility (Jewish Home & Hospital, Chelsea Day program)

Service highlights include:

- Arts and Crafts
- Physical Activities
- Music and Singing
- Cooking
- Discussion Groups
- Parties and Holiday Events
- Diverse Cultural Programs
- Snacks and Lunch

ICS also offers a series of programs that are of interest to a younger disabled population.

This includes:

- Artists on Wheels
- Wheelchair Sports
- Jewelry and Knitting Classes
- Weight Watchers (as part of an identified need in care plan for weight management)

Ordering Guidelines

- Social Day-type programs should be considered for members who can benefit from the socialization provided in this group setting
- Care manager should arrange for member to visit network social day programs and get recommendation for scheduling from the center

Exclusions

None

MD Order Required?

No

Approval Needed

Care manager authorization of need should be included in the care plan.

Transportation

What is Covered?

Non-emergency transportation (e.g. public transportation, Access-A-Ride, car service, ambulette, or ambulance) to medical appointments or adult or social day program activities that are part of the member's care plan.

Ordering Guidelines

- Care manager should assess appropriate mode of transportation based on member's abilities
- Service is provided to and from medical appointments and day program appointments
- Member must give 48-hours notice whenever possible
- Members who can use public transportation or Access-A-Ride are reimbursed for the cost of this transportation when used for medical or day program appointments
- Ambulance transportation is covered for non-emergent appointments only when a member requires transportation in a prone position (i.e. bed to bed transfer needed)

- Members who can self-transfer and fold their wheelchairs for transport can be considered for livery (car) service, instead of ambulette
- Care managers can authorize transportation to socialization activities authorized in the care plan, appointments at ICS, or at government agencies (e.g. court, HRA, Social Security.)

Exclusions

Transportation to non-medical appointments that are not authorized by care management as part of the care plan.

MD Order Required?

No

Approval Needed

Once level of transportation is authorized by care manager, members can arrange transportation to medical or day program appointments or to **care management approved** programs or appointments (referenced above) directly with Member Services Coordinators.

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