Provider Manual

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Table of Contents

Chapter 1: Introduction

Chapter 2: Cultural Competency & Nondiscrimination

Chapter 3: Member Eligibility & Enrollment

Chapter 4: Health Partners Plans Medicaid Summary of Benefits

Chapter 5: Jefferson Health Plans Medicare Advantage Summary of Benefits

Chapter 6: Health Partners Plans CHIP/KidzPartners Summary of Benefits

Chapter 7: Jefferson Health Plans Individual and Family Plan Summary of Benefits

Chapter 8: Utilization Management

Chapter 9: Quality Management

Chapter 10: Clinical Programs

Chapter 11: Provider Practice Standards & Guidelines

Chapter 12: Provider Billing & Reimbursement

Chapter 13: Complaints, Grievances, and Appeals

Chapter 14: Medicare Compliance Requirements

Chapter 15: Member Rights and Responsibilities

Chapter 16: Appendix

This Provider Manual is subject to change. Changes based on State or Federal requirements may be made at any time; this document is reviewed annually. This document applies to all Jefferson Health Plans' products.

Jefferson Health Plans is a marketing name for Health Partners Plans, Inc., and includes the following lines of business: Jefferson Health Plans Individual and Family Plans; Jefferson Health Plans Medicare Advantage; Health Partners Plans Medicaid; and Health Partners Plans CHIP/KidzPartners. If information in a communication pertains to a specific line of business we will specify within the content.

Health Partners Plans, Inc. offers many products and has various lines of business, marketed as: Jefferson Health Plans Individual and Family Plans; Jefferson Health Plans Medicare Advantage; Health Partners Plans Medicaid; and Health Partners Plans CHIP/KidzPartners. If information in a communication pertains to a specific line of business, we will specify within the content.

Chapter 1: Introduction

Purpose: This chapter provides an overview of Health Partners Plans, Inc. and outlines the services available to our members and providers.

Topics: Important topics from this chapter include:

- History and Corporate Mission of Jefferson Health Plans
- Provider Network of Jefferson Health Plans

Introduction

Founded more than 35 years ago, Health Partners Plans, Inc., is a not-for-profit Pennsylvania-licensed Managed Care Organization (MCO) that provides comprehensive healthcare coverage to individuals and families in Pennsylvania and New Jersey. The organization was founded as Health Partners by four local teaching hospitals committed to providing residents of their communities with coordinated, quality healthcare services. With the endorsement of the Pennsylvania Department of Human Services (DHS) and a grant from the Robert Wood Johnson Foundation, under its national program for prepaid managed health care, Health Partners and its member hospitals developed a viable managed care program for the Medical Assistance population. Health Partners (originally, Health Partners of Philadelphia, Inc., and then named Health Partners Plans, Inc. in 2013) was incorporated in 1987. In November 2021, Thomas Jefferson University ("Jefferson") became the sole owner of Health Partners Plans and in 2023, we announced Jefferson Health Plans as the marketing name for some of our Health Plan products.

Nationally recognized for its innovations in managed care, we were the only Medicaid plan in Pennsylvania and were among just 11 Medicaid plans nationwide with an accreditation status of Excellent as of September 26, 2017: at that time, the highest status bestowed by the National Committee for Quality Assurance (NCQA). To date, we continue to earn the highest accreditation status with NCQA for our Medicaid line of business. We're especially proud of our history of strong ratings for member and provider satisfaction.

Our Mission

Our mission includes three major tenets:

- To manage our business to exceed expectations
- To operate with respect and dignity in all relationships
- To continually improve the health outcomes of our members

As part of our commitment to respect others, we work to assure that providers are sensitive to cultural differences in all healthcare encounters.

Our Products

We have four product lines:

- Health Partners Plans Medicaid recipients
- Health Partners Plans CHIP/KidzPartners for Children's Health Insurance Program (CHIP) enrollees
- Jefferson Health Plans Medicare Advantage
- Jefferson Health Plans Individual and Family Plans (ACA)

Our Product History

In 1996, due in part to our growth and recognitions, we were selected as one of only 17 plans nationally to participate in the Health Care Financing Administration's (now known as the Centers for Medicare & Medicaid Services [CMS]) "Medicare Choices" demonstration project. Our first Medicare members were enrolled the following year, and we continued to administer the successful Medicare plans through 2007.

In 2003, we sought and obtained accreditation for the first time from the National Committee for Quality Assurance (NCQA), the nation's leading review organization for health plans. We earned an accreditation rating of Excellent for our Medicaid plan in 2017. We earned this accreditation status for service and clinical quality by meeting NCQA's rigorous requirements for consumer protection and quality improvement. We continued to receive our NCQA accreditation over the years and we most recently earned our Health Plan Accreditation in 2024.

In 2008, we introduced KidzPartners, providing care through Pennsylvania's Children's Health Insurance Program (CHIP), to eligible children throughout Bucks, Delaware, Montgomery and Philadelphia counties. Our first KidzPartners members became active in 2009. Coverage for Chester County residents started in 2015. In December 2023, our KidzPartners, or Health Partners Plans CHIP, expanded to all 67 counties in Pennsylvania.

In 2011, we became the first plan in the nation to earn NCQA's Multicultural Health Care Distinction. This honor recognized our efforts to mitigate language and cultural barriers in obtaining vital health care services. We have continued to earn this distinction from NCQA in the years since. Most recently, in 2023 our plan earned the Health Equity Accreditation from NCQA, which replaces the Multicultural Health Care Distinction.

In 2013, we re-entered the Medicare Advantage program. Our first Medicare Advantage members became effective on January 1, 2014, and membership continues to grow. On January 1, 2020, Jefferson Health Plans Medicare Advantage expanded its service area to serve residents of Berks, Bucks, Carbon, Chester, Dauphin, Delaware, Lancaster, Lebanon, Lehigh, Northampton, Perry, and Philadelphia counties. Today, our Medicare products include HMO, DSNP and PPO (new in 2024), in Berks, Bucks, Carbon, Chester, Cumberland, Dauphin, Delaware, Lancaster, Lebanon, Lehigh, Montgomery, Northampton, Perry, Philadelphia and Schuylkill in Pennsylvania; and HMO in Atlantic, Burlington, Camden, Gloucester, and Mercer counties in New Jersey.

In 2021, Jefferson became the sole owner of Health Partners Plans and we continued to expand and grow our products and operations through our long-standing Health Partners Plans products, our Jefferson Health Plans products, and geographic expansion in Pennsylvania and New Jersey.

In 2023, we continued our growth by entering the Exchange book of business. We successfully launched the Jefferson Health Plans Individual and Family Plans in Philadelphia, Bucks and Montgomery counties.

With more than 35 years of serving the community, we continue to emphasize primary and preventive care. In addition, our health plan offers intensive case management for members identified as high risk or with special needs and care management of members with chronic illnesses. Our focus is on improving health outcomes through a wide range of initiatives that support member compliance and help to eliminate barriers to care.

Our Provider Network

Our provider network, which extends throughout Pennsylvania and New Jersey, ensures that members have access to high quality treatment and coordinated services.

We are proud to work with the thousands of dedicated primary care physicians (PCPs), specialists, CRNP's, PA-C's, behavioral health providers, dentists and vision care providers that comprise our network. Our provider network includes hospitals, home care and hospice facilities, family planning clinics, home health care agencies, durable medical equipment (DME) providers, pharmacies and more.

Our provider network also includes mental health and substance abuse professionals who serve our Medicare, CHIP and Individual and Family plan members. Pennsylvania's HealthChoices program provides our Medicaid members with services through behavioral health managed care organizations contracted with each county.

Thank you for being part of our provider network and helping us to improve the health outcomes of our members.

Service Departments

Our service departments provide members and providers with excellent customer service. Below is a comprehensive list of the various service department and contact information.

Case Management

Our Clinical Programs Care Coordinators who are nurses, social workers and outreach coordinators are ready to assess and address all your patient's needs including behavioral health and SDOH and connecting them to the appropriate resources. These programs are based on collaboration with providers to promote self-management.

- Clinical Programs Provider Line Phone: 1-215-845-4797

Member Relations

- Health Partners Plans Medicaid: **1-800-553-0784**
- Health Partners Plans CHIP/KidzPartners (CHIP): **1-888-888-1211**
- Jefferson Health Plans Medicare: **1-866-901-8000**
- Jefferson Health Plans Individual and Family Plans: **1-833-422-4690**
  (**TTY 1-877-454-8477**)

Note: Members can call Member Relations to receive information in an alternative format (such as CD, Braille or large print), at no cost.

Provider Support Services

- Provider Services Helpline (9:00 a.m. to 5:30 p.m.): **1-888-991-9023**
- Quality Management: **1-855-218-2314**
- SIU (Special Investigations Unit): **1-866-477-4848**
- Skilled Nursing Facility (SNF)/Rehab: Medicaid: **267-385-3825**
  Medicare: **215-991-4395**
  Fax: **215-991-4125**

Pharmacy

- Pharmacy Department: **1-866-841-7659**
  - Fax (Medicaid): **1-866-240-3712**
  - Fax (Medicare): **1-866-371-3239**
  - Fax (Individual and Family Plans): **1-833-605-4407**
- Recipient Restriction Program information: **215-991-4094**
  - Fax: 267-515-6651

Utilization Management

- Utilization Management: **1-866-500-4571**

Credentialing

- Status, Correspondence, Enrollment: Credentialing@jeffersonhealthplans.com

  Fax: 215-967-4473

- Data changes/Terminations: DataValidation@jeffersonhealthplans.com

  Fax: 267-515-6650

- Hospital/Facility Based and Physical/Occupational/Speech Therapy Linkages, Terminations & Changes: ProviderData@jeffersonhealthplans.com

  Fax: 215-967-9274

Online Resources

Websites: www.healthpartnersplans.com and www.jeffersonhealthplans.com

- Prior Authorization: www.hpplans.com/PriorAuth
- Provider News: www.hpplans.com/ProvNews
- Provider Webinars: www.hpplans.com/Webinars
- Provider Manual: www.hpplans.com/ProviderManual
- Eligibility and Claims:www.hpplans.com/EandB
- Formularies: www.hpplans.com/Formulary
- Our Provider Portal: www.hpplans.com/providerportal

Chapter 2: Cultural Competency & Nondiscrimination

Purpose: This chapter provides certain regulatory requirements for providers concerning nondiscrimination, cultural competency and language needs of our membership through valuable resources and references.

Topics: Important topics from this chapter include:

Regulatory requirements
Cultural Competency
Limited English Proficiency
Non-Discrimination Policy
Section 1557 of the Patient Protection and Affordable Care Act
Additional Resources

Overview

We have a diverse membership with many linguistic abilities and cultural and ethnic backgrounds. As part of the credentialing process, providers self-report language spoken by either themselves or office staff, providing a measure of their linguistic ability and a proxy for cultural and ethnic backgrounds. This information is posted in our provider directory allowing members to choose a provider that fits their cultural, linguistic and health care needs. Likewise, a member's self-reported primary language serves as a measure of their linguistic needs and preferences as well as a proxy for cultural and ethnic identity. All of our member facing teams, when communicating with members, confirm the member's language needs and access interpreter services as needed in order to meet our member's needs.

Regulations in this Chapter incorporate our Non-Discrimination Policy including Section 1557 of the Patient Protection and Affordable Care Act.

Our Non-Discrimination Policy

We recognize the diversity of our members and offers services that are sensitive to these differences. Members enrolled in our Plans have the right to receive and expect courteous, quality care regardless of race, color, creed, sex, religion, age, national or ethnic origin, ancestry, marital status, sexual preference, sexual orientation, gender identity and expression, genetic information, physical or mental illness, disability, veteran status, source of payment, visual or hearing limitations, or the ability to speak English. Members also have the right to request any of our printed materials in another language, larger print, on audiotape or in another format.

The medical provider should update its anti-discrimination policies to state expressly that the provider prohibits discrimination based upon sexual orientation and gender identity.

The medical provider should require its physicians contractually to comply with Pennsylvania State law, and the AMA Code of Ethics.

The medical provider should provide yearly training for its physicians about nondiscrimination requirements and culturally competent care. Each physician should be required to participate in these annual trainings and attest in writing to having done so.

The medical provider should provide training about nondiscrimination requirements and culturally competent care to all its non-physician employees and should include similar training in the orientation provided to all new employees.

Providers must also be in compliance with Section 1557 of the Patient Protection and Affordable Care Act (ACA).

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

The Section 1557 final rule applies to any health program, covered entity or activity, any part of which receives funding from the Department of Health and Human Services (HHS), such as hospitals that accept Medicare or doctors who receive Medicaid payments. For more information, please visit https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html.

Protecting Individuals Against Sex Discrimination

Sex discrimination prohibited under Section 1557 includes discrimination based on:

- An individual's sex
- Pregnancy, childbirth, and related medical conditions
- Gender identity
- Sexual Orientation
- Sex stereotyping

We comply with applicable Federal civil rights laws (Section 1557 of the Patient Protection and Affordable Care Act) and do not discriminate on the basis of race, color, national origin, age, disability, gender, sexual orientation, or gender identity.

We expect that all contracted providers/ suppliers, hereinafter referred to as "covered entities" for these purposes, will not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, or gender identity.
In the event an individual with a disability needs assistance, we expect that covered entities will take appropriate steps to ensure that communications with individuals with disabilities are as effective as communication with others. Covered entities are expected to provide appropriate auxiliary aids and services, such as alternative formats (e.g., large print, audio, accessible electronic formats, and other formats), sign language interpreters, etc., where necessary for effective communication.

All Health Plan staff provide free language services to people whose primary language is not English, such as qualified interpreters and materials in languages other than English. We expect that covered entities will take appropriate steps to provide

meaningful access to each individual with limited English proficiency that is eligible to be served or likely to be encountered. Reasonable steps may include the provision of language assistance services, such as oral language assistance or written translation. We are committed to ensuring all members have access to needed health services without fear of being discriminated against.

Covered entities are prohibited from denying health care or health coverage to an individual based on:

- An individual's sex
- Pregnancy, childbirth, and related medical conditions
- Gender identity
- Sex stereotyping

Women must be treated equally with men in the health care they receive and the insurance they obtain.

Categorical coverage exclusions or limitations for all health care services related to gender transition are discriminatory.

Individuals must be treated consistent with their gender identity, including in access to facilities. Providers may not deny or limit treatment for any health services that are ordinarily or exclusively available to individuals of one gender based on the fact that a person seeking such services identifies as belonging to another gender.

Sex-specific health programs or activities are permissible only if the entity can demonstrate an exceedingly persuasive justification, that is, that the sex-specific health program or activity is substantially related to the achievement of an important health-related or scientific objective.

Cultural Competency

Cultural Competency is defined as the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Our providers must demonstrate cultural competency and must understand that racial, ethnic, and cultural differences between a provider and a member cannot be a barrier for a member to access and receive quality health care. We encourage providers to be aware of cultural and linguistic differences among diverse racial,

ethnic, and other minority groups, to be respectful of those differences and take steps to apply that knowledge in their professional practice.

Members have the right to receive services provided in a culturally and linguistically appropriate manner which includes consideration for members with limited knowledge of English, limited reading, vision, hearing skills, and those with diverse cultural and ethnic backgrounds.

The National Culturally and Linguistically Appropriate Services (CLAS) Standards are the collective set of culturally and linguistically appropriate services mandates, guidelines and recommendations issued by the U.S. Department of Health and Human Services Office of Minority Health. The Office of Minority Health explains, "the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the National CLAS Standards) are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services."

To support the CLAS Standards mandate, we have included (in the Appendix) a comprehensive training available on our website that includes educational guidance and materials for its providers on the importance of providing services in a culturally and linguistically competent manner.

Provider Responsibilities to Address Language Needs:

According to Title VI and the Department of Health and Human Services regulations, 45 C.F.R. Section 80.3 (b) (2) Guidance, recipients of Federal financial assistance (hospitals, nursing homes, home health agencies, managed care organizations, universities, and other entities with health or social service research programs) must take reasonable steps to provide meaningful access to Limited English Proficient (LEP) persons.

Individuals who do not speak English as their primary language and who have limited ability to read, write, speak, or understand English are considered LEP. LEP persons must be provided assistance with respect to a particular service, benefit, or encounter upon request.

Note: All providers are required, by law, to provide translation and interpreter services including qualified sign language interpreters.

Provider Responsibilities Include:
Informing and providing patients with access to medical interpreters, signers, and TDD/TTY services to facilitate communication, without cost to them. This includes at all points of contact and during all hours of operation. Federal law and state contractual requirements are applicable to our Network Providers to provide language services to Limited English Proficiency (LEP) and Low Literacy Proficiency (LLP) members. This also includes members with sensory impairments.

Providing members with verbal and written notice (in their preferred language or format) about their right to receive free language interpreters, upon request. Methods of meeting the language needs of patients include telephonic interpreters, video conferencing as well as in person interpreters.

Discouraging members from using family or friends to meet language needs (translators or interpreters). The assistance of family or friends is not considered quality interpretation. The family or friend should only be used if the member insists, and the member has been offered free interpretation services which the member declined. The request and the insistence to use the services of family and friends rather than official interpretation services should be documented in the member record.

Providing care with consideration for the member's race/ethnicity, disability, and language and how it impacts the member's health or illness.

Offering office staff cultural competency training and development.

Posting and have printed materials in English and Spanish, and any other required non-English language upon request by the member.

Posting the notice of nondiscrimination and the taglines in physical locations where providers interact with the public. For more information on taglines, please visit https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Tip: We offer webinar training and self-led eLearning courses on Cultural Competency that provides examples of when a qualified interpreter is required when cultural differences may interfere with the doctor/patient communication.

Resources Available to Providers

Call our Provider Services Helpline at **1-888-991-9023** for more information on how to find Agencies to certify your staff as interpreters, find in-office interpreter services

if you currently do not have such resources, as well as a connection to telephonic language resources to meet the needs of all your patients and to ensure compliance with these regulations.

We will provide interpreter services for our members if the provider is not able to obtain the necessary translations for a member. If your office is not able to provide or contract with in office interpreters, we will assist your office and will invoice your office for the services.

For more information regarding **Limited English Proficiency (LEP)**, please visit HRSA Health Resources & Services Administration.

OCR has translated a sample notice of nondiscrimination and the taglines for use by covered entities into 64 languages. For translated materials, visit www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

For more information regarding **Protections for Individuals with Disabilities (ADA)**, please visit Discrimination on the Basis of Disability. There are several sources of information available, please visit the Appendix.

Nondiscrimination Information

Health Partners Plans Medicaid and **KidzPartners (CHIP)** nondiscrimination information can be located on our website, please visit the bottom of our Health Partners Plans Medicaid Member Welcome webpage.

Nondiscrimination for **Jefferson Health Plans Medicare Advantage and Individual and Family Plans (ACA)** product lines can be found on our website at https://www.jeffersonhealthplans.com/home/about-us/notices-of-discrimination/

Chapter 3: Member Eligibility & Enrollment

Health Partners Plans Medicaid, KidzPartners (CHIP), Jefferson Health Plans Medicare, Jefferson Health Plans Individual and Family Plans

Purpose: This chapter provides an overview of enrollment and eligibility guidelines

Topics: Important topics from this chapter include:

Health Partners Plans Medicaid
Health Partners Plans CHIP/KidzPartners (CHIP)
Jefferson Health Plans Medicare
Jefferson Health Plans Individual and Family Plans

Overview

This chapter provides an overview of the various guidelines and tools available to our providers in determining the eligibility and enrollment status of patients covered by our plans:

Free CHIP:

- Provides free health insurance for children and teens (up to age 19) who qualify and are not eligible for Medical Assistance.

Low-Cost and Full-Cost CHIP:

- Provides low-cost health insurance for children and teens (up to age 19) who qualify and are not eligible for Medical Assistance. Families must pay a monthly premium for each child and there are copayments for certain services.

Medical Assistance:

- Provides free insurance for qualifying children, teens, and adults who qualify.

Medicare Advantage (HMO/PPO):

- Medicare Advantage is a type of Medicare health plan offered by a private company that contracts with Medicare to provide a member with all their Part A and Part B benefits. These plans may also provide Part D benefits.

Jefferson Health Plans Individual and Family Plans:

- Pennie is the official online marketplace made possible by the State of Pennsylvania and private insurance companies to provide affordable, high quality health insurance plans to Pennsylvanians.

Note: Enrollment in CHIP and Medical Assistance is based on household size and income.

Discrimination against our members is prohibited. Accept and treat members without regard to race, age, gender, sexual preference, national origin, religion, health status, economic status, or physical disabilities. No provider may engage in any practice, with respect to any of our members, that constitutes unlawful discrimination under any state or federal law or regulation. No provider may deny, limit, or condition the services offered on the basis of any factor that is related to health status, including, but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history

- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

What is HealthChoices?

HealthChoices is a mandatory state program that requires most Medical Assistance (MA) recipients in Pennsylvania to select a health plan and a primary care provider (PCP) for their health care. Health care providers in the HealthChoices program must participate with the Pennsylvania Department of Human Services (DHS) and have a Medical Assistance identification number.

Enrollment

DHS contracts with an independent vendor, currently MAXIMUS, to provide enrollment assistance services. The vendor is the Enrollment Assistance Contractor (EAC). Enrollment assistance services include educating and assisting newly enrolled Medical Assistance recipients in selecting and changing their PH-MCO, enrollment referral systems and benefits and selecting a primary care physician (PCP). The EAC operates a HealthChoices Hotline to take Medical Assistance recipients' calls and to record their change in PH-MCO and PCP selection. Electronic records of these changes are forwarded weekly to DHS and Jefferson Health Plans. Once a Medical Assistance recipient has enrolled with Health Partners Plans, he or she may make future changes to his or her PCP directly with us.

Our Health Partners members are not required to select a dentist. When dental care is needed, members may self-refer to any primary care dental provider in our dental network.

Newborns are eligible for Health Partners Health Plans benefits if the mother is enrolled at the time of the child's birth. The parent or guardian must contact the County Assistance Office to have the baby added to the mother's coverage, and the EAC or Health Partners Plans to select a PCP for the infant.

The Health Partners Plans Member ID Card

Health Partners Plans Medicaid members are issued an identification card; however, possession of the ID card does not ensure current member eligibility for Health Partners Plans Medicaid benefits. Also, patients without an ID card with them may still be active members.

For these reasons, it's important to verify eligibility.

Verification of Eligibility
Providers may verify member eligibility by:

- Accessing the Pennsylvania State Eligibility Verification System (EVS) at 1-800-766-5387
- Logging on to our provider portal
- Calling the Provider Services Helpline 24 hours a day, seven days a week and providing the patient's name and birth date. Refer to **Chapter 1** for the appropriate contact information.

Members also receive and should always carry a DHS Pennsylvania Access card, which can be used to qualify them for transportation and related services to which they may be entitled. The card, however, does not provide evidence of their eligibility with us.

Providers must use this card to access the Department's EVS and verify the member's eligibility. The ACCESS card will allow the provider the capability to access the most current eligibility information without contacting the PH-MCO directly.

Third Party Liability
We use DHS Third Party Liability Resource information as a base for other insurance coverage. If there is evidence of probable other insurance found through secondary claim submission or contact from other carriers or the member, this information will be recorded on our processing systems and DHS will be notified. Investigation of other possible insurance will be required prior to payment, except when preventive pediatric care services are involved (not including hospital delivery claims).

Third party liability insurance, employer group insurance, Workers' Compensation, and Medicare precede Medicaid as primary payers. Medicaid is the payer of last resort. Claims should be submitted to any other insurance carrier including Medicare, prior to submitting to us. We will coordinate benefits to pay up to the contracted rate or the Medical Assistance rate. If a primary insurer has paid more than we would have paid if its coverage were primary, no additional reimbursement will be paid and the member will be held harmless.

Members may not realize or remember that their dependent children may have coverage under a working spouse's employer group plan or absent parent required (court-ordered) coverage.

Providers should ask for the most current insurance information at every encounter. Please remind members to contact us to update their other insurance information. Medicaid eligibility is not affected by a member having other insurance.

Third party liability also relates to automobile insurance and personal injury insurance coverage (homeowner's, etc.). If a member is injured in an accident, and the liability insurance is known and established, the provider should first bill the member's liability carrier prior to submitting a claim to us. Under HealthChoices, we must notify DHS if we provide reimbursement for the care of a member's auto-related or other accident-related injuries. DHS retains the right of subrogation. Under the HealthChoices contract, we are required to notify DHS of any personal liability lawsuits for purposes of subrogation.

Member Panels
Every month, PCPs will receive a Member Panel Report via the provider portal providing an up-to-date listing of the members assigned to each PCP in their practice. *Note: These lists should not be used to check eligibility. The eligibility function in the provider portal provides the most current eligibility information.*

We require providers to use this list, at minimum, to outreach to members who are non-compliant with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity and immunization schedules.

Member Transfers
Both members and providers may find it necessary to modify the doctor-patient relationship that currently exists between a Health Plan member and his or her PCP. This section provides an overview of the two types of transfers available to both members and participating physicians.

Voluntary Transfers
Members may elect to change their PCP by calling our Member Relations team and requesting a transfer or by signing on to the member portal and selecting the "change your PCP" option. Members requesting a change will be issued new membership cards within seven to ten days of the effective transfer date. When care is required prior to the issuance of the new membership panel, we will notify you by phone. As a Health Partners Plans/Jefferson Health Plans provider, you are expected to facilitate the transfer of records when members choose a new provider.

Our Member Relations will reassign any member requesting a new medical provider for both routine and exceptional circumstances.
Routine transfers are done at the member's discretion and will have a future effective date (routinely the first of the upcoming month) with the newly-selected Primary Care site.

Exceptional transfers requiring an immediate transfer and effective date will be accommodated when there are issues of continuity, when a member has travel difficulties, or when a member is no longer comfortable with a PCP.

Involuntary Transfers
Providers have the right to request that a member select another PCP within 30 days, under the following conditions:

- Member demonstrates a pattern of broken appointments without adequate notice
- Member and the provider have failed to establish an adequate patient/provider relationship

To implement an involuntary transfer for one of the reasons noted above, you must send a certified letter to the member and a copy to us.

Health Partners Plans
Attn: Member Relations Department
1101 Market Street, Suite 3000
Philadelphia, PA 19107

The letter should indicate the reason for requesting an involuntary transfer. Please note that in accordance with DHS regulations and your agreement with us, severity of illness and/or medical diagnosis are not acceptable reasons for a transfer. In fact, our provider contracts prohibit discrimination on the basis of health status. If the request is approved, we will contact the member to assist in selecting a new PCP. The transfer to another PCP will occur within 30 days during which time the transferring provider must be available for urgent care. The transferring provider must also facilitate the transfer of records to the new provider.

Recipient Restriction Program
We participate in the Pennsylvania Department of Human Services (DHS) Recipient Restriction Program. The program calls for us to monitor and identify Medical Assistance recipients who improperly or excessively utilize Medicaid services. In cooperation with the DHS Bureau of Program Integrity, we will refer members with suspected patterns of inappropriate utilization to the Recipient Restriction Program. These members may be restricted to a certain physician and/or pharmacy or another provider in this event. Providers requesting information on this program may contact our Pharmacy department at **215-991-4094**.

Loss of Medical Assistance Eligibility
Members may lose eligibility for Medical Assistance for various reasons at any time during the month. Based on determination communicated to the plan by the Department of Human Services (DHS) regarding member's coverage, our Enrollment department will update the member eligibility until the end of the month according to the notification received from DHS. Except under circumstances where the date communicated by DHS should be the expiration date of the member's coverage (i.e., member deceased, etc.).

Care Gap Report
A monthly report of the status for each member of their age appropriate HEDIS and clinical quality indicators is sent to practice sites via our provider portal. These reports assist practices with outreach to close necessary preventive and chronic disease management gaps in care. We request you use this list to identify members who are non-compliant with specific services and use your own designed outreach efforts to get the non-compliant members in for needed care. This report should not be used to verify eligibility.

What is CHIP?
The Children's Health Insurance Program (CHIP) provides important health benefits to children who are ineligible for Medical Assistance in Pennsylvania. Funded by the Commonwealth of Pennsylvania and the federal government, CHIP provides insurance for children and teens (up to age 19) in the Commonwealth of Pennsylvania.

Enrollment
CHIP is administered by private health insurance companies that are licensed and regulated by the Pennsylvania Department of Human Services (DHS). We contract with the Commonwealth of Pennsylvania to offer CHIP and provide coverage to eligible children in Pennsylvania through our KidzPartners program.

The KidzPartners Member ID Card
All KidzPartners (CHIP) members are issued an identification card, however, possession of the KidzPartners card does not ensure current member eligibility for KidzPartners benefits. And of course, patients who do not have a KidzPartners ID card with them may still be active members.

For these reasons, it's important to verify eligibility.

Verification of eligibility
Providers may verify eligibility by:

Accessing the Pennsylvania State Eligibility Verification System (EVS) at 1-800-766-5387

- Logging on to our provider portal
- Calling the Provider Services Helpline 24 hours a day, seven days a week and providing the patient's name and birth date. Refer to **Chapter 1** for the appropriate contact information.

Third Party Liability
If there is evidence of probable other insurance found through secondary claim submission or contact from other carriers or the member, this information will be recorded on our processing systems. We will contact the primary insurance company to validate the dates of coverage.
Providers should ask for the most current insurance information at every encounter.

Third party liability also relates to automobile insurance and personal injury insurance coverage (homeowner's, etc.). If a member is injured in an accident and liability insurance is known and established, the provider should first bill the member's liability carrier prior to submitting a claim to KidzPartners. If the other insurance does not initially pay, KidzPartners is obligated to pay and recover monies from the other insurer.

Third party liability also includes personal lawsuits brought by a member against a third party. Providers should bill all available medical insurers for any services, even if a member has or intends to bring suit.

Member Panels
Every month, PCPs will receive a Member Panel Report providing an up-to-date listing of the members assigned to each PCP in their practice.

Note: These lists should not be used to check eligibility. The eligibility function in our provider portal provides the most current eligibility information.
We require providers to use this list, at minimum, to outreach to members who are non-compliant with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity and immunization schedules.

Member Transfers
Both members and providers may find it necessary to modify the doctor-patient relationship that currently exists between a KidzPartners member and their provider. This section provides an overview of the two types of transfers available to both members and participating physicians.

Voluntary Transfers
Members may elect to change their PCP by calling KidzPartners Member Relations and requesting a transfer. Members requesting a change will be issued new membership cards within seven to ten days of the effective transfer date. When care is required prior to the issuance of the new membership panel, we will notify you by phone. As a KidzPartners provider, you are expected to facilitate the transfer of records when members choose a new provider.

KidzPartners Member Relations will reassign any member requesting a new medical provider for both routine and exceptional circumstances.

Routine transfers are done at the member's discretion and will have a same day effective date with the newly selected primary care site.

Involuntary Transfers
Providers have the right to request that a member select another provider within 30 days, under the following conditions:

- Member demonstrates a pattern of broken appointments without adequate notice
- Member and the provider have failed to establish an adequate patient-provider relationship

To implement an involuntary transfer for one of the reasons noted above, you must send a certified letter to the member and a copy us.

Health Partners Plans/KidzPartners
Attn: Member Relations Department
1101 Market Street, Suite 3000
Philadelphia, PA. 19107

The letter should indicate the reason for requesting an involuntary transfer. Please note that in accordance with your agreement with us, severity of illness and/or medical diagnosis are not acceptable reasons for a transfer. In fact, our provider contracts prohibit discrimination on the basis of health status. KidzPartners will contact the member to assist in selecting a new PCP. The transfer to another PCP will occur within 30 days during which time the transferring provider must be available for urgent care. The transferring provider must also facilitate the transfer of records to the new provider.

What is Medicare Advantage?

Jefferson Health Plans Medicare plans are Medicare Advantage plans offered in Pennsylvania and New Jersey. We offer HMO and PPO plans. Medicare Advantage is a type of Medicare health plan offered by a private company that contracts with Medicare to provide a member with all their Part A and Part B benefits. Plans may also provide Part D benefits. Medicare services are covered through the Medicare Advantage plan and are not paid for under original Medicare. Members enrolled in an HMO plan are required to select a PCP for their health care.

The Jefferson Health Plans Medicare Member ID Card

All Jefferson Health Plans Medicare members are issued an identification card, however, possession of the Jefferson Health Plans Medicare ID card does not ensure current member eligibility for Jefferson Health Plans Medicare benefits. And of course, patients who do not have a Jefferson Health Plans Medicare ID card with them may still be active members.

For these reasons, it's important to verify eligibility.

Verification of Eligibility:

Providers may verify eligibility by:

Logging on to our provider portal

- Calling the Provider Services Helpline 24 hours a day, seven days a week and providing the patient's name and birth date. Refer to Chapter 1 for the appropriate contact information.

Coordination of Benefits

Jefferson Health Plans uses the Centers of Medicare & Medicaid Services (CMS) Coordination of Benefits information as a base for other insurance coverage. If there is evidence of probable insurance found through secondary claim submission or contact from other carriers or the member, this information will be researched to confirm whether the coverage is primary to Medicare. If coverage is confirmed as primary, it will be recorded on our processing systems and reported to CMS.

Third party liability insurance, employer group insurance, Workers Compensation and commercial coverage may precede Medicare Advantage as primary payers. Claims should be submitted to any other insurance carrier (except Medicaid) prior to submitting to Jefferson Health Plans Medicare. Jefferson Health Plans Medicare will coordinate benefits to pay up to the contracted rate. If a primary insurer has paid more than Jefferson Health Plans Medicare would have paid if its coverage were

primary, no additional reimbursement will be paid, and the member should be held harmless.
Members may not realize or remember that they have coverage under a working spouse's employer group plan.
Providers should ask for the most current insurance information at every encounter.

Third party liability relates to automobile insurance and personal injury insurance coverage (homeowner's, etc.). If a member is injured in an accident, and the liability insurance is known and established, the provider should first bill the member's liability carrier prior to submitting a claim to Jefferson Health Plans Medicare.
Third party liability also includes personal lawsuits brought by a member against a third party. Providers should bill all available medical insurers for any services, even if a member has or intends to bring suit.

Member Panels (not applicable to PPO products)
Every month, PCPs will receive a Member Panel Report providing an up-to-date listing of the members assigned to each PCP in their practice.

Note: These lists should not be used to check eligibility. The eligibility function in our provider portal provides the most current eligibility information.

We require providers to use this list, at minimum, to outreach to members who are non-compliant with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity and immunization schedules.

Member Transfers (not applicable to PPO products)
Both members and providers may find it necessary to modify the doctor-patient relationship that currently exists between a Jefferson Health Plans member and their provider. This section provides an overview of the two types of transfers available to both members and participating physicians.

Voluntary Transfers
Members may elect to change their PCP by calling Jefferson Health Plans Member Relations at **1-866-901-8000 (TTY 1-877-454-8477)** and requesting a transfer. Members requesting a change will be issued new membership cards within seven to ten days of the effective transfer date. When care is required prior to the issuance of the new membership panel, we will notify you by phone. As a Jefferson Health Plans provider, you are expected to facilitate the transfer of records when members choose a new provider.

Jefferson Health Plans Member Relations will reassign any member requesting a new medical provider for both routine and exceptional circumstances.
Routine transfers are done at the member's discretion and will have a future effective date (routinely the first of the upcoming month) with the newly selected primary care site.

Exceptional transfers requiring an immediate transfer and effective date will be accommodated when there are issues of continuity, when a member has travel difficulties, or when a member is no longer comfortable with a PCP.

Involuntary Transfers

Providers have the right to request that a member select another provider within 30 days, under the following conditions:

Member demonstrates a pattern of broken appointments without adequate notice and/or
Member and the provider have failed to establish an adequate patient/provider relationship

To implement an involuntary transfer for one of the reasons noted above, you must send a certified letter to the member and a copy to us.

Jefferson Health Plans
Attn: Member Relations Department
1101 Market Street, Suite 3000
Philadelphia, PA 19107

The letter should indicate the reason for requesting an involuntary transfer. Please note that in accordance with your Medicare agreement with us, severity of illness or medical diagnosis is not an acceptable reason for a transfer. In fact, our provider contracts prohibit discrimination on the basis of health status We will contact the member to assist in selecting a new PCP. The transfer to another PCP will occur within 30 days during which time the transferring provider must be available for urgent care. The transferring provider must also facilitate the transfer of records to the new provider.

Care Gap Report

A monthly report of the status for each member of their age appropriate HEDIS and clinical quality indicators is sent to practice sites via our provider portal. These reports assist practices with outreach to close necessary preventive and chronic disease management gaps in care. We request you use this list to identify members who are non-compliant with specific services and use your own designed outreach

efforts to get the non-compliant members in for needed care. *This report should not be used to verify eligibility.*

What is the Affordable Care Act (ACA)?

Jefferson Health Plans Individual and Family Plans are offered in Pennsylvania's Bucks, Montgomery and Philadelphia Counties. Pennsylvania operates their state-based exchange through Pennie. We offer these plans as a private company to Pennsylvanians directly through the Pennie exchange or an off-exchange option.

The Jefferson Health Plans Individual and Family Plan Member ID Cards
All Jefferson Health Plans Individual and Family Plan members are issued an identification card. However, possession of the Jefferson Health Plans ID card does not ensure current member eligibility for Jefferson Health Plan benefits. And of course, patients who do not have a Jefferson Health Plans ID card with them may still be active members.

For these reasons, it's important to verify eligibility.
Verification of member eligibility:
Providers may verify eligibility by:

- Logging on to our provider portal
- Calling the Provider Services Helpline and providing the patient's name and birth date. For more information, refer to Chapter 1 for the appropriate contact information.

Coordination of Benefits
If there is evidence of probable other insurance found through secondary claim submission or contact from other carriers or the member, this information will be recorded on our processing systems and reported to Pennie for on-exchange members.

Third party liability insurance, employer group insurance, Workers Compensation and commercial coverage may precede ACA as primary payers. Claims should be submitted to any other insurance carrier (except Medicaid) prior to submitting to us. We will coordinate benefits to pay up to the contracted rate. If a primary insurer has paid more than Jefferson Health Plans would have paid if its coverage were primary, no additional reimbursement will be paid, and the member should be held harmless.

Providers should ask for the most current insurance information at every encounter.

Third party liability also relates to automobile insurance and personal injury insurance coverage (homeowner's, etc.). If a member is injured in an accident, and the liability

insurance is known and established, the provider should first bill the member's liability carrier prior to submitting a claim to Jefferson Health Plans.
Third party liability also includes personal lawsuits brought by a member against a third party. Providers should bill all available medical insurers for any services, even if a member has or intends to bring suit.

Member Transfers
Both members and providers may find it necessary to modify the doctor-patient relationship that currently exists between a Jefferson Health Plans member and their provider. This section provides an overview of the two types of transfers available to both members and participating physicians.

Voluntary Transfers
Members may elect to change their PCP by calling Jefferson Health Plans Member Relations at 1-866-901-8000 (TTY 1-877-454-8477) and requesting a transfer. Members requesting a change will be issued new membership cards within seven to ten days of the effective transfer date. When care is required prior to the issuance of the new membership panel, we will notify you by phone. As a Jefferson Health Plans provider, you are expected to facilitate the transfer of records when members choose a new provider.

Jefferson Health Plans Member Relations will reassign any member requesting a new medical provider for both routine and exceptional circumstances.

Routine transfers are done at the member's discretion and will have a future effective date (routinely the first of the upcoming month) with the newly selected primary care site.

Exceptional transfers requiring an immediate transfer and effective date will be accommodated when there are issues of continuity, when a member has travel difficulties, or when a member is no longer comfortable with a PCP.

Involuntary Transfers
Providers have the right to request that a member select another provider within 30 days, under the following conditions:

- Member demonstrates a pattern of broken appointments without adequate notice and/or
- Member and the provider have failed to establish an adequate patient/provider relationship

To implement an involuntary transfer for one of the reasons noted above, you must send a certified letter to the member and a copy to us.

Jefferson Health Plans
Attn: Member Relations Department
1101 Market Street, Suite 3000
Philadelphia, PA 19107

The letter should indicate the reason for requesting an involuntary transfer. Please note that in accordance with your agreement with us, severity of illness or medical diagnosis is not an acceptable reason for a transfer. In fact, our provider contracts prohibit discrimination on the basis of health status. We will contact the member to assist in selecting a new PCP. The transfer to another PCP will occur within 30 days during which time the transferring provider must be available for urgent care. The transferring provider must also facilitate the transfer of records to the new provider.

Chapter 4: Health Partners Plans Medicaid

Purpose: This chapter provides an overview of the benefits available to Health Partners Plans Medicaid members

Topics: Important topics from this chapter include:

Summary of Medicaid benefits

Overview

This chapter provides an overview of the benefits Health Partners Plans Medicaid members are entitled to and guidelines for appropriately utilizing authorizations.

Note: The guidelines provided in this document do not address all benefit packages available to Health Partners Plans Medicaid members. If a conflict exists between this document and the member's benefit package, the benefit package takes precedence.

Summary of Benefits

The following chart is a quick reference that lists many Health Partners Plans Medicaid benefits and services. It indicates whether an authorization is required and summarizes important guidelines. Additional information about covered and non-covered services follows this chart.

Prior authorization is **always required** for out-of-network services, except emergency/urgent care, maternity care, family planning services and renal dialysis services. Pregnant members already receiving care from an Out-of-Network practitioner at the time of enrollment may continue to receive services from that specialist throughout the pregnancy and postpartum period related to the delivery.

Health Partners Plans Medicaid Benefits

The following table list the benefits available to Health Partners Plans Medicaid members and any prior authorization, cost sharing, or benefit limit requirements associated with those services.

Table 4A: Health Partners Plans Medicaid Benefits

Benefit/Service	Covered	Benefit Limit	Prior Authorization	Copay
Advanced Diagnostic Radiology (MRI, CT, PET)	Yes	No	Yes: Contact eviCore	$0
Ambulance (Emergent)	Yes	No	No	$0
Ambulatory Surgery Center/ Short Procedure Unit/Outpatient Surgeries	Yes	No	No	$0
Annual Eye Exam	Yes	2/year	No	$0
Audiology Services	Yes	No	No	$0

Table 4A: Health Partners Plans Medicaid Benefits				
Benefit/Service	**Covered**	**Benefit Limit**	**Prior Authorization**	**Copay**
Clinic (Outpatient Hospital, Independent, & FQHC)	Yes	No	No	$0
Cosmetic Services	No	N/A	Yes: For Restorative Services	$0
Cardiac Rhythm Devices (Pacers and Defibrillators)	Yes	No	Yes: Contact eviCore	$0
Dental (Diagnostic, preventive, restorative and surgical dental procedures, prosthodontics and sedation.)	Yes	Dentures: 1 per lifetime; Exams/prophylaxis 1 per 180 days; Crowns, Periodontics and Endodontics only via approved benefit limit exception	Contact Avesis	$0
Diagnostic Cardiac Catheterizations	Yes	No	Yes: Contact eviCore	$0
Diagnostic Radiology (X-ray)	Yes	No	No	$0
Durable Medical Equipment Purchase	Yes	No	Yes, >$500	$0
Durable Medical Equipment Rental	Yes	No	Yes	$0
Elective Inpatient Surgical Care	Yes	No	Yes	$0 per day up to $0 per admission
Emergency Services	Yes	No	No	$0
Eyewear (Contact, Lenses, or Frames)	Yes	See Vision Care for details.	Yes: Contact Davis Vision	$0

Table 4A: Health Partners Plans Medicaid Benefits				
Benefit/Service	Covered	Benefit Limit	Prior Authorization	Copay
Family Planning	Yes	No	No	$0
Fitness (Gym) Membership	Yes	Annual membership covered program requirements apply	No	$0 probationary visits
Hearing Aids for Children	Yes	N/A	Yes, >$500	$0
Hearing Aids for Adults	No	N/A	N/A	N/A
Home Infusion	Yes	No	Yes	$0
Home Health Nurses, Social Workers, Aids or Therapists	Yes	No	Yes	$0
Hospice (Inpatient only)	Yes	No	Yes: COTI, Election of Hospice Form and Plan of Treatment/ Clinical Documentation	$0
Hyperbaric Oxygen Therapy	Yes	No	Yes	$0
Infertility Treatment	No	N/A	N/A	N/A
Inpatient Acute Hospital	Yes	No	Yes	$0 per day up to $0 per admission
Inpatient Rehab Hospital	Yes	No	Yes	$0 per day up to $0 per admission
Intermediate Care Facility (ICF) for Individuals with Intellectual Disabilities (IID) and Other Related Conditions (ORC)	Yes	ICF/IID Admission results in immediate disenrollment; ICF/ORC admission requires prior auth. 30 days with disenrollment.	Yes	$0
Laboratory	Yes	No	No	$0
Long Term/Custodial Nursing Home Care	Yes	No	Yes	$0

Table 4A: Health Partners Plans Medicaid Benefits				
Benefit / Service	Covered	Benefit Limit	Prior Authorization	Copay
Medical Diagnostics	Yes	No	No	$0
Medical Oncology (Chemotherapy)	Yes	No	Yes: Contact eviCore	$0
Medical/Surgical Supplies	Yes: Diabetic supplies are covered under the RX benefit	No	Yes: >$500	$0
NICU and/or detained newborn	Yes	No	Yes	$0
Non-Emergent Care Outside USA	No	N/A	N/A	N/A
Non-Emergent Ambulance	Yes	No	No	$0
Nuclear Medicine	Yes	No	No	$0
Nutritional Supplements	Yes	No	Yes	$0
Obstetrical - Outpatient (Pre and Post-Natal)	Yes	No	No	$0
Orthotic (Diabetics only)	Yes	No	Yes	$0
Outpatient Physical and Occupational Therapy	Yes	No	Yes: Contact eviCore	$0
Outpatient Speech Therapy	Yes	No	Yes: Contact eviCore	$0
PCP visits (including CRNP, PA)	Yes	No	No	$0
Pain Management	Yes	No	Yes: Contact eviCore	$0
Pharmaceutical	Yes	No	Yes: If designated as prior auth. drug or non-formulary (Prescription)	$0 generic and $0 brand
Podiatrist Services	Yes	No	No	$0
Preventative Physical exam	Yes	No	No	$0
Private Duty Nursing	No	N/A	N/A	N/A

Table 4A: Health Partners Plans Medicaid Benefits				
Benefit / Service	**Covered**	**Benefit Limit**	**Prior Authorization**	**Copay**
Prosthetic Device	Yes	Hearing Aids are not covered. Ocular prosthesis is limited to 1/yr. Low vision aids are limited to 1/2yr.	Yes	$0
Radiation Therapy	Yes	No	Yes: Contact eviCore	$0
Renal Dialysis	Yes	No	No	$0
Respite Care	Yes	5 days every 60 certified days	Yes	$0
Skilled Nursing Facility	Yes	No	Yes	$0
Sleep Studies	Yes	No	Yes: Contact eviCore	$0
Specialist visits (including CRNP, PA)	Yes	No	No	$0
Spine and Joint Surgeries	Yes	No	Yes: Contact eviCore	$0
Stress Echocardiography, Echocardiography, & Cardiac Nuclear Medicine Imaging	Yes	No	Yes: Contact eviCore	$0
Tobacco Cessation	Yes	70 visits per calendar year	No	$0
Transportation (van service)	Yes	No	Yes	$0
Ultrasound (US)	Yes	No	No	$0
Urgent Care	Yes	No	No	$0
Vascular Surgeries	Yes	No	Yes	$0

Benefits During and After Pregnancy

Members who are confirmed to be pregnant are not subject to limitations on the number of services or copayments. Members are eligible for comprehensive medical, dental, vision and pharmacy coverage with no copayments or visit limits during the term of their pregnancy and until the end of their postpartum care. These services include expanded nutritional counseling and smoking cessation services. However, services not ordinarily covered under a pregnant member's benefit package are not covered, even while pregnant.

To receive these comprehensive benefits, a member must inform all her providers at the time of service that she is pregnant.

Pregnant Members Have No Service Limitations

Pregnant members have no service limitations (i.e., limits on the number of services) during their pregnancy and until the end of their postpartum care. After this period the member is moved to her regularly assigned benefit package and may then have service restrictions.

Health Partners Plans Medicaid members with Medicare coverage

For members with Medicare coverage, if Medicare is the primary insurer and Medicaid is secondary, no benefit limits apply. If Medicare denies a service or claim and the Medicaid limits above have been reached, the service will be denied.

For example: A Health Partners Plans Medicaid member has had one inpatient rehab admission and Medicare denies the second inpatient rehab admission. Since that rehab admission exceeds the one per year Medicaid limit, Health Partners Plans will deny the claim. If Medicare pays the second admission, Health Partners Plans will pay the co-insurance or deductible up to the amount Health Partners Plans would have paid had Health Partners Plans been primary.

The following section provides an overview of the services covered by Health Partners Plans. However, member benefits may vary and this section does not address specific benefit packages available to Health Partners Plans Medicaid members. If a conflict exists between this document and the member's benefit package, the benefit package takes precedence.

Abortion Services

Abortion services are covered only when the pregnancy endangers the life of the woman, or the pregnancy is the result of rape or incest. The provider must certify that one of these circumstances applied by completing a Physician Certification for an Abortion (Medical Assistance MA-3) form.

If the pregnancy was the result of rape or incest, a signed statement must be completed within the appropriate law enforcement jurisdiction. In the case of incest, when the victim is a minor, this statement must include the name of the law enforcement agency or child protective service where the report was made. If the provider believes the victim is not capable of reporting the incident, the provider must indicate the reason why on the Medical Assistance MA-3 form. When Part II of the MA-3 form is completed by the physician, an MA-368 form must be attached as well.

A copy of the Medical Assistance MA-3 form (and the Medical Assistance MA-368 form when required) must be attached to the claim for payment.

Claims for abortion services that are submitted electronically (EDI) should have the following paperwork identification as part of the electronic claim: a copy of the Medical Assistance forms (MA-3 and/or MA-368). This copy should be added to the member's file and be available upon request from Health Partners Plans.

Allergy Testing and Treatment

The Primary Care Physician (PCP) is responsible for coordinating the treatment of allergies. The PCP and the allergist should agree upon a treatment plan and determine a schedule for patient visits to the allergist.

Once a desensitization program is initiated, the patient must return to the PCP for ongoing implementation of the treatment. In high-risk circumstances, by mutual agreement of the PCP and the allergist, the allergist may carry out the treatment plan.

In maintenance therapy situations that are carried out in the PCP's office, the Allergist should provide at least a six-month supply of serum. When a new bottle of serum extract is initiated, the Allergist may administer the first injection. The Allergist should use Procedure Code 95165 for preparation of serum.

Allergy RAST testing is covered only when performed by the participating lab.

Ambulance

Health Partners Plans covers all emergency ambulance services with qualified transport services. All non-emergent transportation services must be provided by a Health Partners Plans approved transportation service. All non-emergent services provided by non-participating transportation vendors will not be reimbursed without prior authorization from Health Partners Plans. Also, see Transportation (Non-Emergent).

Ambulatory Surgical Center/Short Procedure Unit/Outpatient Surgery Services

For a procedure to be considered an Ambulatory Surgical, Short Procedure Unit (SPU), or Outpatient Surgical procedure, the care must involve all of the following services:

1. an operating room procedure;
2. general, regional or MAC (Monitored Anesthesia, Conscious) anesthesia; and
3. recovery room services. The procedure must be performed in connection with covered services. Claims for Ambulatory Surgery and SPU procedures must be billed using the appropriate national standard for billing code type, revenue codes and procedures for all three services. All other procedures will be considered Outpatient Services.

*When an ASC/SPU bills on a professional claim (HFCA 1500) they must list the performing provider in the rendering provider field to ensure payment and avoid unnecessary denials.

Blood Pressure Cuffs

Blood pressure cuffs are covered for members 18 years of age or older **OR** pregnant.

Cardiac Rehabilitation

Cardiac rehabilitation services are covered when the member has a documented diagnosis of acute myocardial infarction within the preceding twelve (12) month period; had coronary bypass surgery; and/or have stable angina pectoris. These cardiac rehabilitation services are covered only in outpatient or home settings. No prior authorization is required.

Chiropractic Care

Services of a state-licensed chiropractor are covered only to provide treatment for manual manipulation of the spine to correct a subluxation demonstrated by x-rays. Contact eviCore Inc., for prior authorization.

Colorectal Screenings

Members who are age 45 and older are eligible for this screening to detect polyps and other early signs of colon and rectal cancer.

Dental

Health Partners Plans contracts with a dental benefits administrator/subcontractor. All members are offered dental services effective the first day of eligibility subject to their benefit package. Certain services, including all SPU services, require prior authorization by the dental benefits subcontractor. All dental procedures that require

hospitalization must be prior authorized by Health Partners Plans' Inpatient Services department. Appropriate documentation must be provided when requesting prior authorization.

Members can receive dental services from a participating primary care dentist. All they have to do is choose a dentist from the list of dentists in the online Provider Directory. The primary care dentist will coordinate members to periodontists and other dental specialists according to the policies defined by the dental subcontractor and approved by Health Partners Plans.

Diabetes Self-Management Training and Education

Outpatient Diabetes Self-Management Training and Education services furnished to an individual with diabetes are covered when performed by a provider with Outpatient Diabetes Education Program recognition from the American Diabetes Association. For more information or for help finding a participating provider, the member or PCP should call the Provider Services Helpline or Member Relations department to self-refer. For more information, refer to Chapter 1 for **Contact Information**.

Diabetes Self-Management Supplies

Formulary diabetic test strips, lancets, glucose meters, syringes and alcohol swabs are covered under the pharmacy benefit. These supplies can be obtained from any Health Partners Plans participating pharmacy with a prescription. Please refer to the formulary located on our website for more information.

Dialysis

Hemodialysis and peritoneal dialysis are covered benefits. Members requiring these services should be directed to a participating specialist. In cases where the Health Partners Plans Medicaid member also has Medicare coverage, Health Partners Plans becomes secondary insurance. Dialysis services do not need prior authorization.

Durable Medical Equipment (DME)

Durable Medical Equipment is covered, so long as the provider directs patients to a Health Partners Plans participating DME vendor.

Key points to remember when prescribing DME items for Health Partners Plans Medicaid members:
All purchased DME items or supplies and outpatient services less than $500 per claim line DO NOT require prior authorization from Health Partners Plans.

If any portion of a purchased customized DME device has a reimbursement value greater than $500, an authorization is required for the entire DME device.

All DME rentals require prior authorization, regardless of reimbursement value. When the patient is renting a DME product covered by their previous insurer, it is the DME provider's responsibility to provide Health Partners Plans with the following information:

- Clinical documentation
- Physician orders
- Number of months covered by the previous insurer
- Termination date of the member's previous insurance coverage
- If, at time of the member's transition, the DME rental is deemed medically necessary, Health Partners Plans will approve coverage up to a total maximum coverage period of 10 months (inclusive of the months covered by the previous insurer). If the DME rental is determined to not meet the criteria for medical necessity at time of the member's transition, the DME rental may only be approved for a period of up to two months (60 days) to ensure continuity of care.
- All special items which do not have their own HCPCS code (such as E1399) require prior authorization, regardless of reimbursement value.
- Over 200 diapers/month requires prior authorization.
- Authorizations are based on benefit coverage/medical necessity.
- Preferred nebulizers and humidifiers are covered under the pharmacy benefit.

If you have questions, please call the Health Partners Plans Outpatient Services department during regular business hours. Providers who need help with urgent issues after business hours (about DME or such other outpatient services as discharge planning placements, home care, and transportation) can call Medical Management (refer to Chapter 1 for contact information) and leave a message, which will be forwarded to an on-call nurse case manager.

Home Accessibility DME

Home accessibility DME is a DHS Process that consist of certain modifications, construction or renovation to an existing structure other than a repair or an addition to the private home of the member (including homes owned or leased by parents/relatives with whom the member resides and family living homes that are privately owned, rented, or leased by the host family) which are necessary due to the member's disability, to ensure the health, security of, and accessibility for the member, or which enable the member to function with greater independence in the home.

Health Partners Plans Medicaid members may be approved for Home Accessibility DME services. This approval is contingent upon medical necessity information submitted to

Health Partners Plans along with required DHS support documentation. They can receive adaptations that consist of certain modifications to the private home of the member (including homes owned or leased by parents/relatives with whom the member resides and family living homes that are privately owned, rented, or leased by the host family) which are necessary due to the member's disability, to ensure the health, security of, and accessibility for the member, or which enable the member to function with greater independence in the home.

Emergency Care

Emergency care and post-stabilization services in emergency rooms and emergency admissions are covered in full by Health Partners Plans for both participating and non-participating facilities, with no distinction for in or out-of-area services. Members are not responsible for any payments. Emergency care and post-stabilization services do not require prior authorization.

Non-part follow-up specialty care for an emergency is covered by Health Partners Plans, but our staff will outreach to the members to appropriately arrange for services to be provided in-network, whenever possible. Members are not responsible for any payments.

Emergency Services (Act 68)

Members are instructed to go to the nearest emergency room (ER) or call 911 for emergency care. An emergency medical condition is defined by the Commonwealth's Department of Human Services as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Members are required to call their PCP as soon as possible after receiving emergency care, and to arrange follow-up care through their PCP.

Emergency room services reported with a behavioral health diagnosis are processed through the member's medical benefit. In the case of emergency room evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures

Act, the behavioral health vendor in the member's locality is responsible for the inpatient admission based upon the member's primary diagnosis.

Emergency room services that convert to Observation (OBS) reported with a behavioral health diagnosis are processed through the member's medical benefit and reimbursed at the OBS contracted rate.

Transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service if the condition is as described above.

Family Planning

Family planning counseling services are covered by Health Partners Plans. If the PCP does not perform these services, he/she should refer the member to an obstetrician/gynecologist, nurse midwife or a Family Planning Council site. Members have the option to self-refer to the Family Planning Council, Ob/Gyn or nurse midwife without prior approval from a PCP. Members are not required to obtain family planning services from an in-plan provider. For further information, providers can call (on behalf of their members) the Health Partners Plans Member Relations department. For more information, refer to Chapter 1 for **Contact Information**.

Foot Care

Medical and/or surgical treatment of conditions of the feet, such as, but not limited to, bunions, ingrown toenails, plantar warts and hammertoes, are covered. Treatment of corns, calluses, nails of feet, flat feet, fallen arches, chronic foot strain or symptomatic complaints of the feet, are not covered unless associated with disease affecting the lower limbs which requires the care of a podiatrist or a physician. No prior authorization is needed.

Gynecological and/or Obstetric Examinations

The PCP may perform routine gynecological exams as appropriate. Members may self-refer to OB/GYN specialists or nurse midwives for any routine gynecological and/or maternity services without prior approval from a PCP. Members receiving maternity care from an Out-of-Network OB/GYN at the time of enrollment may continue to receive services from that provider throughout the pregnancy and postpartum period. Providers are encouraged to notify Health Partners Plans as soon as a pregnant member is identified. Providers can call the Baby Partners hotline to advise us of a pregnant member and/or members who are at risk of poor birth outcomes (during business hours or our 24-hour Member Relations line) to arrange to have their care coordinated by Health Partners Plans' care coordination team.

Pennsylvania's Medical Assistance Program (Medicaid) requires all Obstetrical Needs Assessment Forms (ONAFs) to be submitted electronically online via Optum's portal at obcare.optum.com.

For more information, refer to Chapter 1.

EPSDT

The Early, and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit program is a preventive health program mandated by federal and state regulation that is available to children and young adults under the age of 21 as a benefit of the Medical Assistance program.

EPSDT is designed to promote early detection and, as applicable, treatment of conditions and illnesses affecting growth and development in the Medical Assistance population. Services include physical examinations, blood lead testing and treatment, immunizations, dental care, vision testing and treatment, hearing testing, and screening for certain medical conditions. Autism Spectrum Disorder and developmental screenings are also included in the EPSDT schedule. Certain counseling services, such as pregnancy and STD prevention for sexually active adolescents, are also included.

The EPSDT Periodicity Schedule is located on the Health Partners Plans website for easy reference and is available upon request by contacting the Health Partners Plans Provider Services Helpline at **1-888-991-9023**. PCP success in delivering these vital pediatric preventive services in accordance with these standards will be closely audited by Health Partners Plans.

Services not on the Medical Assistance fee schedule, or that exceed the fee schedule in amount, duration, or scope, may be covered under this program. For more information, refer to Chapter 1 for **Contact Information**.

Hearing Examinations

Audiometry/tympanometry is covered for children up to age 21.

Hearing Aids

Hearing aid services are covered for Health Partners Plans Medicaid pediatric members up to age 21. Coverage is limited to 1 hearing aid per ear, per year. Prior authorization is required for hearing aids over $500. Related hearing aid services (fittings, molds, accessories <including batteries>) are covered and do not require prior authorization unless over $500.

Hearing aids for adult members over age 21 are not covered.

Home Health Care

Home care services are covered when medically necessary. Health Partners Plans can facilitate the following care in the home when medically necessary: registered nurse, physical therapy, occupational therapy, speech therapy, and medical social worker intermittent visits. Prior authorization is required for all home health services except the initial evaluation. Parenteral and enteral nutrition, respiratory therapy, and IV antibiotic therapy are also covered home care benefits if they have been authorized prior to the care.

One maternity home health care visit may be provided within 48 hours of discharge and the second is recommended to take place within 7-84 days post-delivery. Additional post-delivery home care visits will require prior authorization.

Hospice Care

Health Partners Plans will refer members to a participating hospice if they wish to elect hospice coverage. Members may remain enrolled in Health Partners Plans Medicaid even though they have elected hospice coverage. If a member requires hospice care, the provider's request must include a signed prescription/order Certificate of Terminal Illness (COTI) (consent by member, not the medical director of the servicing hospice). Health Partners Plans follows PA Charter 1130. The Medical Assistance Program covers hospice care furnished to eligible Medicaid recipients by hospices enrolled in the Program. Payment for hospice care is subject to this chapter, Chapters 1101 and 1150 (relating to general provisions; and Medicaid Assistance Program payment policies) and the procedures listed in the MA Program fee schedule.

Use the home care/hospice request form is available on our form and supply request webpage.

If the required documents electing hospice are not signed timely based on regulatory requirements, then services being rendered are not authorized or approved.

Medicaid will cover hospice services when:

- a doctor certifies that the patient is terminally ill and is expected to live six (6) months or less; and
- a patient chooses to receive palliative care only instead of therapeutic care for the terminal illness; and
- care is provided by a Health Partners Plans participating hospice program.

The hospice benefit is in-home palliative and supportive medical, nursing and other healthcare services which are designed to meet the special physical, psychological, spiritual and social needs of dying members and their families (spouse and children, siblings of a terminally ill child, and other persons involved in caring for the individual).

When hospice services in home are not able to be maintained due to lack of social support or symptom management, an inpatient setting may be indicated and would require prior authorization. For more information, see Chapter 1 for **Contact Information**.

Coverage under the above noted T-codes include:

- Physician and nursing services
- Medications including outpatient prescription drugs for pain relief and symptom management
- Physical, occupational and speech therapy
- Medical social services and counseling to beneficiary and family members
- Short-term inpatient care, including respite care (a short stay intended to give temporary relief-up to five days in a row to the person who regularly assists with home care) is covered while in hospice program.

Health Partners Plans reimbursement to hospice providers includes services rendered by non-hospice providers for conditions related to the member's terminal illness. Therefore, any service provided that is related to the terminal illness should be reported to the hospice provider directly for reimbursement.

These related services include, but are not limited to, pharmacy, laboratory, durable medical equipment, and short-term inpatient stays.

For any service provided that is not related to the member's terminal illness, the following modifiers must be appended to all claims as appropriate:

GV - attending physician not employed or paid under arrangement by the patient's hospice provider.

- GV modifier should only be reported by the attending physician who is not employed by the hospice.
- The GV modifier can only be reported by a professional provider.

GW - service not related to the hospice patient's terminal condition.

Shift Care services reported with HCPCS codes S9122-S9124 and MANNA services are separately reimbursed and do not require the -GW modifier for reimbursement.

Hospital Services

Members are eligible for admission for medically necessary services obtained at a Health Partners Plans participating hospital, when those services can only be provided in an inpatient hospital setting. All hospital admissions, including those admitted through the emergency room, as well as elective admissions, must be called in to Health Partners Plans' Inpatient Services department for authorization within two business days. Transfers to non-participating facilities require prior authorization before transfer occurs. Prior authorization is needed, except in the following instances:

- medical emergency;
- urgently needed services obtained outside of the service area; and
- when Health Partners Plans approves, in advance, a stay in a hospital that does not participate with us.

From the effective date of coverage until discharge, Health Partners Plans will cover medically necessary care including, but not limited to:

- Room, meals and general nursing care in a semi-private room (unless other accommodations are medically necessary)
- Physician services
- Special care units, such as intensive care or coronary care units
- Special diets, when medically necessary
- Blood transfusions and their administration
- X-ray, laboratory and other diagnostic tests
- Services and supplies furnished by the hospital for inpatient medical and surgical treatment
- Operating and recovery room
- Oxygen, medication and anesthesia
- Use of durable medical equipment (DME) such as wheelchairs
- Rehabilitation services such as physical therapy, occupational therapy and speech pathology
- Inhalation therapy, chemotherapy and radiation therapy
- Kidney, heart, heart/lung, lung, liver, bone marrow and corneal transplants for approved indications in Medicare-certified transplant facilities or transplant facilities approved by Health Partners Plans
- Maintenance dialysis in an approved renal dialysis facility or hospital

- Professional services will be eligible for payment when an emergent inpatient stay is downgraded or denied for level of care.
- Professional services are not eligible for payment when the planned acute inpatient denied for medical necessity.

Preadmission services: In alignment with CMS' policy/billing guidelines, preadmission diagnostic and non-diagnostic services related to the admission that are rendered during the 3 days (hospitals subject to IPPS, inpatient prospective payment system) or 1 day (hospitals excluded from IPPS) prior to an inpatient hospital admission (even if the days cross the calendar year) are considered inpatient services and included in the inpatient reimbursement. Preadmission services may be subject to post-payment audits and retraction.

Behavioral health services may include inpatient services, partial hospitalization services for mental illness, emotional disorders and alcohol and drug abuse services and are managed by the Behavioral Health Managed Care Organization (BH-MCO). The admitting physician may request an expedited appeal with the Medical Director. Physician-to- physician discussion is always available during the review process by calling **1-866-500-4571**.

The PCP (or the covering hospital physician or hospitalist) should make rounds on admitted patients regularly regardless of the provider admitting the patient. Health Partners Plans will look to the PCP for assistance in ensuring appropriate utilization of hospital services.

In the event of a serious or life-threatening emergency, the member should be directed to the nearest emergency facility.

Injectables

Certain injectables, such as oncology products and/or home infusion/IV formulations, are covered as a medical benefit.

For injectables covered under the pharmacy benefit, please see information about our Specialty Medication Program located in the Pharmacy entry in this chapter. Please refer to the formulary located on our formularies webpage for more information regarding specific coverage such as prior authorization, for specialty medications.

JW Modifier

Effective January 1, 2017, physicians and hospitals are required by CMS to use the JW modifier to identify discarded drugs and biologicals. The JW modifier is used to report a discarded/unused portion of a drug.

The JW modifier is reported on drug claims to report the amount of drug or biological that is discarded and eligible for payment. The JW modifier requirement applies to all separately payable drugs assigned status indicators G or K under CMS OPPS for which there is an unused or discarded amount. Eligible and participating 340B providers are not exempt from reporting the JW modifier. The JW modifier is not intended for use on claims for hospital inpatient admissions.

When a provider must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological, payment is made for the amount of drug or biological discarded as well as the dose administered, up to amount of the drug or biological as indicated on the vial or package label. The discarded drug amount should be billed on a separate line on the claim with the JW modifier. The administered amount should be billed on a separate line without the modifier.

Note: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Laboratory

Outpatient laboratory services are provided through Health Partners Plans' vendor, Quest Diagnostics, and also hospital locations contracted for laboratory services. Locations of participating labs can be found via our (Healthcare Provider Directory | Health Partners Plans) Physicians must complete the requisition form for all laboratory services. Laboratories must be CLIA-approved for participation in the Medical Assistance Program.

Laboratory services performed in the office

Provider may be reimbursed for lab services performed in the office when the services are medically necessary, the member has a benefit for those services, they are contracted to perform those services and billed according to Health Partners Plans' policy.

Mammograms

Screening mammographic examinations are covered annually. Members may self-refer for mammograms to any participating site that provides this screening. No authorization is needed if the provider is in the Health Partners Plans network.

Medical Oncology Services

Medical oncology services are covered. Inpatient services require prior authorization by Health Partners Plans. Contact eviCore Inc., for prior authorization. https://www.evicore.com/resources/healthplan/health-partners-plans

Medical Supplies

Medically necessary items that are used to treat injuries (including anklets, bandages, soft cervical collars, casts, cartilage knee braces, clavicle straps, wrist splints wrist/forearm splints, cock-up splints, elastic bandages, nasal splints, slings, finger splints, cold/hot packs and straps for tennis elbow) and that have valid HCPCS codes do not require prior authorization from Outpatient Services if items are less than $500 per claim line.

Medical Visits

Outpatient medical visits performed in a physician's office, hospital and skilled nursing facility or at home, by a Health Partners Plans participating physician/provider, are covered.

Mental Health and Substance Abuse Treatment

Under HealthChoices, all Medical Assistance members, regardless of the health plan/MCO to which they belong, receive mental health and substance abuse treatment through the behavioral health managed care organization (BH-MCO) assigned to their county of residence. For more information, see the **Behavioral Health** contact information section of the manual.

PCPs who identify a Health Partners Plans Medicaid member in need of behavioral health services should direct the member to call his or her county's BH-MCO. The BH-MCO will conduct an intake assessment and refer the member to the appropriate level of care.

Pharmacy

Health Partners Plans Medicaid drug benefit has been developed to cover medically necessary prescription products for self-administration in an outpatient setting. Non-self-administered drugs in the outpatient setting — not covered under the pharmacy benefit — are available through the contractual buy and bill process based on Health Partners Plans medical fee schedule.

A formulary, also called statewide preferred drug list (PDL), is a list of medicines that Health Partners Plans covers. The statewide preferred drug list is the same for all Medicaid members across Pennsylvania. In addition to the PDL, Health Partners Plans also covers a supplemental formulary, which includes medications outside the scope of the PDL. The formulary has both brand name and generic drugs. Generic drugs contain the same active ingredients as brand name drugs. Any medicine prescribed that is not on Health Partners Plans' formulary needs prior authorization. The formulary can change from time to time, so you should make sure that you have the

latest information when prescribing a medicine. Links to the statewide PDL, Health Partners Plans supplemental formulary, and drug specific prior authorization forms can be found on our formularies webpage.

For additional printed copies, please call the Provider Services Helpline. For more information, refer to Chapter 1 for Contact Information.

Pharmacy Benefit Design

A maximum of up to a 90-day supply of medication is eligible for coverage in an outpatient setting. Refills can be obtained when 80% of utilization has occurred. You are urged to prescribe in amounts that adhere to FDA guidelines and accepted standards of care.

The formulary covers preferred, medically necessary prescription products and limited over-the- counter (OTC) medications. Certain OTC drugs (e.g., aspirin, acetaminophen, vitamins, hydrocortisone) with an NDC code are covered with a doctor's prescription. Blood glucose test strips, alcohol swabs, syringes and lancets (along with blood glucose monitors, limited to 1 per year) are only covered through the pharmacy benefit with a prescription. Preferred diabetic supplies, meters and test strips are part of the Statewide PDL, they can be found directly at www.papdl.com or accessed through our website's formularies webpage. The OTC products listed in the formulary are covered with a written prescription.

Certain vaccines (such as flu, pneumonia, hepatitis and varicella zoster) are covered under the pharmacy benefit with a prescription for members 19 and older. Please refer to the Vaccines for Children (VFC) program regarding coverage of vaccines for members 0 to 18 years of age. Please refer to the formulary for more information regarding which vaccines are covered at the point-of-sale pharmacy. Members are encouraged to go to a participating network pharmacy which can supply and administer the vaccine.

Pharmacy Prior Authorization

Certain drugs on the Statewide PDL along with the Health Partners Plans supplemental formulary may require a prior authorization. Statewide PDL prior authorizations are based on drug class and Health Partners Plans supplemental prior authorization criteria is drug specific. Both Statewide PDL and Health Partners Plans Supplemental formulary prior authorizations can be found on our prior authorization webpage. There may be occasions when an unlisted drug or non-formulary is desired for medical management of a specific patient. In those instances, the unlisted medication may be requested through a medical exception process using the Non-formulary Prior Authorization form.

To ensure that select medications are utilized appropriately, prior authorization may be required for the dispensing of specific products. These medications may require authorization for the following reasons:

- Non-formulary medications, or benefit exceptions requested for medical necessity
- Medications and/or treatments under clinical investigation
- Duplication of Therapy Edits will be hard coded to assure appropriate utilization of multiple drugs within the same therapeutic categories (e.g., duplication of SSRIs).
- Prescriptions that exceed set plan limits (days' supply, quantity, refill too soon and cost)
- New-to-market products prior to review by the P&T Committee
- Orphan Drugs/Experimental Medications
- Selected injectable and oral medications
- Specialty medications
- Drugs that exceed FDA prescribing limits

To request a prior authorization, the physician or a member of his/her staff should contact Health Partners Plans' Pharmacy department at **1-866-841-7659**. All requests can be faxed (**1-866-240-3712**) 24 hours per day; calls should be placed from 8:00 A.M. to 6:00 P.M., Monday through Friday. In the event of an immediate need after business hours, the call should be made to Member Relations at **1-800-553-0784**. The call will be evaluated and routed to a clinical pharmacist on-call (24/7).

The physician may use Health Partners Plans' drug specific forms or a letter of request, but must include the following information for a quick and appropriate review to take place:

- Specific reason for request
- Name and recipient number of member
- Date of birthdate of member
- Physician's name, license number, NPI number and specialty
- Physician's phone and fax numbers
- Name of primary care physician (PCP) if different
- Drug name, strength and quantity of medication
- Days' supply (duration of therapy) and number of refills
- Route of administration
- Diagnosis
- Formulary medications used, duration and therapy result and documentation such as pharmacy records or chart notes

- Additional clinical information that may contribute to the review decision such as specific lab results.

All forms should be legible and completely filled out. All prior authorization forms are available on the Health Partners Plans Prior Authorization webpage.

Upon receiving the prior authorization request from the prescriber, Health Partners Plans will render a decision within 24 hours. Approval or denial letters are mailed to the member or parent/guardian, in the case of a child. A copy of the member letter will also be faxed or mailed to the prescribing physician. At any time during normal business hours, the prescribing physician can discuss the denial with a clinical pharmacist or can have a peer-to-peer discussion with the medical director by calling the Pharmacy department at **1-866-841-7659**.

If a member presents a pharmacy with a prescription that requires prior authorization, whether for a non-formulary drug or otherwise, and if the prior authorization cannot be processed immediately, Health Partners Plans will allow the pharmacy to dispense an interim supply of the prescription under the following circumstances:

- If the prescription is for a new medication (one that the recipient has not taken before or that is taken for an acute condition), Health Partners Plans will allow the pharmacy to dispense a five (5) day supply* of the medication to ensure that the member receives the prescribed medication while the recipient or pharmacy takes the appropriate steps to complete the prior authorization process in a timely manner.
- If the prescription is for an ongoing medication (one that is continuously prescribed for the treatment of an illness or condition that is chronic in nature in which there has not been a break in treatment for greater than 30 Days), Health Partners Plans will allow the pharmacy to dispense a 15-day supply* of the medication automatically, unless Health Partners Plans mailed to the member, with a copy to the prescriber, an advanced written notice of the reduction or termination of the medication at least 10 days prior to the end of the period for which the medication was previously authorized.

Note: The DHS requirement that the Member be given at least a seventy-two (72) hour supply (Health Partners Plans allows for five days) for a new medication or a fifteen (15) day supply for an Ongoing Medication does not apply when a pharmacist determines that the taking of the prescribed medication — either alone or along with other medication that the Member may be taking — would jeopardize the health or safety of the Member.

Health Partners Plans will respond to the request for prior authorization within 24 hours from when the request was received. If the prior authorization is denied, the recipient is entitled to appeal the decision through several avenues. The 5-day or 15-day requirement does not apply when the pharmacist determines that taking the medication, either alone or along with other medication that the recipient may be taking, would jeopardize the health and safety of the member.

The goal of the drug benefit program is to provide safe and cost-effective pharmacotherapy to our members.

Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST)

Members have coverage for outpatient PT/OT/ST when performed by a participating Health Partners Plans provider. Contact eviCore for prior authorization, which is required for all outpatient PT/OT/ST. Prior authorization is not required for outpatient evaluation. Contact eviCore Inc., for prior authorization- https://www.evicore.com/resources/healthplan/health-partners-plans

Preventive Health Services

Preventive health services, including routine physical exams, health screening, health education and well childcare, are covered according to schedules approved by Health Partners Plans, when provided by the PCP or Health Partners Plans participating gynecologist.

Prosthetics/Orthotics

Purchase and fitting of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body organ require prior authorization by the Health Partners Plans' Outpatient Services department. Orthotics and customized devices require prior authorization.

Radiation Therapy

Radiation therapy services are covered. Contact eviCore Inc., for prior authorization for radiation therapy.

Rehabilitation

Please see alphabetized listings "Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST)." Inpatient rehabilitation requires a prior authorization.

Sigmoidoscopy
Please see alphabetized listing under “Colorectal Cancer Screening.”

Skilled Nursing Facility
Services for inpatient care in a Health Partners Plans participating skilled nursing facility must be prior authorized by Health Partners Plans’ Inpatient Services department.

Smoking Cessation
Various smoking cessation services are available to our members to assist them in quitting smoking. Please reference our website for the most current reimbursable expenses.

Specialist Visits
PCP referrals to Health Partners Plans participating specialists and other providers are not required. Services provided by non-Health Partners Plans participating physicians and other non-participating licensed allied health personnel will be covered only when prior authorized by Health Partners Plans.

While PCP referrals are not required, we still consider the Primary Care Physician (PCP) to be the gatekeeper of care. When coordinating care, the PCP should continue to direct the member to a specialist who the PCP believes can best assist with the care needed. In return, it is extremely important for specialists to continue to keep a patient’s assigned PCP informed of all care they render to the patient. This ensures that the PCP has the appropriate opportunity to manage the overall health of the patient as care is provided, and that the patient, our member, benefits from the robust coordination of care.

Specialty Medication Program
Health Partners Plans supports appropriate use of specialty medications and has established suppliers as well as procedures for appropriate prescribing and monitoring. Under the direction of the Health Partners Plans’ Pharmacy department, the physician provider has the primary responsibility for obtaining prior authorization for medications included in this program. The prescribing physician will need to send the completed medical request to the Health Partners Plans Pharmacy department by fax with all pertinent lab information at **1-866-240-3712**.

Specialty medications are higher cost, biologics, injections or oral medications that require special handling, monitoring, or have limited distribution per manufacturer or FDA guidelines. They are used to treat complex, chronic, and often costly conditions such as rheumatoid arthritis, hepatitis C and hemophilia. Specific specialty pharmacy

vendors who have met high quality measures and accreditation are contracted with Health Partners Plans to handle and distribute these medications.

All requests for prior authorization are reviewed by the Pharmacy department for approval. Approvals, including approvals for shorter durations are coordinated with the contracted specialty vendor for distribution to the provider's office or member's home.

In addition, the prescriber can always call Health Partners Plans' Pharmacy department at **1-866-841-7659** for assistance with the prior authorization on specialty medications and preferred specialty vendors. Specific prior authorization forms are available on our prior authorization webpage.

Certain specialty medications are processed through the Pharmacy department and require a prior authorization. Please refer to the formulary and the website for more information regarding specialty medications, drug specific prior authorization forms, and preferred vendors. For further information visit our specialty medications webpage.

Sterilization

Such sterilization procedures as tubal ligation and vasectomy are covered with no prior authorization required when provided as outpatient services to Health Partners Plans members age 21 or older. Prior authorization is required if these services are provided on an inpatient basis. A properly completed MA-41 form documenting the member's voluntary informed consent must accompany the provider's claim for payment for all sterilization services.

Hysterectomy is not covered if solely for sterilization purposes.

Transportation (Non-Emergent)

Non-emergent transportation services does not require prior authorization.

Health Partners Plans members are eligible for registration with the DHS Medical Assistance Transportation Program (MATP – more info available at http://matp.pa.gov/). MATP can provide help with health-related transportation, including to and from doctor visits. To facilitate the process, members and providers must be registered with their respective county's MATP provider. MATP will determine transport eligibility (reimbursement, paratransit, or mass transit) based on the medical assessment supplied by the provider. Members can call their county's MATP provider to arrange transportation or may call our Member Relations. Providers may

arrange transportation by calling our Clinical Program Provider Line. For more information, refer to the **Contact Information** section.

Some of Health Partners Plans' participating hospitals provide limited, non-urgent transportation to their facilities on a scheduled basis for services such as diagnostic testing.

Vaccines for Children (VFC) program

Participating Health Partners Plans providers, including specialists who are servicing eligible members in the age ranges of 0 through 18, must obtain their vaccines through the VFC program.

Providers in Philadelphia County must obtain their vaccine through the Philadelphia VFC program at https://www.health.pa.gov/topics/programs/immunizations/Pages/VFC.aspx.

Providers outside Philadelphia County should obtain their vaccine from the state VFC program by visiting the website for the PA Department of Immunizations at https://www.pa.gov/en/agencies/health/programs/immunizations/vaccines-for-children.html.

For more information, please view Health Partners Plans' VFC policy on our website: www.hpplans.com/policybulletins.

Vision Care

Health Partners Plans covers vision care for all members through our subcontracted provider, Davis Vision. Members can choose a vision care provider from the online Health Partners Plans Provider Directory.

Davis Vision covers routine eye examinations for all members.

For members under 21, EPSDT services are covered as medically necessary. Children are eligible for eyeglasses and contact lenses when medically necessary.

Health Partners Plans Medicaid members age 21 and over can receive one pair of eyeglasses or contact lenses every year. Members can choose an eye care provider from the Health Partners Plans online provider directory or call Member Relations for a printed list of providers or other help.

Value Added Benefits

Fitness Program

Members are eligible to enroll once a year in any of Health Partners Plans' participating fitness centers and can self-refer to these programs. No prior authorization is required. Once enrolled, members will have a one-year membership from the date of enrollment. There are no minimum visit requirements. However, members will not be able to go to another fitness center for one year after enrollment.

Non-Covered Services

The following services and benefits are excluded or limited under the Health Partners Plans plan. Members may self-refer themselves for these services at their own expense.

- Artificial insemination/infertility treatment
- Cosmetic surgery, except to correct a serious disfigurement or deformity caused by disease or injury that occurred while the patient was a participating member; or for the treatment of congenital anomalies to restore a part of the body to its proper function
- Health club memberships except when stipulated by contract with Health Partners Plans
- Personal convenience items or services
- Reversal of tubal ligation
- Services available through other programs such as workers' compensation, Veterans Administration, other governmental programs/agencies or other insurance coverage
- Services for which neither the member nor another party on his or her behalf has any legal obligation to pay
- Services not provided by, or arranged through a provider, medical office, or dental office participating with Health Partners Plans, except for emergency services or services that may be self-referred, unless authorized by Health Partners Plans
- Services not reasonable or medically necessary for the diagnosis or treatment of an illness or injury, or for restoration of physiologic function (except preventive services)
- Services performed by immediate relatives of members, or by others in the member's household
- Transportation services, other than those Ambulance and Non-Emergent Transportation services described under Health Partners Plans "Covered Services" in this chapter.

Medical Directors will not approve services that are deemed harmful, are of inferior quality, or are medically unnecessary (as may be the case with a serious and clearly preventable adverse event). In addition, based on The Centers for Medicare and

Medicaid Services (CMS) guidelines, financial compensation for any and all services rendered as a result of, or increased by, a preventable serious adverse event will be withheld or recovered.

Recipient Restriction Program

Health Partners Plans participates in the Pennsylvania Department of Human Services Recipient Restriction Program. The program calls for Health Partners Plans to monitor and identify Medical Assistance recipients who improperly or excessively utilize Medicaid services. In cooperation with the Department of Human Services' Bureau of Program Integrity, Health Partners Plans will refer members with suspected patterns of inappropriate utilization to the Pennsylvania Department of Human Services' Recipient Restriction Program. These members may be restricted to a certain physician and/or pharmacy. Providers requesting information on this program may contact the Health Partners Plans Pharmacy department at **1-866-841-7659**.

Chapter 5: Jefferson Health Plans Medicare Advantage Summary of Benefits

Purpose: This chapter provides an overview of the benefits available to Jefferson Health Plans Medicare Advantage members.

Topics: Important topics from this chapter include:
Summary of Medicare Advantage benefits
Jefferson Health Plans Medicare Prime (HMO-POS)
Jefferson Health Plans Medicare Complete (HMO-POS)
Jefferson Health Plans Medicare Special (HMO SNP)
Jefferson Health Plans Medicare Silver (HMO POS)
Jefferson Health Plans Medicare Platinum (HMO POS)
Jefferson Health Plans Giveback (HMO POS), (New! January 1, 2024)
Jefferson Health Plans Dual Pearl (HMO SNP) (New! January 1, 2024)
Jefferson Health Plans Flex (PPO) (New! January 1, 2024)
Jefferson Health Plans Flex Plus (PPO) (New! January 1, 2024)
Non-Covered Services

Overview

This chapter provides an overview of the 2024 benefits that Jefferson Health Plans members are entitled to and guidelines for appropriately utilizing authorizations.

Jefferson Health Plans Background in Medicare

In 2014, we launched our Medicare Advantage product in Philadelphia and the surrounding counties. Since then, our service area has expanded and now includes Berks, Bucks, Carbon, Chester, Cumberland, Dauphin, Delaware, Lancaster, Lebanon, Lehigh, Montgomery, Northampton, Perry, Philadelphia and Schuylkill counties in Pennsylvania as well as Burlington, Camden, and Gloucester counties in New Jersey. Heath Partners Medicare was rebranded as Jefferson Health Plans in 2024 and also expanded into Atlantic and Mercer counties in New Jersey.

Regulatory Compliance

As a Medicare Advantage plan with a Centers for Medicare & Medicaid Services (CMS) contract, we comply with all applicable CMS regulations. Not only does Jefferson Health Plans have a comprehensive Medicare Compliance program, led by a Medicare Compliance officer, but every operational area at our Health Plan is also responsible for the compliance of its functions. Should you have any questions about our Medicare Compliance program, please contact our Provider Services Helpline at **1-888-991-9023**.

Among the requirements with which Jefferson Health Plans complies, are:

- We provide CMS with specific information about our plans that CMS makes available to current and potential beneficiaries to enable them to make informed decisions about their Medicare options. This includes plan benefits; cost sharing; service area; rate of disenrollment; enrollee satisfaction; health outcomes; the plan's compliance record; member appeals; and formal actions of other regulatory bodies.
- We comply with all applicable regulations and instructions from CMS. Among the topics covered are enrollment and disenrollment, non-discrimination, provision of basic benefits, and access to benefits.
- We meet the required manner and form of communicating information to beneficiaries.
- We submit formal reporting on the financial status of our Health Plans.

Summary of Benefits

Jefferson Health Plans

The benefits offered by Medicare Advantage plans can change annually. Each year Jefferson Health Plans submits its proposed plans for the next year to CMS for approval. Benefits for the coming year are usually approved by CMS by early August; and in most cases benefits stay the same for a calendar year. CMS may require Medicare Advantage plans to make benefit changes within a calendar year, but this is rare.

A full description of all plan benefits can be found at www.jeffersonhealthplans.com

It is especially important for Jefferson Health Plans providers to be aware of the plans, the benefits available to members, and cost-sharing that providers should expect from members.

Please note: Providers are prohibited from billing our dual eligible members for any Medicare cost-sharing for Part A & B covered services. Additionally, providers should bill any Medicare cost-sharing to the member's assigned Community HealthChoices (CHC) plan.

Please note that Jefferson Health Plans does not require PCP referrals for plan specialists.

Prior authorization is ALWAYS REQUIRED for out-of-network services for our HMO plans, except emergency care and (for dual eligible members only) family planning and maternity care. Prior authorization is not required for out-of-network urgent care or dialysis services when the member is temporarily out of the Jefferson Health Plans service area. Prior authorization is not required for certain services out-of-network for PPO plans (available January 1, 2024. Please go to Jeffersonhealthplans.com for details.

Cost-Sharing for Dual Eligible Members

Medicare cost-sharing includes copayments, coinsurance, and deductibles. The cost-sharing responsibility of members who are dual eligible (Medicare and Medicaid) is based on their category of Medicaid eligibility. Medicaid will pay the Medicare Part A and B service cost-sharing for any Cost Share Protected Dual Eligible members as long as the benefit is covered by both Medicare and Medicaid. Medicaid will cover Medicare cost-sharing up to the difference between the Medicare paid amount and the Medicaid rate for the service. If the Medicaid rate is lower than the Medicare rate, Medicaid may not remit payment and the provider will be considered paid in full.

Coverage of Medicaid benefits is now being administered by the Community HealthChoices (CHC) plans, those Managed Care Organizations that provide Pennsylvania Medicaid coverage to dual eligible beneficiaries. Providers should bill any Medicare cost-sharing to the member's CHC for remittance of payment. As the member's Medicare provider, you are not obligated to participate in the CHC's network in order to submit claims.

Reminder Related to Dual Eligible Billing
Federal law prohibits the billing of any Medicare Part A and B cost-sharing if a member's Medicaid category is Qualified Medicare Beneficiary Plus (QMB Plus); therefore, you are never to bill a QMB Plus member for Medicare Part A and B cost-sharing, even if the service is not covered by Medicaid.

Keep in mind that while Jefferson Health Plans Medicare Special is a Dual Eligible Special Needs Plan whose membership is limited to members with cost share protection, dual eligible individuals (including those who are full dual eligible) may also be members of our other health plans.

Hospice Care
Jefferson Health Plans will refer members to a participating hospice if they wish to elect hospice coverage. Members may remain enrolled in Jefferson Health Plans Medicare even though they have elected hospice coverage. If a member requires hospice care, the provider's request must include a signed prescription/order Certificate of Terminal Illness (COTI) (consent by member, not the medical director of the servicing hospice). Jefferson Health Plans follows PA Charter 1130. The MA Program covers hospice care furnished to eligible MA recipients by hospices enrolled in the Program. Payment for hospice care is subject to this chapter, Chapter 1 (relating to general provisions; and MA Program payment policies) and the procedures listed in the MA Program fee schedule.

Use the home care/hospice request form available at www.jeffersonhealthplans.com.

When a Jefferson Health Plans Medicare member elects to receive hospice care, the hospice services will be managed and reimbursed by original Medicare. Most members will disenroll from Jefferson Health Plans Medicare after they elect hospice care. However, the member may continue enrollment in Jefferson Health Plans Medicare and is entitled to receive any benefits other than those that are the responsibility of fee-for-service Medicare hospice.

The Primary Hospice Agency would submit for payment of general hospice services under the 4 primary T-codes to receive payment in full for services:

- T2042 – HOSPICE ROUTINE HOME CARE
- T2045 – HOSPICE GENERAL CARE
- T2044 – HOSPICE RESPITE CARE
- T2043 – HOSPICE CONTINUOUS HOMECARE

JW Modifier
Effective January 1, 2017, physicians and hospitals are required to use the JW modifier to identify discarded drugs and biologicals. The JW modifier is used to report a discarded/unused portion of a drug.

The JW modifier is reported on drug claims to report the amount of drug or biological that is discarded and eligible for payment. The JW modifier requirement applies to all separately payable drugs assigned status indicators G or K under CMS OPPS for which there is an unused or discarded amount. Eligible and participating 340B providers are not exempt from reporting the JW modifier. The JW modifier is not intended for use on claims for hospital inpatient admissions.

When a provider must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological, payment is made for the amount of drug or biological discarded as well as the dose administered, up to amount of the drug or biological as indicated on the vial or package label. The discarded drug amount should be billed on a separate line on the claim with the JW modifier. The administered amount should be billed on a separate line without the modifier.

Note: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Non-Covered Services
The following services and benefits are excluded or limited under Jefferson Health Plans Medicare.

- Services considered not reasonable and necessary, according to the standards of original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment, and medications, unless covered by original Medicare or under a Medicare-approved clinical research study or by our plan. Experimental procedures and items are those items and procedures determined by our plan and original Medicare to not be generally accepted by the medical community.

- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in the room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in-home.
- Custodial care, including care provided in a nursing home, hospice, or other facility setting when skilled medical care or skilled nursing care is not required. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps with bathing, dressing or other activities of daily living.
- Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.
- Fees charged by an immediate relative or members of the member's household.
- Meals delivered to the member's home (except as provided by the meals benefit in certain plans).
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless needed due to an injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care except as shown in plan Evidence of Coverage documents. Non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines, and services shown in plan Evidence of Coverage documents.
- Orthopedic shoes unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.

- Hearing aids or exams to fit hearing aids beyond the services shown in plan Evidence of Coverage documents.
- Eyeglasses beyond the coverage shown in plan Evidence of Coverage documents. (However, eyeglasses are covered for people after cataract surgery.) Radial keratotomy, LASIK surgery, vision therapy and other low vision aids are not covered.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Acupuncture, except for services shown in plan Evidence of Coverage documents.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Drugs used to treat anorexia, weight loss, or weight gain, even if used for a non-cosmetic purpose (e.g., morbid obesity).
- Drugs used to promote fertility.
- Drugs used for cosmetic purposes or hair growth.
- Drugs used to treat symptomatic relief of cough and colds, including over the counter (OTC) medications, except as covered by the OTC benefit in our plans.
- Prescription vitamin and mineral products, except prenatal vitamins and fluoride preparations, except as covered by the OTC benefit in our plans.
- Covered outpatient drugs which the manufacturer seeks to require, as a condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
- Agents used to treat sexual or erectile dysfunction except when prescribed to treat medically accepted indications other than sexual dysfunction or erectile dysfunction.
- Non-prescription drugs, such as over the counter (OTC) products, except items used in the administration of insulin and those items covered by the OTC benefit in our plans.

The plan will not cover the excluded services listed above. Even if received at an emergency facility, the excluded services are still not covered.

Chapter 6: Health Partners Plans CHIP/KidzPartners Summary of Benefits

Purpose: This chapter provides an overview of the benefits available to Health Partners Plans CHIP/KidzPartners members.

Topics: Important topics from this chapter include:

- Summary of KidzPartners benefits
- Covered Services
- Non-Covered Services

Overview

This chapter provides an overview of the benefits Health Partners Plans CHIP/ KidzPartners members are entitled to and guidelines for appropriately utilizing authorizations.

Summary of Benefits

The following chart is a quick reference that lists many KidzPartners benefits and services and summarizes important guidelines. Additional information about covered and non-covered services follows this chart.

Prior authorization is **ALWAYS REQUIRED** for out-of-network services, except emergency/urgent care, family planning and dialysis services. Pregnant members already receiving care from an Out-of-Network practitioner at the time of enrollment may continue to receive services from that specialist throughout the pregnancy and postpartum period related to the delivery.

KidzPartners Benefits

The following table lists the benefits available to KidzPartners members and their related benefit limits, prior authorization requirements, and copays when applicable.

Table 6A: KidzPartners Benefits

Benefit/Service	Covered	Benefit Limit	Prior Authorization
Advanced Diagnostic Radiology (MRI, CT, PET)	▪ Yes	▪ No	▪ Yes (Contact eviCore)
Ambulance (Emergent)	▪ Yes	▪ No	▪ No
Ambulatory Surgery Center/ Short Procedure Unit/Outpatient Surgeries (POS 22, 24/Rev codes 360, 490)	▪ Yes	▪ No	▪ No
Annual Eye Exam	▪ Yes	▪ 1/year	▪ No

Table 6A: KidzPartners Benefits			
Benefit/Service	**Covered**	**Benefit Limit**	**Prior Authorization**
Audiology Services	▪ Yes	▪ No	▪ No
Autism Services	▪ Yes	▪ No	▪ No
Bariatric Surgery	▪ No	▪ No	▪ No
Chemotherapy	▪ Yes	▪ No	▪ No
Chiropractic Services	▪ Yes	▪ 20 visits/year	▪ No
Clinic (Outpatient Hospital, Independent & FQHC)	▪ Yes	▪ No	▪ No
Cosmetic Services	▪ No	▪ N/A	▪ Yes
Diagnostic Radiology (X-ray, US)	▪ Yes	▪ No	▪ No
Dental Services	▪ Yes	▪ See Dental section	▪ Contact Avesis
Durable Medical Equipment Purchase > $500	▪ Yes	▪ No	▪ Yes
Durable Medical Equipment Rental	▪ Yes	▪ No	▪ Yes
Elective Inpatient Surgical Care	▪ Yes	▪ No	▪ Yes
Emergency Services	▪ Yes	▪ No	▪ No
Eyewear (Contact, Lenses, or Frames)	▪ Yes	▪ See Vision Care section	▪ No (Contact Davis Vision)

Table 6A: KidzPartners Benefits			
Benefit/Service	**Covered**	**Benefit Limit**	**Prior Authorization**
Family Planning	▪ Yes	▪ No	▪ No
Fitness (Gym) Membership	▪ Yes	▪ Annual membership covered. Program requirements apply	▪ No
Hearing Aids	▪ Yes	▪ 1 hearing aid per ear every two years	▪ Yes
Home Infusion	▪ Yes	▪ No	▪ Yes
Home Health Nurses, Social Workers, Aids, and Therapists	▪ Yes	▪ No	▪ Yes
Hospice (Inpatient only)	▪ Yes	▪ No	▪ Yes: Certification of Terminal Illness, Election of Hospice Form and Plan of Treatment / Clinical Documentation
Infertility Treatment	▪ No	▪ N/A	▪ N/A
Inpatient Acute Hospital	▪ Yes	▪ No	▪ Yes
Laboratory	▪ Yes	▪ No	▪ No
Medical Diagnostics	▪ Yes	▪ No	▪ No
Medical/Surgical Supplies	▪ Yes (Diabetic supplies are covered under the RX benefit)	▪ No	▪ Yes (If >$500)

Table 6A: KidzPartners Benefits			
Benefit/Service	**Covered**	**Benefit Limit**	**Prior Authorization**
NICU and/or detained newborn	Yes	No	Yes
Non-Emergent Care Outside USA	▪ No	▪ N/A	▪ N/A
Non-Emergent Ambulance	▪ No	▪ No	▪ N/A
Nuclear Medicine	▪ Yes	▪ No	▪ No
Nutritional Supplements	▪ Yes	▪ No	▪ Yes (If >$500)
Obstetrical – Outpatient (Pre and Post-Natal)	▪ Yes	▪ No	▪ No
Orthotic (Diabetics only)	▪ Yes	▪ No	▪ Yes (If >$500)
Outpatient Physical, Occupational, and Speech Therapy	▪ Yes	▪ 30 visits/year for each type of therapy	▪ Yes (Contact eviCore)
PCP Visits (including CRNP, PA)	▪ Yes	▪ No	▪ No
Pharmaceutical	▪ Yes	▪ No	▪ Yes (If designated as prior authorization drug or non-
Podiatrist Services (Routine)	▪ No	▪ N/A	▪ N/A
Preventative Physical Exam	▪ Yes	▪ No	▪ No
Private Duty Nursing (Inpatient)	▪ Yes	▪ No	▪ Yes

Copays for KidzPartners Members

KidzPartners members may be responsible for copayments. This information is distributed to members through their Member Handbook on the KidzPartners section of our website, www.jeffersonhealthplans.com, and key copay information is printed on their member ID card.

All members enrolled in KidzPartners:

There are no CHIP copays for preventive care services, including well-child visits and visits for immunizations, for members in any premium category.

Members enrolled in "free" KidzPartners:

There are no CHIP copays for any services for any members enrolled in the free program.

Members enrolled in "low-cost" KidzPartners pay the following CHIP copays:

- $5 for visits to your children's primary care physician (PCP), except for well-child visits
- $5 for visits to specialists
- $25 for visits to the emergency room.
  - Copay is waived if your child is admitted
- $9 for brand name formulary drugs and $6 for generics

The annual maximum you will pay for copays is five percent of your family income.

Members enrolled in "full-cost" KidzPartners pay the following CHIP copays:

- $15 for visits to your children's primary care physician (PCP), except for well-child visits
- $15 for visits to specialist
- $50 for visits to the emergency room.
  - Copay is waived if your child is admitted.
- $18 for brand name formulary drugs and $10 for generics

Covered Services

The following section provides an overview of the services covered by KidzPartners. However, member benefits may vary and this section does not address specific benefit packages available to KidzPartners members. If a conflict exists between this document and the member's benefit package, the benefit package takes precedence.

- PCP referrals are not required to receive services from a specialist or a non-participating provider; however, an authorization is usually required for services performed by a non- participating provider.

Abortion Services
Abortion services are covered if the physician has determined, within the physician's best clinical judgment, as required by 18 PA. C.S. §3204, that the abortion is medically necessary to save the life of the mother. This information must be clearly documented in the member's medical record.

Acupuncture
KidzPartners covers acupuncture. Services must be provided by a network provider specifically credentialed to perform acupuncture. Prior authorization or copay is required.

Ambulance
KidzPartners covers all emergency ambulance services with qualified transport services. All non- emergent transportation service is not covered.

Ambulatory Surgical Center/Short Procedure Unit/Outpatient Surgery Services

For a procedure to be considered an Ambulatory Surgical, Short Procedure Unit (SPU), or Outpatient Surgical procedure, the care must involve all of the following services:

- an operating room procedure;
- general, regional or MAC (Monitored Anesthesia, Conscious) anesthesia; and
- recovery room services.

The procedure must be performed in connection with covered services. Claims for Ambulatory Surgery and SPU procedures must be billed using the appropriate national standard for billing code type, revenue codes and procedures for all three services. All other procedures will be considered Outpatient Services. **Prior authorization is not required.**

*When an ASC/SPU bills on a professional claim (HFCA 1500) they must list the performing provider in the rendering provider field to ensure payment and avoid unnecessary denials.

Asthma Checkups
Please refer any Member with asthma to our Member Relations team at **1-888-888-1211 (TTY 1-877-454-8477)** for information on KidzPartners' Asthma Management program.

Chemotherapy

Chemotherapy treatment is a covered benefit for KidzPartners members.

Child Visits

Parents can make appointments with their children's PCP for well-child visits designed to keep them healthy. The primary and preventive care services children should have during these visits include:

- **Regular checkups:** From the time members are born, it is very important for children to visit their PCP regularly for well-child checkups, including routine blood pressure screening. Babies need checkups at 1, 2, 4, 6, 9, 12, 15, and 18 months; children need annual checkups starting at age 2. In addition to providing a comprehensive physical exam, PCP should arrange for any needed lab or other diagnostic testing. These visits help assure children stay healthy.
- **Shots/Immunizations:** Children should have many important shots before age two in order for the shots to have the most effect. Children should also continue to have shots, including boosters and flu shots, as necessary. Whenever children see their PCP, be sure to check that their shots are up to date.

Chiropractic Care

Services of a state-licensed chiropractor are covered only to provide treatment for manual manipulation of the spine to correct a subluxation demonstrated by X-rays. Contact eviCore for prior authorization. The benefit is limited to 20 visits per year.

Clinical Trials

Routine costs associated with Qualifying Clinical Trials. If your patient is eligible to participate in an approved clinical trial (according to trial protocol), with respect to treatment of cancer or other life-threatening disease or conditions, and either the referring provider is a participating provider who has concluded that participation in the trial would be appropriate, or you furnish medical and scientific information establishing that his or her participation in the trial would be appropriate, benefits shall be payable for routine patient costs for items and services furnished in connection with the trial. We must be notified in advance of the member's participation in the qualifying clinical trial.

Covered Preventative Medications

Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen, and raloxifene are considered preventive medications and are covered at no cost to the member when filled at a participating pharmacy with a valid prescription. If you or the member have questions about whether a preventive

medication is covered, call Member Services at **1-888-888-1211** (**TTY 1-877-454-8477**).

Dental
KidzPartners contracts with Avesis, a dental benefits administrator/subcontractor. All members are offered dental services effective the first day of eligibility as KidzPartners members. Coverage includes:

- Diagnostic and Treatment Services
- Preventative Services,
- Palliative Treatment of Dental Pain
- Minor Restorative Services
- Endodontic Services
- Periodontal Services
- Prosthodontic Services
- Major Restorative Services.

Certain services, including all endodontic, prosthodontic, orthodontic, SPU and non-emergent oral and maxillofacial surgical services, require prior authorization by the dental benefits subcontractor. All dental procedure(s) that require hospitalization must be prior authorized by our Inpatient Services department. Appropriate documentation must be provided when requesting prior authorization.
Members can receive dental services from a participating primary care dentist. All they have to do is choose a dentist from the list of dentists in the online KidzPartners Provider Directory. Prior authorization is not required to be seen by dental specialists, however the primary care dentist will coordinate members to dental specialists according to the policies defined by the dental subcontractor and approved by us.

Diabetes Self-Management Training and Education
Outpatient Diabetes Self-Management Training and Education services furnished to an individual with diabetes are covered by KidzPartners when performed by a provider with Outpatient Diabetes Education Program recognition from the American Diabetes Association. For more information or for help finding a participating provider, the member or PCP should call the Provider Services Helpline or members can call the Member Relations department. For more information, please visit Chapter 1 for Contact Information.

Diabetes Self-Management Supplies
Formulary diabetic test strips, lancets, glucose meters, syringes, and alcohol swabs are covered under the pharmacy benefit. These supplies can be obtained from any KidzPartners participating pharmacy with a prescription. Please refer to the formulary located on our Formulary webpage for more information.

Dialysis
Hemodialysis and peritoneal dialysis are covered benefits. Members requiring these services should be directed to a participating specialist. Most dialysis patients are eligible for Medicare benefits. In this case, KidzPartners becomes secondary insurance. Dialysis services do not need prior authorization.
Please remember to submit a 2728-U form for members with end-stage renal disease (ERSD). If a 2728-U form is not filed, KidzPartners' Enrollment department will contact the dialysis center and request a copy.

Durable Medical Equipment (DME)
Durable Medical Equipment is covered, so long as the provider directs patients to a KidzPartners participating DME vendor.
Key points to remember when prescribing DME items for KidzPartners members:

- All **purchased** DME items and outpatient services less than $500 per claim line DO NOT require prior authorization from KidzPartners.
- All DME **rentals** require prior authorization, regardless of reimbursement value.
- If any portion of a purchased customized DME device has a reimbursement value greater than $500, an authorization is required for the entire DME device.
- When the patient is renting a DME product covered by their previous insurer, it is the DME provider's responsibility to provide Jefferson Health Plans with the following information:
  - Clinical documentation
  - Physician orders
  - Number of months covered by the previous insurer
  - Termination date of the member's previous insurance coverage

  If, at time of the member's transition, the DME rental is deemed medically necessary, Health Partners Plans will approve coverage up to a total maximum coverage period of 10 months (inclusive of the months covered by the previous insurer). If the DME rental is determined to not meet the criteria for medical necessity at time of the member's transition, the DME rental may only be approved for a period of up to two months (60 days) to ensure continuity of care.
- All special items that do not have their own HCPCS code (such as E1399) require prior authorization, regardless of reimbursement value.
- Authorizations are based on benefit coverage/medical necessity as defined

in Chapter 8 – Utilization Management of this manual.

If you have questions, please call our Outpatient Services department during regular business hours. Providers who need help with urgent issues after business hours (about DME or such other outpatient services, such as discharge planning placements, and home care) can also call Outpatient Services For more information, please visit Chapter 1 for contact information).and leave a message, which will be forwarded to an on-call nurse case manager.

Emergency Care

Emergency care and post-stabilization services in emergency rooms and emergency admissions are covered by KidzPartners for both participating and non-participating facilities, with no distinction for in- or out-of-area services. Copays may apply. Emergency care and post- stabilization services do not require prior authorization. Non-par follow-up care for an emergency is covered by KidzPartners, but plan staff will outreach to the member to appropriately arrange for services to be provided in-network, whenever possible.

Emergency Services (Act 68)

Members are instructed to go to the nearest emergency room or call 911 for emergency care. An emergency medical condition is defined by the Commonwealth's Department of Human Services as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual or, in respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

Members are required to call their PCP as soon as possible after receiving emergency care, and to arrange follow-up care through their PCP.

Emergency room services reported with a behavioral health diagnosis are processed through the member's medical benefit. In the case of emergency room evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act, the behavioral health vendor in the member's locality is responsible for the inpatient admission based upon the member's primary diagnosis.

Emergency room services that convert to Observation (OBS) reported with a behavioral health diagnosis is processed through the member's medical benefit and reimbursed at the OBS contracted rate.

Transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service if the condition is as described above.

Family Planning
Family planning counseling services are covered by our plan. If the PCP does not perform these services, he/she should refer the member to an obstetrician/gynecologist (Ob/Gyn), nurse midwife or a Family Planning Council site. Members have the option to self-refer to the Family Planning Council, Ob/Gyn, or nurse midwife without prior approval from a PCP. Members are not required to obtain family planning services from an in-plan provider. For further information, providers can call (on behalf of their members) KidzPartners Member Relations. Please see Chapter 1 for contact information.

Fitness Program Membership
Exercise helps children stay healthy and feel good about themselves. That's why KidzPartners offers special memberships at participating area YMCAs and other fitness centers. KidzPartners members qualify for a one-year membership from the enrollment date. Once a fitness center is selected, the member is locked into the selected facility for one year. There are no minimum visit requirements or copays.

Foot Care
Medical and/or surgical treatment of conditions of the feet, such as, but not limited to, bunions, ingrown toenails, plantar warts and hammer toes, are covered. Treatment of corns, calluses, nails of feet, flat feet, fallen arches, chronic foot strain or symptomatic complaints of the feet, are not covered unless associated with disease affecting the lower limbs which requires the care of a podiatrist or a physician. No prior authorization is needed.

Gynecological and/or Obstetric Examinations
The PCP may perform routine gynecological exams and/or refer members to gynecologists as appropriate. Members may self-refer to Ob/Gyn specialists or nurse midwives for any routine gynecological and/or maternity services without prior approval from a PCP. Members receiving maternity care from an out-of-network Ob/Gyn at the time of enrollment may continue to receive services from that provider throughout the pregnancy and postpartum period.

- Pennsylvania's Medical Assistance Program (Medicaid) requires all Obstetrical Needs Assessment Forms (ONAFs) to be submitted electronically online via Optum's portal at obcare.optum.com.

Providers can call our Baby Partners unit to advise us of a pregnant member and/or members who are at risk of poor birth outcomes during business hours or our 24-hour Member Relations line to arrange to have their care coordinated by our care management team.

Hearing Care Services
Hearing aids and devices and the fitting and adjustment of such devices are covered when determined to be medically necessary.

Benefits Limits: One routine hearing examination and one audiometric examination per 12 months. Hearing aids are covered for 1 device per ear every 24 months. Prior authorization is required. Related hearing aid services (fittings, molds, accessories <including batteries>) are covered and do not require prior authorization unless over $500.

Home Health Care
Home Care services are covered when medically necessary KidzPartners can facilitate the following care in the home when medically necessary: registered nurse, physical therapy, occupational therapy, speech therapy, and medical social worker intermittent visits. Prior authorization is required for all home health services except the initial evaluation. Parenteral and enteral nutrition, respiratory therapy, and IV antibiotic therapy are also covered home care benefits if they have been authorized prior to the care.
One maternity home health care visit may be provided within 48 hours of discharge and the second is recommended to take place within 21-56 days post-delivery. Additional post-delivery home care visits will require prior authorization.

Hospice Care
Health Partners Plans will refer members to a participating hospice if they wish to elect hospice coverage. Members may remain enrolled in Health Partners Plans even though they have elected hospice coverage. If a member requires hospice care, the provider's request must include a signed prescription/order Certificate of Terminal Illness (COTI) (consent by member, not the medical director of the servicing hospice). Health Partners Plans follows PA Charter 1130. The MA Program covers hospice care furnished to eligible MA recipients by hospices enrolled in the Program. Payment for hospice care is subject to this chapter, Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the procedures listed in the MA Program fee schedule.

Use the home care/hospice request form available at on our Forms and Supply Request webpage.

If the required documents electing hospice are not signed timely based on regulatory requirements, then services being rendered are not authorized or approved. KidzPartners will cover hospice services when:

- a doctor certifies that the patient is terminally ill and is expected to live six (6) months or less; and
- a patient chooses to receive palliative care only instead of therapeutic care for the terminal illness; and
- care is provided by a Health Partners Plans participating hospice program.

The hospice benefit is in-home palliative and supportive medical, nursing and other healthcare services, which are designed to meet the special physical, psychological, spiritual and social needs of dying members and their families (spouse and children, siblings of a terminally ill child, and other persons involved in caring for the individual).

When hospice services in home are not able to be maintained due to lack of social support or symptom management, an inpatient setting may be indicated and would require prior authorization. For more information, please visit Chapter 1 for contact information.

Coverage under the above noted T-codes includes:

- Physician and nursing services
- Medications including outpatient prescription drugs for pain relief and symptom management
- Physical, occupational and speech therapy
- Medical social services and counseling to beneficiary and family members
- Short-term inpatient care, including respite care (a short stay intended to give temporary relief [up to five days in a row to the person who regularly assists with home care]) is covered while in hospice program.

Health Partners Plans' reimbursement to hospice providers includes services rendered by non-hospice providers for conditions related to the member's terminal illness. Therefore, any service provided that is related to the terminal illness should be reported to the hospice provider directly for reimbursement.
These related services include but not limited to pharmacy, laboratory, durable medical equipment, and short-term inpatient stays.

For any service provided that is not related to the member's terminal illness, the following modifiers must be appended to all claims as appropriate:

GV - attending physician not employed or paid under arrangement by the patient's hospice provider.

- GV modifier should only be reported by the attending physician who is not employed by the hospice. The GV modifier can only be reported by a professional provider.

GW - service not related to the hospice patient's terminal condition.

- Shift Care services reported with HCPCS codes S9122-S9124 and MANNA services are separately reimbursed and do not require the -GW modifier for reimbursement.

Hospital Services

All medical hospital admissions, including those admitted through the emergency room, as well as elective admissions, must be called in to our Inpatient Services department for authorization within two business days. Transfers to non-participating facilities require prior authorization before transfer occurs. Prior authorization is needed, except in the following instances:

- medical emergency;
- inpatient maternity services
- urgently needed services obtained outside of the service area;
- when the plan approves, in advance, a stay in a hospital that does not participate with KidzPartners.

After the effective date of coverage, medically necessary care will be provided until discharge including room, meals and general nursing care in a semi-private room (unless other accommodations are medically necessary):

- Physician services
- Special care units such as intensive care or coronary care units
- Special diets, when medically necessary
- Blood transfusions and their administration
- X-ray, laboratory and other diagnostic tests
- Services and supplies furnished by the hospital for inpatient medical and surgical treatment
- Operating and recovery room
- Oxygen, medication and anesthesia
- Use of durable medical equipment such as wheelchairs
- Rehabilitation services such as physical therapy, occupational therapy and speech pathology

- Inhalation therapy, chemotherapy, and radiation therapy
- Kidney, heart, heart/lung, lung, liver, bone marrow and corneal transplants for approved indications in Medicare-certified transplant facilities or transplant facilities approved by the plan
- Maintenance dialysis in an approved renal dialysis facility or hospital

Preadmission services: In alignment with CMS' policy/billing guidelines, preadmission diagnostic and non-diagnostic services related to the admission that are rendered during the 3 days (hospitals subject to IPPS, inpatient prospective payment system) or 1 day (hospitals excluded from IPPS) prior to an inpatient hospital admission (even if the days cross the calendar year) are considered inpatient services and included in the inpatient reimbursement. Preadmission services may be subject to post-payment audits and retraction.

The PCP (or the covering hospital physician or hospitalist) should make rounds on admitted patients regularly regardless of the provider admitting the patient. KidzPartners will look to the PCP for assistance in ensuring appropriate utilization of hospital services.

In the event of a serious or life-threatening emergency, the member should be directed to the nearest emergency facility.

Immunizations
All child immunizations are a covered benefit under the KidzPartners Preventive/Well-Child Care benefit.

Immunizations and Screenings

- Coverage will be provided for pediatric Immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control (CDC), U.S. Department of Health and Human Services. Pediatric and Adult Immunization ACIP schedules may be found by accessing the following link: https://www.cdc.gov/vaccines/schedules/index.html.
- **Influenza Vaccines** can be administered by a participating pharmacy for members starting at the age of nine years old, with parental consent, according to PA Act 8 of 2015.
- **Health education:** A child's PCP will provide information and advice on important health issues, including prevention/cessation of all types of tobacco use, and healthy eating habits.

- **Developmental screening:** Checkups by a child's PCP will include screenings to check that your children's physical and learning development are on track.
- **Allergy diagnosis and treatment:** For children exhibiting symptoms of possible allergies, preventive care includes diagnosis and treatment.
- **BMI:** Body Mass Index (BMI) may help you determine whether the member is at risk for obesity.
- **Young women's health screens:** As your members become young women, routine women's health care should include checkups, Pap tests and breast exams. Check with the child's PCP for more information.

Injectables

Certain injectables, such as oncology products and/or home infusion/IV formulations, are covered as a medical benefit. For injectables covered under the pharmacy benefit, please see information about our Specialty Medication Program located in the Pharmacy section of this chapter. Please refer to the formulary located on our Formulary webpage for more information regarding specific coverage such as prior authorization, for specialty medications.

JW Modifier

Effective January 1, 2017, physicians and hospitals are required to use the JW modifier to identify discarded drugs and biologicals. The JW modifier is used to report a discarded/unused portion of a drug.

The JW modifier is reported on drug claims to report the amount of drug or biological that is discarded and eligible for payment. The JW modifier requirement applies to all separately payable drugs assigned status indicators G or K under CMS OPPS for which there is an unused or discarded amount. Eligible and participating 340B providers are not exempt from reporting the JW modifier. The JW modifier is not intended for use on claims for hospital inpatient admissions.

When a provider must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological, payment is made for the amount of drug or biological discarded as well as the dose administered, up to amount of the drug or biological as indicated on the vial or package label. The discarded drug amount should be billed on a separate line on the claim with the JW modifier. The administered amount should be billed on a separate line without the modifier. *NOTE: Multi-use vials are not subject to payment for discarded amounts of drug or biological.*

Laboratory
Outpatient laboratory services are provided through Health Partners Plans' vendor, Quest Diagnostics, and also hospital locations contracted for laboratory services. Locations of participating labs can be found via our online provider directory. Physicians must complete the requisition form for laboratory services rendered by Quest. Laboratories must be CLIA-approved for participation in the Medical Assistance Program.

Mammograms
Screening mammographic examinations are covered annually. Members may self-refer for mammograms to any participating site that provides this screening. No authorization is needed if the provider is in the KidzPartners network.

Maternity Care
Prenatal care, delivery and postpartum care are covered. These services do not require prior authorization or PCP referrals. There are no limits to OB visits for prenatal care.

Through our Baby Partners program, KidzPartners provides all pregnant moms with important information about prenatal dental care (e.g., moms who take good care of their teeth have healthier babies). Dental insurance covers routine prophylaxis (including cleaning, scaling and polishing of teeth) once every 6 months, with the exception of a member under the care of a medical professional for pregnancy, who shall be eligible for one additional prophylaxis during pregnancy.
Staying with KidzPartners throughout your pregnancy will help assure that you and your baby receive all necessary care.

KidzPartners offers its pregnant members additional assistance through our Baby Partners program. For more information on our Baby Partners program, members can contact Member Relations at **1-888-888-1211** or the Baby Partners line at **1-866-500-4571 (TTY 1-877-454-8477)**.

CHIP coverage will be extended to babies born to CHIP members for 31 days. It is important to apply for Medical Assistance or CHIP right after the birth of the child to provide continued coverage for the baby. Only one application needs to be completed to apply for both programs.

Maternity Services
A female member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Hospital and physician care services relating to antepartum, intrapartum, and postpartum care, including complications resulting from the member's pregnancy or delivery, are covered.

Under federal law, health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Coverage is also provided for at least one (1) home health care visit following an inpatient release for maternity care when the CHIP member is released prior to forty-eight (48) hours for a normal delivery and ninety-six (96) hours for a caesarean delivery in consultation with the mother and provider, or in the case of a newborn, in consultation with the mother or the newborn's authorized representative. Home health care visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed health care provider whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the provider. Home health care visits following an inpatient stay for maternity services are not subject to copayments, deductibles, or coinsurance, if otherwise applicable to this coverage.

Medical Supplies
Perishable but medically necessary items that are used to treat injuries (including anklets, bandages, soft cervical collars, casts, cartilage knee braces, clavicle straps, wrist splints wrist/forearm splints, cock-up splints, elastic bandages, nasal splints, slings, finger splints, cold/hot packs, and straps for tennis elbow) and that have a specific HCPCS code do not require prior authorization from Outpatient Services if items are less than $500 per claim line.

Medical Visits
Outpatient medical visits performed in a physician's office, hospital, skilled nursing facility, or at home, by a KidzPartners participating physician/provider, are covered.

Member Education Classes
KidzPartners offers educational programs in many communities. Classes include ones to help children quit smoking, have a healthy baby, and become a better parent. KidzPartners also offers education to help members deal with special health problems, like asthma. Information about these and other education sessions can be found in the member newsletter. Members can also call the Member Relations department for details about current classes.

Mental Health and Substance Abuse Treatment
Mental Health and Substance abuse services are provided through a subcontractor, Magellan Behavioral Health. There is no limits or copays for these services. All services other than emergency must be authorized by Magellan Behavioral Health. Members should call **1-877-710- 8222** to obtain mental health or substance abuse services.

All drug and alcohol abuse treatment must be authorized by Magellan Behavioral Health.

Newborn Care
Newborns are covered under the mother's insurance for 31 days following birth. Services include, but are not limited to, routine nursery care, prematurity services, newborn hearing screens, preventive/well-child healthcare services and coverage for injury or sickness including the necessary care and treatment of medically-diagnosed congenital defects and birth abnormalities.

Orthodontics
KidzPartners offers comprehensive orthodontic treatment and other orthodontic services provided by the CHIP program. Services must be medically necessary and require prior authorization.
Braces for cosmetic reasons are not covered.

Pediatric Preventive Care
Pediatric preventive care includes the following, with no cost-sharing or copays:

- Physical examination, routine history, routine diagnostic tests.
- Oral Health Risk Assessment, fluoride varnish for children ages five months -five years old (US Preventative Task Force Recommendation)
- Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling.
- Blood lead screening and lead testing to detect elevated lead levels in the blood.
- Hemoglobin/Hematocrit to measure the size, shape, number and content of red blood cells.

Pharmacy
The KidzPartners drug benefit has been developed to cover medically necessary prescription products for self-administration in an outpatient setting. Non-self-administered drugs in the outpatient setting — not covered under the pharmacy

benefit — are available through the contractual buy and bill process based on Health Partners Plans medical fee schedule. The KidzPartners formulary and prior authorization processes are key components of the benefit design. Health Partners Plans, through its Pharmacy department, provides prescription benefits for our members with the use of a closed formulary. The KidzPartners formulary covers many generic drugs, with exceptions such as DESI (Drug Efficacy Study Implementation) drugs, medications used for weight gain or loss (except for drug products being used to treat AIDS wasting and cachexia), drugs from manufacturers who do not participate in the Federal Rebate program, and agents used for cosmetic purposes. Generic drugs must be prescribed and dispensed when an A- rated generic drug is available.

The drugs listed in the KidzPartners formulary are intended to provide broad options to treat the majority of patients who require drug therapy in an ambulatory setting. The medications included in the formulary are reviewed and approved by the plan's Pharmacy and Therapeutics Committee, which includes practicing physicians and pharmacists from the Health Partners Plans provider community. The goal of the formulary is to provide safe and cost-effective pharmacotherapy based on prospective, concurrent, and retrospective review of medication therapies and utilization. The formulary as well as drug specific prior authorization forms are posted on our website on our Formulary webpage.

For additional printed copies, please call Jefferson Health Plans.

A maximum of up to a 90-day supply of medication is eligible for coverage in an outpatient setting. Refills can be obtained when 80% of utilization has occurred. You are urged to prescribe in amounts that adhere to FDA guidelines and accepted standards of care.

The KidzPartners pharmacy benefit design features:

- No prescription limits for any group.
- Over-the-Counter (OTC) medications are covered. Specific covered agents are listed in the formulary.
- All groups have the same formulary and benefit design but may differ in copayment amounts.
- Copayments do not apply to specialty medications, diabetic supplies including test strips, glucose meters and lancets.
- Preferred diabetic supplies including test strips, glucose meters, lancets, syringes and insulin are covered and processed under the pharmacy benefit according to the formulary.

- Specialty medications are covered and processed under the pharmacy benefit with prior authorization, if applicable. The specialty vendor will be utilized for these services unless prior approval has been provided by the Pharmacy department. Please refer to the Formulary and Specialty Pharmacy webpages for more information and specific drug coverage.

Pharmacy Copay Design
Copayments for pharmacy benefits vary depending upon the level of coverage the member has. This design is:

- No Cost Group - no prescription copayments
- Low-Cost Group - copayments include
  - $6 generics
  - $9 brand
- Full Cost Group - copayments include
  - $10 generics
  - $18 brand

The formulary covers preferred, medically necessary prescription products. Certain listed over- the-counter (OTC) medications, such as aspirin and acetaminophen, are formulary and are covered with a doctor's prescription. Blood glucose test strips, alcohol swabs, syringes and lancets (along with one blood glucose monitor per year) are only covered through the pharmacy benefit with a prescription. The preferred diabetic supplies can be found on the formulary located on our Formulary webpage.

Pharmacy Prior Authorization
There are specific medications on the formulary that require prior authorization. Drug specific prior authorization forms are available to help expedite the process with specific clinical criteria on our Prior Authorization webpage. There may be occasions when an unlisted drug or non-formulary is desired for medical management of a specific patient. In those instances, the unlisted medication may be requested through a medical exception process using the "Non-formulary Prior Authorization" form.

To ensure that select medications are utilized appropriately, prior authorization may be required for the dispensing of specific products. These medications may require authorization for the following reasons:

- Non-formulary medications, or benefit exceptions requested for medical necessity
- Medications and/or treatments under clinical investigation

- Duplication of Therapy Edits will be hard coded to assure appropriate utilization of multiple drugs within the same therapeutic categories (e.g., duplication of two SSRIs)
- All brand name medications when there is an A-rated generic equivalent available
- Prescriptions that exceed set plan limits (day's supply, quantity, refill too soon, and cost)
- New-to-market products prior to review by the P&T Committee
- Orphan Drugs/Experimental Medications
- Selected injectable and oral medications
- Specialty medications
- Drugs that exceed FDA prescribing limits

To request a prior authorization the physician or a member of his/her staff should contact the Health Partners Plans' Pharmacy department at **1-866-841-7659**. All requests can be faxed (**1-866-240-3712**) 24 hours per day; calls should be placed from 8:00 A.M. to 6:00 P.M., Monday through Friday. In the event of an immediate need after business hours, the call should be made to Member Relations at **1-888-888-1211**. The call will be evaluated and routed to a clinical pharmacist on-call (24/7).

The physician may use the Health Partners Plans' drug specific forms or a letter of request, but must include the following information for a quick and appropriate review to take place:

- Specific reason for request
- Name and member number of member
- Date of birth of member
- Physician's name, license number, and specialty
- Physician's phone and fax numbers
- Name of primary care physician (PCP) if different
- Drug name, strength, and quantity of medication
- Day's supply (duration of therapy) and number of refills
- Route of administration
- Diagnosis
- Formulary medications used, duration and therapy result, and

documentation such as pharmacy records or chart notes

- Additional clinical information that may contribute to the review decision such as specific lab results

All forms should be legible and completely filled out. All prior authorization forms are available on our Prior Authorization webpage.

Upon receiving the prior authorization request from the prescriber, Health Partners Plans will render a decision within 24 hours. Approval or denial letters are mailed to the member or parent/guardian, in the case of a child. A copy of the member letter will also be faxed or mailed to the prescribing physician. At any time during normal business hours, the prescribing physician can discuss the denial with a clinical pharmacist or can have a peer-to-peer discussion with the medical director by calling the Pharmacy department at **1-866-841-7659**.

Whenever the Pharmacy department is unavailable for consultation or prior authorization for a new medication, an automated five (5) day supply of medication (if FDA approved) can be dispensed at the point of sale at the discretion of the dispensing pharmacist. In the case of a refill for a medication used continuously without a break of more than 30 days, or a PRN (as needed) medication used without a break of more than six months, a 15-day supply can be dispensed. This automated override is available one time per member per medication per year. Prior to dispensing medication, the pharmacy must confirm member eligibility.

If a member presents a pharmacy with a prescription, which requires prior authorization, whether for a non-formulary drug, or otherwise, and if the prior authorization cannot be processed immediately, the plan will allow the pharmacy to dispense an interim supply of the prescription under the following circumstances:

- If the recipient is in immediate need of the medication in the professional judgment of the pharmacist and if the prescription is for a new medication (one that the recipient has not taken before or that is taken for an acute condition), the plan will

allow the pharmacy to dispense a 5-day supply of the medication to afford the recipient or pharmacy the opportunity to initiate the request for prior authorization.

- If the prescription is for an ongoing medication (one that is continuously prescribed for the treatment of an illness or condition that is chronic in nature in which there has not been a break in treatment for greater than 30 days), the plan will allow the pharmacy to dispense a 15-day supply of the medication automatically, unless the plan mailed to the member, with a copy to the prescriber, an advanced written notice of the reduction or termination of the medication at least 10 days prior to the end of the period for which the medication was previously authorized.

Health Partners Plans will respond to the request for prior authorization within 24 hours from when the request was received. If the prior authorization is denied, the recipient is entitled to appeal the decision through several avenues. The 5-day or 15-day requirement does not apply when the pharmacist determines that taking the medication, either alone or along with other medication that the recipient may be taking, would jeopardize the health and safety of the member.

The goal of the drug benefit program is to provide safe and cost-effective pharmacotherapy to our members.

Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST)

Members may be referred for outpatient PT/OT/ST to a participating KidzPartners provider. Prior authorization is required for all outpatient PT/OT/ST. Requests should be addressed to eviCore, our delegated vendor. Prior authorization is not required for outpatient evaluation. This benefit covers up to 30 visits per year for each type of therapy.

Please note: Home Health Care is offered with no copayments and no limitations. This benefit can only be provided to a CHIP member who is

homebound by a home health care provider in the CHIP member's home within the service area.

Preventive "Well Child" Services
Preventive health services are designed to ensure early detection and treatment of conditions and illnesses in KidzPartners members. Services include physical examinations, immunizations, dental care, vision testing and treatment, hearing testing, and screening for certain medical conditions. Certain counseling services, such as pregnancy and STD prevention for sexually active adolescents, are also included.

Our Pediatric and Adolescent Preventive Care Flow Sheets, Screening Schedule, and Pediatric Immunization Schedule are designed to assist PCPs in delivering services. For more information, visit www.healthpartnersplans.com and refer to the "Clinical Information" web page within the Provider section. PCP success in delivering these vital pediatric preventive services in accordance with these standards will be closely audited by the plan. Please recognize that CHIP may cover services that are not on the Medical Assistance fee schedule, or that exceed the fee schedule in amount, duration or scope. Contact the plan for further information.

Primary and Preventive Health Services
KidzPartners periodically reviews the Primary and Preventive Care Covered Services based on recommendations from organizations such as The American Academy of Pediatrics, the American College of Physicians, the U.S. Preventive Services Task Force (USPSTF) (all items or services with a rate of A or B in the current recommendations), the American Cancer Society and the Health Resources and Services Administration (HRSA). Examples of covered "USPSTF A" recommendations are folic acid supplementation, chlamydial infection screening for non-pregnant women, and tobacco use counseling and interventions. Examples of covered "USPSTF B" recommendations are dental cavities prevention for preschool children, healthy diet counseling, oral fluoride supplementation/rinses and vitamins, BRCA risk assessment and genetic counseling and testing, prescribed Vitamin D, prescribed iron supplementation, mineral supplements, chlamydial infection screening for pregnant women, and sexually transmitted infections counseling. Examples of covered HRSA-required benefits include all Food and Drug Administration approved contraceptive methods, sterilization procedures, breast feeding equipment, and patient education and counseling for all women with reproductive capacity. All services required by HRSA are covered. Accordingly, the preventive services are provided at no cost to the member.

Prosthetics/Orthotics
Purchase and fitting of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body organ require prior authorization by the plan's Inpatient or Outpatient Services department.

Radiation Therapy
Radiation therapy services are covered and require prior authorization. Requests should be addressed to eviCore, our delegated vendor.

Reconstructive Surgery
Reconstructive Surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of 18; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a mastectomy.

Mastectomy and Breast Reconstruction: Benefits are provided for a mastectomy performed on an inpatient or outpatient basis, and for the following:

- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a mastectomy; and
- Physical complications of all stages of mastectomy, including lymphedemas.
- Coverage is also provided for one Home Health Care visit, as determined by the member's physician, received within forty-eight (48) hours after discharge.

Rehabilitation
Inpatient Rehabilitation services (medical and mental health are covered) in a KidzPartners participating rehabilitation facility. Inpatient rehabilitation requires prior authorization.

Skilled Nursing Facility
Inpatient care in a Skilled Nursing Facility (SNF) is covered in a KidzPartners participating skilled nursing facility. Services must be prior authorized by the plan's Inpatient Services department. Medically necessary skilled nursing and related

services are covered on an inpatient basis in semi-private accommodations for patients requiring skilled nursing services, but not requiring confinement in a hospital.

Smoking Cessation
Various smoking cessation services are available to our members to assist them in quitting smoking. Please visit our website at https://www.healthpartnersplans.com/health-and-wellness/healthier-you/quit-smoking for the most current reimbursable expenses. Smoking cessation programs generally include scheduled activities and meetings designed to help participants stop the habit of smoking. These programs are a covered benefit for KidzPartners members and do not require prior authorization from the member's PCP.

Specialist Visits
Services by non-participating physicians and other licensed non-participating allied health personnel will be covered only when prior authorized by the plan. Referrals are not required to receive care regardless of the provider participation status.

Specialty Medication Program
Health Partners Plans supports appropriate use of specialty medications and has established suppliers as well as procedures for appropriate prescribing and monitoring. Under the direction of the Health Partners Plans Pharmacy department, the physician provider has the primary responsibility for obtaining prior authorization for medications included in this program. The prescribing physician will need to send the completed medical request to the Health Partners Plans Pharmacy department by fax with all pertinent lab information at **1-866-240-3712**.

Specialty medications are higher cost, biologics, injections or oral medications that require special handling, monitoring, or have limited distribution per manufacturer or FDA guidelines. They are used to treat complex, chronic, and often costly conditions such as rheumatoid arthritis, hepatitis C and hemophilia. Specific specialty pharmacy vendors who have met high quality measures and accreditation are contracted with Health Partners Plans to handle and distribute these medications.

All requests for prior authorization are reviewed by the Pharmacy department for approval. Approvals, including approvals for shorter durations, are coordinated with the contracted specialty vendor for distribution to the provider's office or member's home.

In addition, the prescriber can always call Health Partners Plans' Pharmacy department at **1-866-841-7659** for assistance with prior authorization on specialty medications and preferred specialty vendors. Specific specialty prior authorization forms are available on our Prior Authorization webpage.

Certain specialty medications are processed through the Pharmacy department and require a prior authorization. Please refer to the formulary and the website for more information regarding specialty medications, drug specific prior authorization forms, and preferred vendors. For further information visit our Specialty Pharmacy webpage.

Suturing
PCPs are reimbursed fees for suturing performed in their offices.

Transportation (Non-Emergent)
Non-emergent transportation services are not covered.

Vision Care
KidzPartners covers vision care for all members through our subcontracted provider, Davis Vision. Members can choose a vision care provider from the online KidzPartners Provider Directory.

Visits for routine eye exams and glasses or medically necessary contacts are covered. A participating vision provider must be used. There are no copayments for routine eye examinations.
*If any vision service is provided under the medical benefit for a diagnosis of cataracts, keratoconus or aphakia, then a copayment may apply.

Frames and Lenses: One set of eyeglass lenses that may be plastic or glass, single vision, bifocal, trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low vision items.

Frequency of eye exam: One routine examination and refraction every 12 months. The examination includes dilation, if professionally indicated. There is no cost to member in network services. There is no coverage for out-of-network *.

Frequency of lens and frame replacement: One pair of eyeglasses every 12 months, when medically necessary for vision correction.

Lenses: In Network – One pair covered in full every calendar year. There is no coverage for out- of-network.* There are no copayments for covered standard eyeglass lenses (single vision, conventional (lined) bifocal, conventional (lined) trifocal, and lenticular).

Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses.

Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters.

All lenses include scratch resistant coating.

There may be copayments for optional lens types and treatments:

Ultraviolet Protective Coating	**$15**
Polycarbonate Lenses (if not child, monocular or prescription	**$35**
Blended Segment Lenses	**$20**
Intermediate Vision Lenses	**$30**
Standard Progressives	**$65**
Premium Progressives (Varilux®, etc.)	**$105**
Photochromic Glass Lenses	**$20**
Plastic Photosensitive Lenses (Transitions®)	**$65**
Polarized Lenses	**$75**
Standard Anti-Reflective (AR) Coating	**$40**
Premium AR Coating	**$55**
Ultra AR Coating	**$69**
Hi-Index Lenses	**$60**

Frames: Collection Frame – no cost to member.** Non-collection frame: Expenses in excess of $100 allowance payable by member. Additionally, a 20% discount applies to any amount over $100.** There is no coverage for out-of-network services.*

Replacement of lost, stolen or broken frames and lenses, (one original and one replacement per calendar year), when deemed medically necessary.

Contact Lenses: One prescription every year – in lieu of eyeglasses or when medically necessary for vision correction.

Expenses in excess of a $100 allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount applies to any amount over $100.**

Note: In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the Contact Lenses received is less than the allowance, members may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance).

**Out-of-network exclusion only applies if child is in their coverage area at time of eyeglass/contact replacement. If a child is unexpectedly out of the area, e.g., vacation, and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement.*

***Note: Additional discounts **may be** available from participating providers.*

Expenses in excess of $600 for medically necessary contact lenses, with pre-approval — these conditions include:

> Aphakia, pseudophakia or keratoconus, if the patient has had cataract surgery or implant, or corneal transplant surgery, or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses.

KidzPartners covers routine vision exams. (Treatment of other eye problems may be covered as a medical benefit. The child's PCP can refer you to an eye specialist if necessary.)

When your children need a vision exam, just check your KidzPartners Provider Directory or call Member Relations at **1-888-888-1211 (TTY 1-877-454-8477)** for help finding a convenient vision care provider. When you call to make an appointment, be sure to tell the office your children are members of KidzPartners. Remember to bring your children's membership ID cards with you to the appointment.

Vision benefit for children also includes one comprehensive low vision evaluation every 5 years, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care - four visits in any five-year period, with a maximum charge of $100 per visit.

Providers will obtain the necessary pre-authorization for these services. The benefit is not covered if performed by an out of network provider.

Well Woman Preventive Care
There is no cost sharing for preventative services under the services of family planning, women's health, and contraceptives.

Well Woman Preventive Care includes services and supplies as described under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act. Covered Services and Supplies include, but are not limited to, the following:

- **Routine Gynecological Exam, Pap Smear**: Female Members are covered for one (1) routine gynecological exam each year. This includes a pelvic exam and clinical breast exam; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Female Members have "direct access" to care by an Obstetrician or Gynecologist. This means there is no Primary Care Physician referral needed.
- **Mammograms**: Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Copayments, if any, do not apply to this benefit.
- **Breastfeeding:** Comprehensive support and counseling from trained providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under DME with medical necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the Member.
- **Contraception**: FDA-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; voluntary sterilization procedures, and patient education and counseling, not including abortifacient drugs, at no cost share to the member. Contraception drugs and devices are covered under the prescription drug benefit issued with the plan.
- **Osteoporosis Screening (Bone Mineral Density Testing or BMDT):** Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration- approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a professional provider legally authorized to prescribe such items.

Non-Covered Services

The following services and benefits are excluded or limited under the KidzPartners plan:

- Artificial insemination/infertility treatment
- Cosmetic surgery, except to correct a serious disfigurement or deformity caused by disease or injury that occurred while the patient was a participating member; or for the treatment of congenital anomalies to restore a part of the body to its proper function
- Health club memberships except when stipulated by contract with the plan
- Personal convenience items or services
- Reversal of tubal ligation
- Services available through other programs such as workers' compensation, Veterans Administration, other governmental programs/agencies or other insurance coverage
- Services for which neither the member nor another party on his or her behalf has any legal obligation to pay
- Services not provided by, or arranged through a provider, medical office, or dental office participating with KidzPartners, except for emergency services, unless authorized by the plan
- Services not reasonable or medically necessary for the diagnosis or treatment of an illness or injury, or for restoration of physiologic function (except preventive services)
- Services performed by immediate relatives of members, or by others in the member's household
- Non-Emergent Transportation services

Medical Directors will not approve services that are deemed harmful to our members, are of inferior quality, or are medically unnecessary (as may be the case with a serious and clearly preventable adverse event). In addition, based on CMS guidelines, financial compensation for any and all services rendered as a result of, or increased by, a preventable serious adverse event will be withheld or recovered.

Chapter 7: Jefferson Health Plans Individual and Family Plans Summary of Benefits

Purpose: This chapter provides an overview of the benefits available to Jefferson Health Plans Individual and Family Plans members.

Topics: Important topics from this chapter include:

Summary of Benefits
Prior Authorization Requirements
2024 Preventive Benefit Schedule

Overview

This chapter provides an overview of the benefits for Jefferson Health Plans Individual and Family Plans members who are entitled to, and guidelines for, appropriately utilizing authorizations.

Note: The guidelines provided in this document do not address all benefit packages available to Jefferson Health Plans Individual and Family Plans members. If a conflict exists between this document and the member's benefit package, the benefit package takes precedence.

Summary of Benefits

The following chart is a quick reference that lists many Jefferson Health Plans Individual and Family Plans benefits and services. It indicates whether an authorization is required and summarizes important guidelines. Additional information about covered and non-covered services follows this chart.

Prior authorization is **always required** for out-of-network services, except emergency/urgent care, maternity care, family planning services and renal dialysis services.

Jefferson Health Plans Individual and Family Plans

Below is a detailed list of our health plans based on a member's enrollment status in Jefferson Health Plans Individual and Family Plans.

QHP ID	Plan Name
93909PA0010001-00	*Jefferson Health Plans + $0 Deductible + Bronze + HMO + Off Exchange*
93909PA0010001-01	*Jefferson Health Plans + $0 Deductible + Bronze + HMO + On Exchange*
93909PA0010001-02	*Jefferson Health Plans + $0 Deductible + Bronze + HMO + No Cost Sharing*
93909PA0010001-03	*Jefferson Health Plans + $0 Deductible + Bronze + HMO + Limited Cost Sharing*
93909PA0010002-00	*Jefferson Health Plans + Total + Bronze + HMO + Off Exchange*
93909PA0010002-01	*Jefferson Health Plans + Total + Bronze + HMO + On Exchange*
93909PA0010002-02	*Jefferson Health Plans + Total + Bronze + HMO + No Cost Sharing*
93909PA0010002-03	*Jefferson Health Plans + Total + Bronze + HMO + Limited Cost Sharing*
93909PA0010003-00	*Jefferson Health Plans + $0 Deductible + Silver + HMO + Off Exchange*
93909PA0010003-01	*Jefferson Health Plans + $0 Deductible + Silver + HMO + On Exchange*
93909PA0010003-02	*Jefferson Health Plans + $0 Deductible + Silver + HMO + No Cost Sharing*
93909PA0010003-03	*Jefferson Health Plans + $0 Deductible + Silver + HMO + Limited Cost Sharing*

93909PA0010003-04	*Jefferson Health Plans + $0 Deductible + Silver + HMO + 73%*
93909PA0010003-05	*Jefferson Health Plans + $0 Deductible + Silver + HMO + 87%*
93909PA0010003-06	*Jefferson Health Plans + $0 Deductible + Silver + HMO + 94%*
93909PA0010004-00	*Jefferson Health Plans + Balanced + Silver + HMO + Off Exchange*
93909PA0010004-01	*Jefferson Health Plans + Balanced + Silver + HMO + On Exchange*
93909PA0010004-02	*Jefferson Health Plans + Balanced + Silver + HMO + No Cost Sharing*
93909PA0010004-03	*Jefferson Health Plans + Balanced + Silver + HMO + Limited Cost Sharing*
93909PA0010004-04	*Jefferson Health Plans + Balanced + Silver + HMO + 73%*
93909PA0010004-05	*Jefferson Health Plans + Balanced + Silver + HMO + 87%*
93909PA0010004-06	*Jefferson Health Plans + Balanced + Silver + HMO + 94%*
93909PA0010005-00	*Jefferson Health Plans + Total + Silver + HMO + Off Exchange*
93909PA0010005-01	*Jefferson Health Plans + Total + Silver + HMO + On Exchange*
93909PA0010005-02	*Jefferson Health Plans + Total + Silver + HMO + No Cost Sharing*
93909PA0010005-03	*Jefferson Health Plans + Total + Silver + HMO + Limited Cost Sharing*
93909PA0010005-04	*Jefferson Health Plans + Total + Silver + HMO + 73%*
93909PA0010005-05	*Jefferson Health Plans + Total + Silver + HMO + 87%*
93909PA0010005-06	*Jefferson Health Plans + Total + Silver + HMO + 94%*
93909PA0010006-00	*Jefferson Health Plans + $0 Deductible + Gold + HMO + Off Exchange*
93909PA0010006-01	*Jefferson Health Plans + $0 Deductible + Gold + HMO + On Exchange*
93909PA0010006-02	*Jefferson Health Plans + $0 Deductible + Gold + HMO + No Cost Sharing*
93909PA0010006-03	*Jefferson Health Plans + $0 Deductible + Gold + HMO + Limited Cost Sharing*
93909PA0010007-00	*Jefferson Health Plans + Total + Gold + HMO + Off Exchange*
93909PA0010007-01	*Jefferson Health Plans + Total + Gold + HMO + On Exchange*
93909PA0010007-02	*Jefferson Health Plans + Total + Gold + HMO + No Cost Sharing*
93909PA0010007-03	*Jefferson Health Plans + Total + Gold + HMO + Limited Cost Sharing*
93909PA0010008-00	*Jefferson Health Plans +$0 Deductible Value + Silver + HMO + Off Exchange*
93909PA0010009-00	*Jefferson Health Plans + Balanced Value+ Silver + HMO + Off Exchange*
93909PA0010010-00	*Jefferson Health Plans + Total Value + Silver + HMO + Off Exchange*

Jefferson Health Plans Individual and Family Plans Coverage

The following table list the coverage of benefits available to Jefferson Health Plans Individual and Family Plans members and any prior authorization associated with those services. Members cost share will vary based on the plans listed above. Members and providers should follow the process below to confirm coverage and cost share. Coverage is also based on Provider network tier based on the current Individual and Family Plans network. Please check the provider portal to confirm current tier.

1. Members should reach out to Jefferson Health Plans Member service team, and, Providers should utilize our Jefferson Health Plans Provider Services Helpline. See contact information in Chapter 1.
2. Receive written and verbal confirmation of the service coverage.
3. Determine if Prior Authorization is needed or has been completed.
4. Schedule service*.
5. Follow up with Jefferson Health Plans with any issues or questions.

* Coverage should be confirmed with Jefferson Health Plans before procedure is scheduled or performed

Plan Name	Includes all Individual and Family Plans: Bronze, Silver, Gold, Off Exchange Plans*		
	Tier 1	Tier 2	Out-of-Network
Accidental Dental	Covered	Covered	Not Covered
Dental Check-Up for Children	Not Covered	Not Covered	Not Covered
Basic Dental Care - Child	Not Covered	Not Covered	Not Covered
Major Dental Care - Child	Not Covered	Not Covered	Not Covered
Orthodontia - Child	Not Covered	Not Covered	Not Covered
Routine Dental Services (Adult)	Not Covered	Not Covered	Not Covered
Basic Dental Care - Adult	Not Covered	Not Covered	Not Covered
Major Dental Care - Adult	Not Covered	Not Covered	Not Covered
Orthodontia - Adult	Not Covered	Not Covered	Not Covered
Vision Services			
Eyeglasses for Children (1 Item per Plan Year)	Covered	Covered	Not Covered
Routine Eye Exam (Adult)	Not Covered	Not Covered	Not Covered
Routine Eye Exam for Children (1 Exam per Plan Year)	Covered	Covered	Not Covered
Medical Services			
Abortion for Which Public Funding is Prohibited	Covered	Covered	Not Covered
Acupuncture	Not Covered	Not Covered	Not Covered
Allergy Testing	Covered	Covered	Not Covered
Bariatric Surgery	Not Covered	Not Covered	Not Covered
Chemotherapy	Covered	Covered	Not Covered
Chiropractic Care (20 visits per year)	Covered	Covered	Not Covered

Cosmetic Surgery	Not Covered	Not Covered	Not Covered
Delivery and All Inpatient Services for Maternity Care	Covered	Covered	Not Covered
Diabetes Education	Covered	Covered	Not Covered
Dialysis	Covered	Covered	Not Covered
Durable Medical Equipment	Covered	Covered	Not Covered
Emergency Room Services	Covered	Covered	Covered
Emergency Transportation/Ambulance	Covered	Covered	Covered
Gender Affirming Care	Not Covered	Not Covered	Not Covered
Habilitation PT/OT Services (30 combined per Year)	Covered	Covered	Not Covered
Habilitation Speech Therapy Services (30 per Year)	Covered	Covered	Not Covered
Hearing Aids	Not Covered	Not Covered	Not Covered
Home Health Care Services (60 Visits per Year)	Covered	Covered	Not Covered
Hospice Services	Covered	Covered	Not Covered
Imaging (CT/PET Scans, MRIs)	Covered	Covered	Not Covered
Infertility Treatment (Artificial Insemination)	Covered	Covered	Not Covered
Infusion Therapy	Covered	Covered	Not Covered
Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Covered	Not Covered
Inpatient Physician and Surgical Services	Covered	Covered	Not Covered
Laboratory Outpatient and Professional Services	Covered	Covered	Not Covered
Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered	Not Covered
Mental Health/Substance Abuse Outpatient Visits	Covered	Covered	Not Covered
Mental/Behavioral Health/SUD Inpatient Services	Covered	Covered	Not Covered
Nutritional Counseling (6 visits per Year)	Covered	Covered	Not Covered
Other Practitioner Office Visit	Covered	Covered	Not Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Covered	Not Covered
Outpatient Cardiac, Pulmonary, and Respiratory Rehabilitation Services (36 Visits per Year)	Covered	Covered	Not Covered
Outpatient Surgery Physician/Surgical Services	Covered	Covered	Not Covered
Prenatal and Postnatal Care	Covered	Covered	Not Covered
Preventive Care/Screening/Immunization	Covered	Covered	Not Covered
Primary Care Visit to Treat an Injury or Illness	Covered	Covered	Not Covered
Private Duty Nursing	Not Covered	Not Covered	Not Covered
Prosthetic Devices	Covered	Covered	Not Covered
Radiation Inpatient and Outpatient Physician Services	Covered	Covered	Not Covered
Radiation Office Visit	Covered	Covered	
Reconstructive Surgery	Covered	Covered	Not Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy (30 visits combined per year)	Covered	Covered	Not Covered
Rehabilitative Speech Therapy (30 visits per year)	Covered	Covered	Not Covered

Routine Foot Care	Not Covered	Not Covered	Not Covered
Skilled Nursing Facility (120 Inpatient days per year)	Covered	Covered	Not Covered
Specialist Visit	Covered	Covered	Not Covered
Tobacco Cessation (2 attempts per year))	Covered	Covered	Not Covered
Transplant	Covered	Covered	Not Covered
Treatment for Temporomandibular Joint Disorders	Not Covered	Not Covered	Not Covered
Urgent Care Centers or Facilities	Covered	Covered	Not Covered
Virtual Care - Primary Care Visit	Covered	Covered	Not Covered
Virtual Care - Specialist Visit	Covered	Covered	Not Covered
Weight Loss Programs	Not Covered	Not Covered	Not Covered
Well Baby Visits and Care	Covered	Covered	Not Covered
X-rays and Diagnostic Imaging	Covered	Covered	Not Covered
Pharmacy Services			
Preventive Drugs	Covered	Covered	Not Covered
Generic Drugs Tier 1	Covered	Covered	Not Covered
Generic Drugs Tier 2	Covered	Covered	Not Covered
Preferred Brand Drugs	Covered	Covered	Not Covered
Non-Preferred Brand Drugs	Covered	Covered	Not Covered
Specialty Drugs	Covered	Covered	Not Covered

Prior Authorization for Inpatient Services

- Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. **FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A PENALTY OR DENIAL OF PAYMENT FOR THE SERVICES PROVIDED.**
- Prior Authorization can be obtained by the member, the member's Family Member(s) or the Provider by calling the number on the back of the ID card.
- To verify Prior Authorization requirements for inpatient services, including which other types of facility admissions require Prior Authorization, members can:
  - Call us at the number on the back of their ID card, or www.myjeffersonhealthplans.com
  - Visit our website at https://www.healthpartnersplans.com/providers/prior-authorization
- Please note that emergency admissions will be reviewed post admission.
- Inpatient Prior Authorization reviews both whether admission to the hospital and whether continued confinement in the hospital are Medically Necessary and eligible for coverage under the terms and conditions of this Policy.

Prior Authorization for Outpatient Services

- Prior Authorization is also required for certain outpatient procedures and services in order to be eligible for benefits. **FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO CERTAIN ELECTIVE OUTPATIENT PROCEDURES AND SERVICES MAY RESULT IN A PENALTY OR DENIAL OF PAYMENT FOR THE SERVICES PROVIDED.**
- Prior Authorization can be obtained by the member, the member's Family Member(s) or the Provider by calling the number on the back of the ID card.
- To verify Prior Authorization requirements for outpatient services, members can:
  - Call us at the number on the back of their ID card, orwww.myjeffersonhealthplans.com
    Visit our website at https://www.healthpartnersplans.com/providers/prior-authorization
- Please note that emergency admissions will be reviewed post admission.
- Inpatient Prior Authorization reviews both whether admission to the hospital and whether continued confinement in the hospital are Medically Necessary and eligible for coverage under the terms and conditions of this Policy.

Prior Authorization Is Not a Guarantee of Payment

- Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of this Policy, including limitations and exclusions, payment of Premium, and eligibility at the time care and services are provided.

Retrospective Review

- If Prior Authorization was not performed, we may use retrospective review to determine if a scheduled or emergency admission or other service was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this Policy subject any limitations and exclusions, payment of Premium and eligibility at the time care and services are provided. If it is determined that a service was not Medically Necessary, we will not cover any charges for that service.

Prior Authorization of Prescription Drugs

- Prior Authorization is required for certain Prescription Drugs and Related Supplies. For complete, detailed information about Prescription Drug authorization procedures, exceptions and Step Therapy, please refer to the section of this Policy titled "Prescription Drug Benefits."
- To verify Prior Authorization requirements for Prescription Drugs and Related Supplies, including which Prescription Drugs and Related Supplies require authorization, you can:

- Log on to https://www.jeffersonhealthplans.com/individuals-families/prescription-drugs/prior-authorization.

Note Regarding Prior Authorization of Inpatient Services, Outpatient Services, and Prescription Drugs

- Some services or therapies may require the use of particular providers approved by us for the particular service or therapy and will not be covered if received from any other Provider regardless of participation status.

For additional prior authorization guidelines, visit our Prior Authorization webpage.

Benefit Schedule

- The benefit schedule shows the Individual and Family Plans Deductible and Out-of-Pocket Maximums, and the maximum Covered Expense for each type of benefit.

- No benefits are payable unless the Insured Person's coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms, conditions, limitations and exclusions of this Policy.

- In addition, no benefits are payable unless the Insured Person receives services from a Participating Provider, except as indicated below under "Special Circumstances."

- Participating Hospitals, Participating Physicians and Other Participating Providers
  - Covered Expenses for services provided by Participating Providers are based on Our Negotiated Rate. Participating Providers have agreed NOT to balance bill Members for Covered Services beyond the Member cost share amounts set forth in the Policy. Participating Providers may charge the Insured Person for services that are not Covered Services under the Policy. In addition, Participating Providers will file claims with Us for the Insured Person and will request Prior Authorization when it is required.
  - Be sure to check with the Provider prior to an appointment to verify that the Provider is currently contracted with Us.

- Emergency Services
  - Covered Expenses incurred for the treatment of an Emergency Medical Condition provided in the emergency department of a Non-Participating Hospital or of a licensed outpatient emergency department are paid as described in the benefit schedule. Any additional expenses incurred for services of a Non-Participating Provider after the patient is Stabilized and his/her condition permits transfer to a Participating Hospital and/or to the care of a Participating Physician are not covered, except as stated in the

Other Circumstances section below. For such Covered Services, the Health Benefit Plan will reimburse the Non-Participating Hospital-Based Provider based upon the methodology established by the Consolidated Appropriations Act (CAA). The Member is protected from surprise billing, cannot be balanced billed, and will be subject to the in-network cost-sharing levels by the Non-Participating Hospital-Based Provider, and the Non-Participating Hospital-Based Provider cannot ask the Member to give up their protections not to be balanced billed. If the Member receives other services at a Participating Hospital or other Participating Facility Provider, Non-Participating Providers cannot balance bill the Member, unless the Member gives written consent and gives up the protections not to be balanced billed.

- Hospital-Based Provider
  - When Covered Services are received from a Hospital-Based Provider (including anesthesiologists, radiologists, pathologists and other ancillary providers) while Inpatient at a Participating Hospital or receiving outpatient Covered Services at a Participating Facility (i.e., hospital outpatient department or ambulatory surgical center) Provider and are being treated by a Participating Professional Provider, benefits will be received for the Covered Services provided by the Non-Participating Hospital-Based Provider. For such Covered Services, the Health Benefit Plan will reimburse the Non-Participating Hospital-Based Provider based upon the methodology established by the Consolidated Appropriations Act (CAA). The Member is protected from surprise billing, cannot be balanced billed, and will be subject to the in-network cost-sharing levels by the Non-Participating Hospital-Based Provider, and the Non-Participating Hospital-Based Provider cannot ask the Member to give up their protections not to be balanced billed. If the Member receives other services at a Participating Hospital or other Participating Facility Provider, Non-Participating Providers cannot balance bill the Member, unless the Member gives written consent and gives up the protections not to be balanced billed.
- Other Circumstances
  - Covered Expenses for non-emergency, Medically Necessary services of a Non-Participating Provider will be paid according to the Participating Provider Cost Share shown in the benefit schedule in the following cases:
  - When reasonable and appropriate treatment of the disease, illness or injury present is unavailable from a Participating Provider, or
  - For any other reason We determine, based on the unique fact pattern present that it is reasonable to receive services from a Non- Participating Provider

2024 Preventive Benefit Schedule

The preventative benefit schedule is a reference tool for planning preventive care and lists items/services required under the Patient Protection and Affordable Care Act of 2010

(PPACA), as amended. In accordance with the PPACA, the schedule is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force, Health Resources and Services Administration, U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and other applicable laws and regulations. Accordingly, the content of this schedule is subject to change. A member's specific needs for preventive services may vary according to personal risk factors. The health care provider is always the best resource for determining if a member is at increased risk for a condition. Some services may require precertification/preapproval. The complete preventative benefit schedule can be found in the appendix. For questions about this schedule, precertification/preapproval, or benefit coverage, please call the Provider Services Helpline.

Chapter 8: Utilization Management

Purpose: This chapter introduces our Medical Management team and the guidelines and criteria used by the department to achieve optimal benefit utilization for our members.

Topics: Important topics from this chapter include:

Our commitment to providing appropriate medical care for members
Prior authorization rules and guidelines
Medical Management decision process and criteria
Appeals process

Overview

Medical management is a process that monitors the use of a comprehensive set of integrated components including, but not limited to, the following:

- pre-certification review
- admission review
- concurrent review
- retrospective review
- discharge planning

The Medical Management department works in conjunction with our medical providers to determine medical necessity, cost effectiveness, and conformity to evidence-based medical necessity criteria so that members receive optimal use of their benefit plans.

Due to possible interruptions of a member's State Medical Assistance coverage, it is strongly recommended that providers call for verification of a member's continued eligibility on the first of each month when a prior authorization extends beyond the calendar month in which it was issued. If the need for service extends beyond the initial authorized period, the provider must submit clinical information justifying medical necessity for continuation of services to our Inpatient and Outpatient Services departments to obtain prior authorization for continuation of service.

Providing Appropriate Medical Care for Members

We are committed to providing our members with the most appropriate medical care for their specific situations. To achieve this goal, our utilization management decisions are based on medical necessity, appropriateness of care and whether an item is medically necessary or considered a medical item. This means we do not provide financial incentives for utilization management decision makers that encourage denials of coverage or service.

We adhere to the following standards related to the Utilization Management decision making:

- Utilization Management decision-making is based only on appropriateness of care and services and existence of coverage.
- We do not reward practitioners or other individuals for issuing denials of coverage.
- There are no financial incentives for Utilization Management decision makers that would encourage decisions that result in underutilization.

Medically Necessary Services

Medically Necessary: Health Partners Medicaid (Medical Assistance) – A service or benefit is medically necessary if it is compensable under the Medicaid program and if it meets any one of the following standards:

- Request for services must be ordered by a physician as directed by regulatory guidelines.
- The service/benefit will or is reasonably expected to prevent the onset of an illness, condition or disability.
- The service/benefit will or is reasonably expected to reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service/benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

Medically Necessary: Jefferson Health Plans Medicare and the Medicare Advantage (MA) Program — A service or benefit is medically necessary if it is compensable under Medicare's program and if it meets the following:

- The service, item, procedure or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- The service, item, procedure or level of care will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service, item, procedure or level of care will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.
- Services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member or otherwise medically necessary under 42 U.S.C. § 1395y

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review and/or exception basis, must be documented in writing.

The determination is based on medical information provided by the member, the member's family/caretaker and the primary care physician (PCP), as well as any other providers, programs or agencies that have evaluated the member.

All such determinations must be made by qualified and trained healthcare providers. A healthcare provider who makes such determinations of medical necessity is not considered to be providing a healthcare service under their agreement.

National and local coverage determinations are always considered during all types of medical necessity reviews for our Medicare members.

Medical Necessity or Medically Necessary and Appropriate: Health Partners Plans CHIP/KidzPartners — Refers to services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Determinations are based on covered services under a given benefit package, medical necessity and clinical appropriateness using clinical criteria and guidelines that are the accepted standard of care in the medical community. In addition, the physician reviewer must override the criteria when, in his/her professional judgment, the requested service is medically necessary. Individual member assessment must occur.

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review or exception basis, must be documented in writing to members and providers.

The determination is based on medical information provided by the member, the member's family/caretaker and the primary care physician (PCP), as well as any other providers, programs or agencies that have evaluated the member.

All such determinations must be made by a qualified and trained healthcare professional. A healthcare professional that makes such determinations of medical necessity is not considered to be providing a healthcare service under their agreement.

Authorizations are not a guarantee of payment.

Medicare Members' Plan Directed Care

If a Jefferson Health Plans participating provider directs a Jefferson Health Plans Medicare member to an out-of-network provider without obtaining the required authorization then the member ***cannot*** be held financially responsible by any party (including in-network provider, out-of-network provider, or Plan) due to Medicare's plan-directed care rules.

CMS considers plan-directed care to be the financial responsibility of the health plan and/or its contracted network. Plan-directed care is care the member believes they were instructed to obtain by a health plan representative such as network providers. Therefore, if care cannot be delivered in network then the Jefferson Health Plans Medicare participating providers must obtain prior authorization from us prior to referring a member to an out-of-network provider. If prior authorization is not obtained, the participating referring provider will be held financially accountable.

A complete listing of Jefferson Health Plans participating providers can be found in our online Provider Directory.

Medicaid & CHIP Timeliness of Utilization Management Decisions

Decision Type	Decision Timeframe from Receipt of Clinical	Extension[1]
Urgent Prior Authorization Request[3]	**24 hours**	**72 Hours**
Non-urgent Prior Authorization Request	**48 hours[2]**	**14 days[2]**
Concurrent Request	**2 business days[2]**	**N/A**
Retrospective Request	**30 days**	**N/A**

[1] *Timeframes may be extended if additional information is needed to process the request. If the provider or member does not send the additional information within the above extended timeframes from the request for additional information, We will base our decision on the information available.*

[2] *We define a business day as a single full business day, not calendar day, after the date of the request receipt.*

[3]*All medications/drugs requests must have a medical necessity decision in 24 hours from receipt.*

We will notify the health care provider and members within 48 hours of the non- urgent pre-service request for service for additional facts, documents or information required to complete the request.

When we receive a non-urgent pre-service request for prior authorization, we will contact the member by phone within two days of the date of the request for service with our determination. A written decision will be mailed to the member and provider within two business days from the date of our decision. We will issue all determinations in accordance with regulatory guidelines and notification time frames. All written determination notifications are sent via mail to the member in accordance with current federal and state requirements utilizing mandated notification templates, which include associated complaint/grievance/Fair Hearing rights.

An urgent review will be processed as expeditiously as the member's health condition requires but no later than 24 hours from receipt of the request for any urgent service or item requested by the member or provider. (Refer to Policy 520.2.9 Prior Authorization)

After hours the reviews are handled by the on-call case manager (Inpatient and Outpatient) and the on-call medical director. We provide twenty-four (24) hour staff availability to authorize weekend and holiday services, including but not limited to: home health care, pharmacy, DME, and medical supplies. Determinations will be made within the required regulatory timelines.

Medicare Timeliness of Utilization Management Decisions

Type	Processing Timeframe	With Extension*
Pre-Service	14 calendar days	28 days
Part B Drug	72 hours	N/A
Expedited: Pre-Service	72 hours	17 days
Expedited: Part B Drug	24 hours	N/A

Emergent/Concurrent Processing Timeframes: 14 calendar days with no extension.

Please note: Timeframes may be extended if additional information is needed to process the request.

We will notify the healthcare provider after the request for service for additional facts, documents or information required to complete the request. If the provider does not send

the additional information within time frame of the original request category of our request for more information, then we will base our decision on the information available.

We can provide extensions up to 14 days if requested by the member. This extension may occur if it is requested by the member or if we grant ourselves an extension and justifies the need for collection of additional information and documents how the delay is in the interest of the member (e.g., the receipt of additional clinical evidence from non-contracted providers). If the latter is the basis for the extension, we will notify the member in writing of the reason(s) for the delay and of their right to file a grievance if he or she disagrees with our decision to grant an extension.

Prior Authorization Guidelines

The following information is provided to our members so that they are aware of the prior authorization process and timeframes. If you have any questions about the information below, please call us at 1-888-991-9023. For pharmacy prior authorizations, please call 215- 991-4300 or visit our Prior Authorization webpage for more information on the formulary and drug specific prior authorizations forms.

CHIP and MEDICAID MEMBERS: Long Term Acute Care (LTAC) Admission Criteria: requires prior authorization and are reviewed for medical necessity and referred to the medical directors for final determination. View guidelines for Prior Authorization submission instructions on the provider portal.
Sometimes there are services or items that the PCP must ask us to approve for the member. For our members, services requiring prior authorization can be found on our Prior Authorizations webpage.

Pre-Service Reconsiderations:
If we issue a denial of a prior authorization, a provider has 7 days from the date of that denial to request a Reconsideration only if the following criteria are met:

- The provider has additional information to submit to support the request that was not available at the time we issued the denial
    - AND
- The failure to submit the information prior to the denial was due to no fault of the provider
    - If you would like to submit a request for Reconsideration, you must do so within 7 days from the date on the denial letter.
- For reviews performed by our vendor, eviCore, please send requests for Reconsideration via fax to the below numbers and include with your request the information that was previously not available for review:
    - PT/OT/ST and Chiropractic: 855-774-1319
    - Chemotherapy - Outpatient and Home Infusion: 800-540-2406

- Radiation Therapy: 800-540-2406
- Radiology, Cardiology, Sleep, Pain Management, Joint & Spine: 888-693-3210

    - For reviews performed by our Utilization Management Department, please send requests for Reconsideration via fax to the below numbers and include with your request the information that was previously not available for review:
    - Durable Medical Equipment: 215-849-4749
    - Home Care/Home Infusion: 215-967-4491
    - Shift Care/Medical Day Care: 267-515-6667
    - Air Transport: 267-515-6627

eviCore Prior Authorization Program

**These programs are not applicable to CHIP*

Cosmetic Services

Cosmetic services are excluded from coverage in all places of service for the DHS and CMS programs. However, cosmetic services may be considered for coverage when the surgery is medical necessary and needed to improve the functioning of a body part, correct a congenital anomaly or relieve pain. Certain Short Procedure Unit (SPU)/Ambulatory procedures would be excluded from coverage because they are often performed for cosmetic purposes, rather than for medical necessity reasons. As a result, if these services are billed, medical records will be requested to validate the medical necessity of the procedure. When a procedure is cosmetic, please contact our prior authorization unit with supporting clinical information for medical necessity.

Prior Authorization Programs & Services	Phone	Website/Portal
Advanced radiology services (CT, MRI, Pet Scans, echocardiography, stress echocardiography, cardiac nuclear medicine imaging, and radiation therapy)	**1-888-693-3211 prompt #3**	**www.eviCore.com**
Automatic Implantable Cardioverter Defibrillators*		
Diagnostic Cardiac Catheterizations*		
Pain Management*		
Permanent Pacemakers		
Radiation Oncology		
Sleep Management*		
Therapy services (physical therapy, occupational therapy, or speech therapy) Initial Evaluation is ONLY for first visit		
Medical Oncology (chemotherapy including home infusion chemotherapy	**1-888-444-6178**	
Chiropractic Services*	**1-877-531-9139 prompt #2**	
Outpatient joint and back surgeries		

Short Procedure Unit (SPU)/Ambulatory Procedures

The following is a list of a few examples of cosmetic procedures that require medical necessity review to be considered for payment. This list is **not** all inclusive.

- Bariatric services such as but not limited to: sleeve gastrectomy, vertical or adjustable bands, Roux-En-Y, gastric balloons
- Blepharoplasty or Ptosis surgery
- Botox treatments
- Breast Reconstruction surgery
- Circumcision (except newborn)
- Rhinoplasty
- Scar or keloid repair, revisions or releases
- Tissue Expander
- Panniculectomy

Please note: Office procedure in a dermatologist office may be submitted for retrospective review for medical necessity to the Precertification Unit in order to avoid delays in care.

How to Obtain Prior Authorization

The following section provides guidelines for properly obtaining a prior authorization from us.

Please Note: Providers should obtain prior authorization at least **seven** days in advance for elective (non-emergent) procedures and services. Authorizations will remain active for 90 days after which the provider will need to re-request. Your request will be processed according to state and federal regulations. Failure to comply with this guideline may result in the medically non-urgent services being delayed. For elective admissions and transfers to non-participating facilities, the PCP, referring specialist or hospital must call our Inpatient Services Department at **1-866-500-4571** or submit the request through our provider portal. These requests for prior authorization must be made before the anticipated admission. Please include the following:

- Member's name and plan ID number
- Scheduled date of hospital admission
- Anticipated length of stay for hospital admission
- Name of attending physician
- Diagnosis (Please use the most appropriate code with the highest level of specificity.)
- Procedure (Please use the most appropriate code with the highest level of specificity.)
- Supporting clinical/medical information for requested procedure

- Admitting hospital

For **Medicaid/KidzPartners CHIP requests for Home Care authorization** please fax requests to the Ancillary Services department at **215-967-4491**.

For **Medicare Advantage Home Care authorization requests** please fax requests to the Ancillary Services department at **267-515-6633**.

For **Shift Care/Medical Day Care authorization requests** please fax requests to **267-515-6667**.

For **Transport (ambulance) authorization requests**, fax request to the Ancillary Services department at
267-515-6627.

For **Medicaid/KidzPartners CHIP DME authorization requests**, fax request to the Ancillary Services department at **215-849-4749.**

For **Medicare DME authorizations requests**, fax request to the Ancillary Services department at **267-515-6636**.

Notifications for urgent or emergent admissions (inpatient and maternity) can be submitted through our secure provider portal.

For Health Partners Plans Medicaid, clinical trial authorization requests must include the "Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial" (MA584) form along with supporting clinical information, to be completed by the requesting provider. The MA584 form can be found on the Prior Authorizations page- Prior Authorization | Health Partners Plans

Note: Due to circumstances regarding member eligibility and timeliness standards, an authorization is not a guarantee for payment.

Pharmacy Prior Authorization

There are specific medications on the formulary that require prior authorization. Drug specific prior authorization forms are available to help expedite the process with specific clinical criteria on our Prior Authorization webpage. There may be occasions when an unlisted drug or non-formulary drug or medication is desired for medical management of a specific patient. In those instances, the unlisted medication may be requested through a medical exception process using the "Non-formulary Prior Authorization" form.

To ensure that select medications are utilized appropriately, prior authorization may be required for the dispensing of specific products. These medications may require authorization for the following reasons:

- Non-formulary medications or benefit exceptions requested for medical necessity
- Medications and/or treatments under clinical investigation
- Duplication of Therapy edits will be hard coded to assure appropriate utilization of multiple drugs within the same therapeutic categories (e.g., duplication of SSRIs)
- All brand name medications when there is an A-rated generic equivalent available
- Prescriptions that exceed set plan limits (days' supply, quantity, refill too soon, and cost)
- New-to-market products prior to review by the P&T Committee
- Orphan drugs/experimental medications
- Selected injectable and oral medications
- Specialty medications

To request a prior authorization, the physician or a member of his/her staff should contact our Pharmacy department at **1-866-841-7659**, Monday through Friday, 8 a.m. to 6 p.m. Requests can also be faxed to **1-866-240-3712**. In the event of an immediate need after business hours, please call Member Relations at **1-800-553-0784**. The call will be evaluated and routed to a clinical pharmacist on-call 24/7.

The physician may use the our drug specific forms or a letter of request, but must include the following information for a quick and appropriate review to take place:

- Specific reason for request
- Member name and recipient Health Partner Plans ID number
- Member date of birth
- Physician's name, license number, NPI number and specialty
- Physician's phone and fax numbers
- Name of primary care physician, if different
- Drug name, strength and quantity of medication
- Days' supply (duration of therapy) and number of refills
- Route of administration

- Diagnosis
- Formulary medications used, duration and therapy result, and documentation such as pharmacy records or chart notes.

Additional clinical information may contribute to the review decision such as specific lab results. All forms should be legible and completely filled out.

Clinical Review Process

We use the product's specific definition of medical necessity, Medicare's two midnight rule when applicable, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and available InterQual® criteria as guidelines for the review and decision making. Effective 08/28/2023, we implemented the 2023InterQual criteria in the following modules:

- Acute Adult Criteria
- Acute Pediatric Criteria
- Long Term Acute Care Criteria
- Acute Rehabilitation
- Subacute & SNF
- Home Care Criteria
- Durable Medical Equipment
- Procedures Criteria
- Guidelines for Surgery and Procedures Performed in the Inpatient Setting

Providers can request a copy of specific InterQual® Level of Care/Acute Level of Care Criteria — or information about the criteria — by calling the Jefferson Health Plans Inpatient Services Unit at **1-866-500-4571 (prompt 2, prompt 3)** from Monday through Friday 9:00 a.m. – 5:30 p.m. EST. To request a copy of our specific outpatient criteria or related information, please contact Ancillary Services at **1-866-500-4571**.

Inpatient Services UM Process

Obtaining inpatient UM assistance after business hours:

All admissions as inpatient should be submitted through our portal, fax to 215-967-9247, or called to our Inpatient Services department during normal business hours at **1-866-500-4571**, Monday through Friday 8:30am – 5pm EST.

All after-hours admissions should be directed to the participating facilities. If providers require assistance for urgent issues after business hours, please call **1-866-500-4571** and

leave a message, which will be forwarded to an on-call nurse case manager. If non-emergency services (including transfers) cannot be obtained from a participating provider, prior authorization is required.

Community HealthChoices (CHC) UM Process (Medicaid)

We will cover all skilled days that meet medical necessity via InterQual or Medical Director review. Once the member is approved at a custodial level of care, you will be authorized 30 days up front. On day 31 of custodial level of care, the case will be placed into CHC pended status until a determination on Long Term Care eligibility is made. Once determination is made, the authorization will be updated with a last cover day which is through the day before the CHC effective date or CHC eligibility. MCOs are responsible for the determination period for CHC. We require confirmation that the application was submitted to the Commonwealth.

Transfer Admission Requirements

All hospital transfers should be directed to participating facilities. If services are not available within the network, prior authorization is required prior to the transfer. All hospital-to- hospital transfers ***must*** be considered medically necessary, meaning that the patient requires a higher level of medical care than your hospital (the *transferring* hospital) can provide. The *receiving* hospital ***must*** be able to provide the necessary care. Additionally, prior authorization is required for hospital-to- hospital transfers when the receiving hospital is out-of-network.

Transferring facilities can obtain prior authorization by faxing or calling Inpatient Services during normal business hours, Monday through Friday, 8:30 a.m. to 5 p.m. After-hours, please call **1-866-500-4571** and leave a message for the on-call Inpatient Services case manager.

Note: Life-threatening emergent situations constitute an exception to the prior authorization requirements.

Elective Admissions

Elective admissions require prior authorization. All requests for services should be submitted through our provider portal. All elective hospital admissions should be provided by a participating physician. To maximize continuity of care, the PCP or specialist should direct care to the PCP's affiliated health system. Please refer to our online Provider Directory for more information.

Our Inpatient Services department issues a written and verbal notification (including a reference number) to the hospital when determinations are made or completed. Excluding transplantation authorizations, which will remain open for one year, all elective procedure

authorizations will remain open for 3 months. If the date of the elective admission changes, we will need to be notified so that the authorization can match the incoming claim.

Preadmission Services

In alignment with CMS' policy/billing guidelines, preadmission diagnostic and non-diagnostic services related to the admission that are rendered during the 3 days (hospitals subject to IPPS, inpatient prospective payment system) or 1 day (hospitals excluded from IPPS) prior to an inpatient hospital admission (even if the days cross the calendar year) are considered inpatient services and included in the inpatient reimbursement. Preadmission services may be subject to post-payment audits and retraction.

Elective Admissions at a Non-Participating Provider

Requests for elective admission or SPU service at a non-participating hospital will be considered only when the service is not available at a participating hospital or ASC. All requests for services at non- participating facilities will require written documentation noting the clinical and other circumstances involved.

For all of our members, requests for elective admissions and transfers to non- participating facilities not authorized by us before admission will be denied for lack of prior authorization. An administrative denial letter will be issued for all elective admissions and transfers to non-participating facilities not authorized by us.

If the date of the non-participating elective admission or procedure changes, we will need to be notified so that the authorization can match the incoming claim.

For administrative denial reconsideration, the facility must submit, within 30 days, a letter of appeal detailing why prior authorization has not been obtained. The address for appeals is:

Health Partners Plans/Jefferson Health Plans
Attn: Medical Management Appeals
Unit 1101 Market Street, Suite 3000
Philadelphia, PA 19107

For more information on appeals, please refer to the Provider Appeals section.

Emergent Admissions

All admissions, whether elective or urgent, must be reported to our Inpatient Services department within 48 hours of admission. Failure to do so could result in a denial for untimely notification.

Emergency Care

Emergency care and post-stabilization services in emergency rooms and emergency admissions are covered services for both participating and non-participating facilities, with no distinction between in or out-of-network services. Emergency care and post-stabilization services do not require prior authorization.

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

- Serious jeopardy to the health of the **patient**
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or **body part**

Non-par follow-up specialty care for an emergency is covered by us, but our staff will outreach to the member to appropriately arrange for services to be provided in- network, whenever possible.

In the event of a serious or life-threatening emergency, the member should be directed to the nearest emergency facility.

Concurrent Review Process

All hospitals that are contracted on a DRG basis will contact Inpatient Services within 48 hours with clinical review for each admission. We utilize medical necessity, Medicare's two midnight rule, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and InterQual as a guideline for admission review. Failure to provide clinical information within 48 hours of admission or by the next assigned review date may result in an administrative denial for untimely clinical review.

Medical necessity for acute care hospitals is determined by using the product's specific definition of medical necessity, Medicare's two midnight rule when applicable, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and the InterQual® Level of Care criteria. We do not reimburse at the DRG level if the services do not require acute hospital levels of care. If the Inpatient Services decision denies or reduces to a lower level of care, a written notice of denial is issued to the hospital. The notice includes instructions for requesting a peer-to-peer reconsideration and pursuing an appeal of this determination. Our Medical Directors are available to discuss medical necessity review decisions with peers by calling **215-967-4570**. If the inpatient admission extends longer than 5 days it is expected that a weekly clinical update with a

discharge plan be submitted to our Inpatient Services Department.

We review inpatient readmissions within 30 days following DHS and CMS payment policy for readmissions. Decisions to combine DRG payments related to readmissions can be appealed within 30 days at the below email address. Providers are able to initiate a peer-to-peer discussion related to the decision to combine admissions. Both admission records are required for the appeal to be reviewed.

A facility that has been denied services can also submit a letter of appeal and a copy of the medical chart within 30 calendar days to following address:

Health Partners Plans/Jefferson Health Plans
Inpatient Provider Appeals

Email: appeals@healthpartnersplans.com or appeals@jeffersonhealthplans.com for more information on appeals, please refer to the Provider Appeals section.

Notification of Discharge/Discharge Management

Clinical reviews of all types of inpatient admissions are required to avoid administrative denials. Discharge date and disposition must be reported to our Inpatient Services department within one business day from discharge to promote effective case management when needed and to avoid claim suspension issues.

We will continue to look to the PCP for all issues related to appropriate utilization. PCPs are responsible for coordinating follow-up care after hospital discharge. While PCP referrals are not required for Medicaid or CHIP, the PCP may direct members to participating specialists when medically necessary. In these plans, the absence of requirement for a physical or electronic PCP referral to a specialist or surgeon does not relieve the PCP of his or her responsibility to remain involved in the care of the member. For more details regarding Jefferson Health Plans Medicare plans that require PCP referrals to see participating specialists, please see the PCP Referrals section in Chapter 12: Provider Billing & Reimbursement. Failure to provide clinical information by the next assigned review date may result in a denial for untimely clinical review.

Skilled Nursing Admissions

All skilled nursing care admissions will require prior authorization by the Inpatient Services department for reimbursement. Requests for skilled nursing admissions should be submitted through our provider portal or faxed to **215-991-4125**. All requests will be processed according to state and federal regulations. All determinations will be communicated in writing to members and providers.

For benefit limitation information for each line of business, please refer to the individual benefits chapters of this provider manual:

- **Health Partners Plans Medicaid:** Members in a licensed skilled nursing or intermediate care facility are covered by Health Partners Plans for up to 365 days (including bed hold days). Members can be admitted to skilled nursing facilities directly from the community.
- **Health Partners Plans CHIP/KidzPartners:** KidzPartners Members have a limit of 90 days annually for inpatient medical, skilled nursing and mental health combined.
- **Jefferson Health Plans Medicare Advantage:** Members in a licensed skilled nursing or intermediate care facility are covered by Jefferson Health Plans Medicare should the services be supported by medical necessity for up to 100 days (no bed hold days reimbursed by Jefferson Health Plans) per episode of illness. Members can be admitted to skilled or intermediate care facilities directly from the community.
  - Jefferson Health Plans Medicare providers are expected to issue all CMS member notices with appeal rights according to state and federal guidelines/regulations. Each notice includes information on the member's or their representative's right to file an expedited appeal.
  - Skilled Nursing Facilities and Home Care Agencies are expected to send a copy of the member's signed Notices of Medicare Non-Coverage (NOMNC) to the appropriate fax number along with keeping the original on file for auditing and compliance purposes.,
    - Skilled Nursing facilities should fax completed forms to **215-991-4125**.
    - Home Care Agencies should be email signed document to Homecarenomnc@Jeffersonhealthplans.com or fax completed forms to **267-515-6633** upon completion.

Ancillary Services UM Process

Authorization requirements may vary depending upon whether or not the services rendered take place in an inpatient or outpatient setting. The following section provides an overview of common outpatient services requiring prior authorization and how the authorization is obtained. The Ancillary Services department will review outpatient services that require prior authorization for medical necessity or plan covered services. We will issue a notice of its determination. Adverse determination notices include the members appeal rights.

Outpatient services that require prior authorization:

- Home Health services. This includes skilled nursing (RN, LPN) visits, home infusion, shift care, home health aide services, Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and Social Work (SW) visits
- All DME rentals
- All DME purchases over $500
- Any service(s) performed by non-participating providers, except non-emergent transportation providers.
- Any service/product not listed on the Medical Assistance Fee Schedule, including EPSDT Expanded Services.
- Air or water ambulance

Obtaining Ancillary UM Assistance after Business Hours

Our Ancillary Services department's normal business hours are Monday through Friday, 8 a.m.- 5:00 p.m.

For any ancillary request after business hours, please call **1- 866-500-4571** and leave a message, which will be forwarded to an on-call nurse case manager who will return your call.

Ambulance/Non-Emergent Transportation

We are responsible for the coordination of covered services related to transportation and reimburse for medically necessary transportation for our members.

We have contracted with specific Ambulance providers throughout the service area. Non-emergent transportation, including Behavioral Health related transport, does not require prior authorization. All service requests should be submitted through our provider portal. You will find request forms and physician certification forms on our Form and Supply Requests webpage for prior authorization submission. Once completed, they can be faxed to **267- 515-6627**.

Members experiencing a medical emergency are instructed to immediately contact their local emergency rescue service by dialing **911**.

- **Health Partners Plans CHIP/KidzPartners:** Members are covered for emergency and behavioral ambulance transportation only.
- **Health Partners Plans Medicaid: Non-Emergent Transportation does not**

require prior authorization from a par or non-par provider. We will assist members in accessing non-ambulance transportation services for physical health appointments through the Medical Assistance Transportation Program (MATP). However, we are not financially responsible for payment for these services.

- Our members should be advised to contact the Case Management Department for support in accessing and setting up transportation options. BH-MCO in their county of residence for assistance in accessing non-ambulance transportation for behavioral health appointments.
- **Jefferson Health Plans Medicare Advantage:** Members are covered for emergency and non-emergent ambulance transportation. Non-emergent transportation is reviewed for medical necessity following the criteria set forth by Medicare and guided by Novitas: Local Coverage Determination (LCD): Ambulance Services (Ground Ambulance) (L35162). These criteria can be accessed at www.novitas-solutions.com/webcenter/portal/MedicareJL/.
    - Jefferson Health Plans Medicare Prime and Special additionally offer a benefit for routine transportation limited to 30 one-way trips (for Prime members) or 85 one-way trips (for Special members) for health services at plan-approved locations yearly. Members can contact the Care Navigation Unit for assistance at **1-866-213-1681**.

Durable Medical Equipment (DME) and Medical Supplies

Our members are eligible to receive medically necessary durable medical equipment (DME) needed for home use. Coverage of DME may be based on a member's benefit package and plan type. All requests for services should be submitted through our provider portal.

All DME purchases and medical supplies over $500 and all DME rentals must be prior authorized.

PCPs, specialists and hospital discharge planners are directed to contact our Ancillary Services department at **1-866-500-4571**. Because members may lose eligibility or switch plans, DME providers are directed to log on to the Provider Portal for verification of the member's continued eligibility and continued enrollment with us, when equipment is authorized for more than a one-month period. Failure to do so could result in claim denials.

Occasionally, members require equipment or supplies that are not traditionally covered. We will reimburse participating DME network providers based on their documented invoice cost or the manufacturer's suggested retail price for DME and medical supplies. Payment requires that the equipment or service is medically necessary, and the network provider has received prior authorization from us. In order to receive prior authorization, the requesting network provider should submit through the provider portal or can fax a completed request form and letter of medical necessity or complete prescription to our DME unit at **215-849-4749** for Medicaid/KidzPartners (CHIP) members and **267-515-6636** for Medicare members.

Forms can be found on our Form and Supply Requests webpage.

The letter of medical necessity/ complete prescription MUST contain the following information:

- Member's name
- Member's ID number
- Item being requested with CPT code(s)
- Expected duration of use and frequency
- Specific diagnosis and medical reason that necessitates use of the requested item
- Other failed therapies
- Complete signed order by an allowed practitioner (MD, DO, NP, PA, Certified Nurse Midwife, Podiatrist)

DME prescription requests MUST include:

- Complete signed order by an allowed practitioner (MD, DO, NP, PA, Certified Nurse Midwife, Podiatrist)
- Correct HCPC codes and monthly billing units for all items requested along with Dates of service being requested
- Name and NPI number of the company supplying the equipment
- Provider contact name telephone and fax number
- All miscellaneous codes require prior authorization

Each request is reviewed by a Health Plan medical director for medical necessity. Occasionally, additional information is required and the network provider will be notified by us of the need for such information. If you have questions regarding any DME item or supply, please contact the DME unit at **1-866-500-4571**.

Home Accessibility DME

Home accessibility DME is a DHS Process that consist of certain modifications, construction or renovation to an existing structure other than a repair or an addition to the private home of the member (including homes owned or leased by parents/relatives with whom the member resides and family living homes that are privately owned, rented, or leased by the host family) which are necessary due to the member's disability, to ensure the health, security of, and accessibility for the member, or which enable the member to function with greater independence in the home.

A Health Partners Plans Medicaid member may be approved for Home Accessibility DME services. This approval is contingent upon medical necessity information submitted to Health Partners Plans along with required DHS support documentation. They can receive adaptations that consist of certain modifications to the private home of the member (including homes owned or leased by parents/relatives with whom the member resides and family living homes that are privately owned, rented, or leased by the host family) which are necessary due to the member's disability, to ensure the health, security of, and accessibility for the member, or which enable the member to function with greater independence in the home.

Medical Supplies

Certain medical supplies are available with a valid prescription through us, based on the benefits of the specific plan (Medicaid, Medicare Advantage, CHIP, or Individual and Family Plans). Items may be covered as a medical or pharmacy benefit and are provided through participating pharmacies and DME suppliers.

Examples include but are not limited to the following items for **Medicaid members**:

- Vaporizers (one per calendar year) — covered under pharmacy benefit for under 21
- Humidifiers (one per calendar year) — covered under pharmacy benefit for under 21
- Diabetic supplies — covered under pharmacy benefit
- Insulin, disposable insulin syringes and needles
- Disposable blood and urine testing agents
- Glucose meters, alcohol swabs, strips and lancets
- Diapers/Pull-Up Diapers are limited to 300 per month for adults. Prior authorization is required for any member needing over 200 diapers or pull-ups per month and may be obtained as follows:
  - Members are eligible to obtain diapers/pull-up diapers when medically necessary
  - A written prescription from participating practitioner is required — generic diapers/pull-up diapers must be dispensed
  - Brand diapers/pull-up diapers require prior authorization and a Letter of Medical Necessity (LOMN)

For **Medicare Advantage** members, glucose monitors and strips are covered under the DME benefit. Insulin and related supplies such as syringes and needles are covered under the pharmacy benefit.

Home Health Services

For all Health Plan members, prior authorization for **initial evaluations** for homecare services is not required. Once a member has had an initial evaluation, prior authorization will be required for further treatment. If no further treatment is necessary, the initial evaluation request must be faxed to **215-967-4491** within five business days of the initial visit in order to get paid for initial visit, along with the singed NOMNC. Physician orders or prescription can be verbally accepted but must be noted and signed as such by RN. The initial evaluation date must be included in the dates of service on your authorization request. Services cannot be billed without an authorization number for the following services:

- Skilled nursing (RN/LPN)
- Infusion therapy
- Home health aide
- Physical therapy
- Occupational therapy

- Speech therapy
- Social Work

For benefits limitations information for each line of business, please refer to the individual benefit chapters of this manual.

We encourage home health care as an alternative to hospitalization when medically appropriate. Home health care services are recommended:

- To allow an earlier discharge from the hospital.
- To provide services that are medically necessary in a home setting.
- To avoid unnecessary admissions of members who could effectively be treated at home.
- To allow members to receive care in greater comfort because they are in familiar surroundings.

Our Ancillary Services Unit will coordinate medically necessary home care needs with the PCP, attending specialist, hospital home care departments and other providers of home care services. All requests for services should be submitted through the provider portal but can also be faxed to our Ancillary Services Unit at **215-967-4491** to obtain an authorization for Medicaid/KidzPartners (CHIP) members. Request forms can be found on our Forms and Supply Requests webpage.

Medicare Advantage:

- Jefferson Health Plans home health providers are expected to issue all member CMS notices with appeal rights according to state and federal guidelines/regulations. Each notice includes information on the member's or their representative's right to file an expedited appeal.
- Home health providers are expected to fax the member's signed Notices of Medicare Non-Coverage (NOMNC) to **267-515-6633** or email Homecarenomnc@jeffersonhealthplans.com for auditing.

Orthotics and Orthopedic Shoes

For Health Partners Plans Medicaid members, the following benefit limitations for members age 21 or older apply:

- Orthopedic shoes will not be covered unless there is a diabetic diagnosis
- Orthopedic shoes for diabetic purposes will be covered once per year from date of service

- Orthopedic devices will be covered once every three years from date of service

Prior authorization for all members requiring orthopedic shoes and devices over $500 will continue to be required. Requests for orthotics and/or shoes should be submitted through the provider portal or faxed to **215-849-4749**.

For Jefferson Health Plans Medicare Advantage members with diabetes, coverage of the footwear and inserts is limited to one of the following within one calendar year:

- No more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts; or
- No more than one pair of depth shoes and three pairs of inserts (not including the non- customized removable inserts provided with such shoes).

EPSDT Expanded Services (Medicaid)

EPSDT Expanded Services are defined as any medically necessary healthcare services provided to a Medical Assistance recipient younger than 21 years of age that are covered by the federal Medicaid Program (Title XIX of the Social Security Act) but not currently recognized in the State's Medicaid Program. These services, which are required to treat conditions detected during an encounter with a healthcare professional, are eligible for payment under the Federal Medicaid Program but are not currently included under DHS's approved State Plan. EPSDT Expanded Services may include items such as medical supplies or enteral formula or shift care services.

Eligibility for EPSDT Expanded Services

All members younger than 21 years of age are eligible for EPSDT Expanded Services when such services are determined to be medically necessary. There is no limitation on the length of approval for services, as long as the conditions for medical necessity continue to be met and the member remains eligible for Health Partners Plans Medicaid benefits.

EPSDT Expanded Services Requiring Prior Authorization

EPSDT Expanded Services require prior authorization. All requests for EPSDT Expanded Services should be forwarded to our Ancillary Services Unit where they will be reviewed for medical necessity. Requests should be accompanied by a letter of medical necessity outlining the rationale for the request and the benefit that the requested service(s) will yield for the member. DME and medical supply requests should be faxed to **215-849-4749**

and requests for shift care services (private duty nursing) should be faxed to **267-515-6667**.

EPSDT Expanded Services Approval Process

When the Health Plan medical director or his/her designee approves a request for EPSDT Expanded Services, the requesting network provider will be asked to identify a network provider for the service if this was not already done. The provider of service should contact our Ancillary Services Unit at **1-866-500-4571**. The provider of service will be responsible for obtaining authorization to extend the approval of services prior to the end date of current authorization. The provider of service is also responsible for verifying the member's eligibility prior to each date of service.

EPSDT Expanded Services Denial Process

Prior to denying any request, the Health Plan medical director or his/her designee will make two attempts, as an effort of good faith, to contact the requesting network provider to discuss the case. If the request is denied in full or in part, a letter detailing the rationale for the decision will be sent to the member, the requesting network provider and, if identified, the provider of service or advocate working on the behalf of the member. This letter will also contain information regarding the grievance or appeal process and for members, information on how to contact community legal service agencies who might be able to assist in filing the grievance.

We will honor EPSDT Expanded Service treatment plans that were approved by another HealthChoices Managed Care Organization or DHS prior to the member's enrollment with Health Partners Plans Medicaid. The healthcare provider of service is responsible for forwarding documentation of the prior approval in order for us to continue to authorize previously approved services. We will not interrupt services pending a determination of medical necessity in situations where the healthcare provider is unable to document the approval of services by the previous insurer.

Medicaid Program Exception Process

Health Partners Plans, under extraordinary circumstances, will authorize a medical service or item that is not on the Medicaid Program Fee Schedule or will expand the limits for services or items that are listed on the Medicaid Program Fee Schedule. If a provider concludes that lack of the service or item would impair the member's health, the provider may request a program exception. A request for program exception must contain sufficient information to justify the medical necessity for all requested services.

Program exceptions are allowed for review of requests for:

- Services and items not listed on the Medical Assistance Fee Schedule, if they are types of services/items covered by the Medical Assistance Program and generally accepted by the medical community
- Expansion of coverage limitations for services/items that are listed on the Medical Assistance Fee Schedule
- Coverage under Program Exception is not allowed when the service, item or limits on the service/item is prohibited from payment by statute or regulation.

Medicaid Acute Rehab Inpatient Benefit Limit Exception Process

Health Partners Medicaid member benefit packages may have limits to inpatient acute rehab.

A request for an exception may be made prospectively before the service has been delivered, or retrospectively after the service is delivered. The following time frames will be adhered to in addressing benefit exception requests:

- Prospective urgent benefit exception requests: two business days.
- Prospective benefit exception requests: two business days of receipt of complete information. If additional information is required, the provider has 14 calendar days to submit information.
- Decision will be rendered within two business days of the receipt of additional information with written notification generated within two business days of communicating the decision. Written notification is to be received by the member within 21 days.
- Retrospective exception requests: 30 days.

We will review exceptions to benefit limitations using DHS approved guidelines.

A provider or member can request an exception to the Benefit Limit within the member's benefit package within 30 days from the date notice is received. A request form will be issued to the member and provider for completion. It details the medical information needed to process the request and make a determination.

The provider should send the completed form and any other information he/she deems important to:

Health Partners Plans
Attn: Medical Management/Benefit Exception
1101 Market Street, Suite 3000
Philadelphia, PA 19107

Exceptions will be reviewed according to approved guidelines, such as:

- The member has a serious chronic systemic illness or other serious health condition and without the additional service the member's life would be in danger
- The member has a serious chronic illness or other serious health condition and without the additional service the member's health will get much worse
- The member would need more costly services if the exception is not granted
- The member would have to go into a nursing home or institution if the exception is not granted

Approved exceptions will be processed according to the prior authorization policy and procedures. Note: The inpatient benefit limit exception process does not apply to Medicare or CHIP members.

Decision Process for Covering Emerging Medical Technology

Before we approve new treatments, drugs or equipment that are still considered experimental, we want to make sure that these new advances are safe and effective. When we receive a provider's request, the request goes through the following processes:

- We request that the provider submit a detailed narrative description of the service or item.
- We check to ensure that existing Federal and State Regulations do not preclude coverage.
- We research available data via online medical resources to obtain more detailed information on the service or item including, but not limited to:
  - FDA approval status
  - Peer-review literature
  - Whether the service/item is considered the accepted standard of care in the medical community.

If current clinical reference websites do not have information regarding the requested service or item, we contact medical experts directly to obtain pertinent information.

A Health Plan medical director reviews the information obtained from current clinical reference guidelines (or medical experts) and determines if the service or item should be covered.

Gender Reassignment Surgery coverage:

We follow the Medicare and Medicaid regulatory coverage requirement for Gender Reassignment surgery. All services require pre-authorization and are reviewed for medical necessity.

Provider Appeals

Any disagreement between us and a facility concerning concurrent or retrospective denials based on procedural errors or medical necessity/appropriateness, and in which the member received service(s) and is held financially harmless, shall be resolved in accordance with the following appeal procedures:

Medicaid Appeals Procedure:

In the event a case is referred to the Health Partners Plans medical director or physician advisor for a medical necessity determination, and the initial decision is adverse to the facility's request, the facility may request a peer-to-peer reconsideration within 48 hours providing member is still in the hospital after the decision is relayed to the provider by calling **215-967-4570.**

The facility has the right to appeal the adverse decision. Pursuant to the terms of facility contractual agreement with us, the facility may appeal within thirty (30) calendar days of the date of notification or date of discharge (whichever occurs last), by providing a copy of the UM denial, the hospital medical record for the entire admission, along with a cover letter from the attending physician of record or a hospital-designated physician describing the grounds for appeal to:

Inpatient Provider Appeals Department
Department Email: appeals@hpplans.com

If the denial is upheld in the first level of appeal, then the facility has 30 calendar days from the date of the written notification to request a second level appeal from the Utilization Management Committee at the appeals address above.

The Utilization Management Committee (UMC) is a subcommittee of our Quality Management Committee, which serves as a peer review panel and is composed of representatives from our participating providers. The Utilization Management Committee responds to second level appeals. The UMC will complete its review within 30 calendar

days of receipt of a second level appeal request and supporting documents. The UMC will communicate the decision to our Inpatient Provider Appeals department, who will inform the facility in writing of the decision within five business days of the UMC's decision. The decision of the UMC is final; no further right of appeal is provided.

For more information related to the concurrent review process, please refer to the Concurrent Review Process section of the provider manual.

Pre-Service Reconsiderations:

If we issue a denial of a prior authorization, a provider has 7 days from the date of that denial to request a Reconsideration only if the following criteria are met:

- The provider has additional information to submit to support the request that was not available at the time we issue the denial

AND

- The failure to submit the information prior to the denial was due to no fault of the provider

If you would like to submit a request for Reconsideration, you must do so within 7 days from the date on the denial letter.

- For reviews performed by our vendor, eviCore, please send requests for Reconsideration via fax to the below numbers and include with your request the information that was previously not available for review:
  - PT/OT/ST and Chiropractic: 855-774-1319
  - Chemotherapy - Outpatient and Home Infusion: 800-540-2406
  - Radiation Therapy: 800-540-2406
  - Radiology, Cardiology, Sleep, Pain Management, Joint & Spine: 888-693-3210
  - For reviews performed by our Utilization Management Department, please send requests for Reconsideration via fax to the below numbers and include with your request the information that was previously not available for review:
  - Durable Medical Equipment: 215-849-4749
  - Home Care/Home Infusion: 215-967-4491
  - Shift Care/Medical Day Care: 267-515-6667
  - Air Transport: 267-515-6627

Member Appeals of Denied Services

Members (or their parent/guardian on their behalf) have the right to appeal any decision made by us about payment for, or failure to arrange or continue to arrange for, what they believe are covered services (including non-covered benefits).

Out-of-Plan Care

We strongly discourage directing care to non-participating providers. Treatments or services available within the Health Plan's network should be performed by a participating provider. Out-of-plan services require prior authorization from our Inpatient Services or Outpatient Services department. Failure to obtain prior authorization will result in a denial of payment. We require a written request documenting the reason(s) the member cannot be treated within the plan's network. While continuity of care is a consideration, it does not automatically result in authorization of these out-of-plan services.

In accordance with federal access standards, family planning is an exception from the above requirements for our members. Members may be referred, or may self-refer, to any family planning provider, regardless of whether the provider participates with the plan. The right of a member to choose a healthcare provider for family planning services shall not be restricted.

Second Opinion

Health Partners Plans Medicaid and Jefferson Health Plans members have the right to a second opinion from a qualified healthcare professional. We provide for a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. If an appropriate professional is not available in-network, the provider or member may identify and arrange for the member to obtain the second opinion out of network. A Letter of Medical Necessity/ LOMN for should be submitted for prior authorization of the out-of-network services.

Continuity of Care for New Members

We are responsible for helping new members transition from another Physical Health Managed Care Organization (PH-MCO) or Fee-for-Service health insurer to our health plan.

We must coordinate and continue to authorize services under the previous provider reimbursement agreement for 60 days up to 90 days if necessary, as outlined below. This allows the new member to continue services with a provider outside of our provider network during this transition period only. We must also send written notification to both the member and the non-participating provider, confirming that the member wishes to follow this arrangement.

For new members under age 21

We will honor the number, length, and scope of services as approved by the prior authorization his/her provider received from the previous plan (for up to 90 days from the date of enrollment with us).

For members 21 and older

We will honor the number, length and scope of services as approved by the prior authorization his/her provider received from the previous plan (for up to 90 days from the date of enrollment with us). However, we may reduce or terminate services prior to the expiration of this period after concurrent clinical review to determine the need for continued services.

If, as a result of the concurrent clinical review, we authorize an alternative course of treatment, a reduction or termination of another MCO's or the Department of Human Services FFS program's approved prior authorization, we must provide proper written notification of the changes to the member and the prescribing provider and honor the member's right to exercise his/her full grievance and fair hearing rights.

If a new member 21 or older is receiving a course of treatment that did not require prior authorization from the member's previous Medical Assistance fee-for-service plan or another PH- MCO, continuation of the service must occur without interruption even if we would ordinarily require prior authorization for that service. This would apply to the transitional period of up to 90 days from the member's date of enrollment with us.

Pregnant members and newborns

If a new (and pregnant) member is already receiving care from an out-of-network OB/GYN specialist at the time of enrollment, she may continue to receive services from that specialist throughout the pregnancy and delivery-related postpartum care. This coverage period may also be extended if a Health Plan medical director finds that the postpartum care is related to the delivery.

We may recruit the new member's non-participating provider to our network or arrange for the service to be delivered by a participating provider if the enrollee consents to the change.

Per Department of Health regulations, providers must agree to our terms and conditions prior to providing service. If the provider does not agree before rendering the service, he/she is required to notify the member.

For Health Partners Plans Medicaid members, coverage will be provided for the mother's delivery and for any inpatient normal newborn stay.

Direct Access for Our Members

Women are permitted direct access to women's health specialists for routine and preventive health care services without being required to obtain a PCP referral or prior authorization as a condition to receiving such services. Women's health specialists include, but are not limited to, specialists such as gynecologists or certified nurse midwives.

In situations where a new (and pregnant) member is already receiving care from an out-of-network OB/GYN specialist at the time of enrollment, the member may continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery.

Abortion

Abortion is only covered in cases of rape, incest or when the life of the member is in danger. A Federal Certification (MA-3) form must be completed by the provider and submitted with the claim to obtain payment.

Specialist as PCP/School-Based Health Centers

A member, provider, caregiver, or advocate acting on the member's behalf may request that his/her specialist/school-based health center be allowed to serve as the member's PCP. Our evaluation of such a request will include a written letter of medical necessity (LOMN) from the specialist/school-based health center and a determination by our medical director.

Our Special Needs Unit (SNU) should be contacted to initiate the request at **1-866-500-4571**. The SNU case manager will confirm that both the member and the specialist/school-based health center agree to the request and will ask that the specialist provide a supporting LOMN. On receipt of the LOMN, the case manager will forward the request to a Health Plan medical director, who will have up to 45 days to make a determination.

The case manager will notify the member and specialist/school-based health center of the determination. If approved, the case manager will also initiate credentialing of the specialist as a PCP/school-based health center. Upon satisfactory completion of the credentialing process, the case manager will notify the member and provider that the requested change is complete. A specialist/school-based health center seeking to serve as PCP must agree to provide or arrange for all primary care, consistent with our preventive care guidelines, including routine preventive care, and to provide those specialty medical services consistent with the member's special need and within the scope of the specialist's training and clinical expertise.

It is routine for an OB provider to act as the PCP throughout a member's pregnancy and the post-partum period; ***no formal request is required*** but the OB provider is expected to coordinate needed care beyond their scope of practice with the member's assigned PCP.

Behavioral Health

Behavioral health services include both mental health and substance abuse services.

Mental Health Services and Substance Abuse Treatment

Health Partners Plans Medicaid: For Health Partners members, the Behavioral Health Managed Care Organization (BH-MCO) for the county in which the member lives is responsible for coordinating and providing all mental health and drug and alcohol services. For the complete listing of BH-MCO's by county, visit https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/ BehavioralHealth-MCOs.aspx.

Jefferson Health Plans Medicare Advantage and Health Partners Plans CHIP/KidzPartners: Appropriate behavioral health services are coordinated for all members in collaboration with Magellan. Our care managers work closely with the behavioral health MCO to ensure that each member receives the right care, in the right place and at the right time. Our care managers will assist with making the connection to an appropriate provider for care and follow through to support the ongoing needs and progress of the member.

All services other than emergency services must receive prior authorization by Magellan.

- Jefferson Health Plans Medicare Advantage – **1-800-424-3706**
- Health Partners Plans CHIP/KidzPartners – **1-800-424-3702**

Please note: members are required to contact Magellan within 24 hours of an emergency admission.

Members may self-refer for behavioral health services. However, PCPs and other physical healthcare providers often need to recommend that a member access behavioral health services. The healthcare provider or his/her staff can obtain assistance for members needing behavioral health services by calling the toll-free numbers noted above.

Cooperation between network providers and the BH-MCOs is essential to assure members receive appropriate and effective care. Network providers are required to:

- Adhere to state and Federal confidentiality guidelines for mental health and drug and alcohol treatment
- Refer Members to the appropriate BH-MCO, once a mental health or drug

and alcohol problem is suspected or diagnosed

- Participate in the appropriate sharing of necessary clinical information (to the extent permitted by law) with the Behavioral Health provider including, if requested, all prescriptions the member is taking
- Be available to the Behavioral Health provider for consultation
- Participate in the coordination of care when appropriate
- Connect with social, vocational, educational and human services resources when a need is identified through an assessment
- Refer to the behavioral health provider when it is necessary to prescribe a behavioral health drug, so that the Member may receive appropriate support and services necessary to effectively treat the problem.

The BH-MCO provides access to diagnostic, assessment, behavioral health referral and treatment services including, but not limited to, the following:

- Inpatient and outpatient psychiatric services
- Inpatient and outpatient drug and alcohol services (detoxification and rehabilitation)
- EPSDT behavioral health rehabilitation services for members up to age 21

Healthcare providers may call the Special Needs Unit at **1-866-500-4571** whenever they need help referring a member for behavioral health services.

Coordination with Behavioral Health

Health Partners Plans Medicaid: All Clinical Programs staff will collaborate with the appropriate Behavioral Health Managed Care Organization (BH-MCO) to coordinate psychiatric services and/or drug and alcohol treatment for any Health Partners member. A case manager will assist members interested in treatment by coordinating conference calls with the appropriate providers to ensure that the connection to the provider is completed.

In addition, the staff will assist members with transportation to either behavioral or physical medical appointments by helping them complete application (http://matp.pa.gov/) to the Medical Assistance Transportation Program (MATP). MATP coordinates rides to and from these appointments for Medical Assistance recipients. MATP offices are located in Chester, Bucks, Delaware, Montgomery and Philadelphia counties. Contact the Special Needs Unit at **1-866-500-4571**.

Health Partners Plans CHIP/KidzPartners: Behavioral health services are covered benefits

for KidzPartners members. Case Managers are available to help KidzPartners members with any special coordination needs.

Jefferson Health Plans Medicare Advantage: Appropriate behavioral health services are coordinated for all members in collaboration with Magellan. Jefferson Health Plans Care Coordinators work closely with the behavioral health MCO to ensure that each member receives the right care, in the right place and at the right time. Our care coordinators will assist with the connection to the provider and follow through to support the ongoing needs and progress of the member.

Anti-Gag Policy

The provider may freely communicate with each member regarding the treatment options available, including information regarding the nature of treatment, alternative treatment, risks of alternative treatments, or the availability of alternative therapies, consultation or tests — regardless of benefit coverage limitations. The provider is expected to educate patients regarding their health needs; share findings of the member's medical history and physical examinations, discuss potential treatment options, side effects and management of symptoms without regard to plan coverage and recognize that the member has the final say in the course of action to take among clinically acceptable choices. No provision of this manual or the Participating Provider Agreement shall prohibit open clinical dialogue between the provider and members.

Our goal is to ensure that all members receive the most appropriate medical care available. We do not directly or indirectly reward physicians, providers, contracted entities, employees or any other individuals participating in utilization review decisions for denying or limiting coverage or service. We also do not provide financial incentives for utilization management decision makers that result in the under-utilization of care or service.

While we may utilize incentives to foster efficient and appropriate care, we do not employ incentives to encourage barriers to care and service. It is therefore expected that all contracted and delegated physicians and providers, as well as employees who deal with utilization review activities, make utilization determinations regarding benefits covered by us based only upon the appropriate use of care and services for the member.

Chapter 9: Quality Management

Purpose: This chapter provides a description of our Quality Management standards.

Topics: Important topics from this chapter include:

Quality Management principles
Quality Management initiatives

Overview

Our Quality Management (QM) program supports the commitment of the organization to provide quality care and service in a cost-effective manner to its members. This is reflected in the National Committee for Quality Assurance (NCQA) awarding an accreditation status to our Medical Assistance plan for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

The QM program is an organization-wide, dynamic, systematic program designed to monitor and oversee all aspects and components of care and service. Monitoring activities include credentialing, utilization management, appeals and grievances, complaints, access and availability of practitioners, assessment of member satisfaction, sentinel event monitoring, medical record reviews, pharmacy service drug utilization reviews, peer review and assessment of our service improvements.

Our health promotion initiatives include preventive health screening reminders, an interactive member portal as well as active care coordination services. We offer a full range of care coordination services for our members that includes Baby Partners (our Maternity Program), Pediatric Care Coordination (for members under the age of 21), Adult, Care Coordination for our adult members with complex needs, and Medicare Advantage and Dual Special Needs programs. For a full description of all the programs as well as contact information please go to Chapter 10.

Quality Management Principle

The QM program is based on the principles and concepts of continuous quality improvement.

The QM program is reviewed and approved annually by our Quality Management Council and Board of Directors. Implementation of all QM activities are monitored by the Medical Director for Quality Management. Updates may be made as necessary throughout the year. A summary of the QM program annual description and work plan are available on request by calling the Provider Services Helpline. For more information, please visit Chapter 1 for Contact Information.

All participating providers are expected to support and participate in the QM program as identified in the provider contracts. Participation by the provider is required to improve the quality of care and services and the member experience. Participation occurs through involvement in various committees and task forces, review and recommendations for draft guidelines, provision of chart copies as requested, providing access to medical records for various chart review studies or investigation of member complaints or quality of care issues, taking part in the credentialing and re-credentialing process, and collection and evaluation of data. Performance data may be used in the development of future quality improvement programs.

Goals
The primary goals of the QM program are to develop and refine monitoring systems that allow us to identify opportunities for improvement in the quality of care being delivered and to craft interventions directed at these opportunities with the ultimate goal of improving the health outcomes of our members.

The specific steps in the process include: analyzing data collected by us for selected quality of care and service indicators to assess plan performance; comparing plan performance to established benchmarks and goals; identifying opportunities for improvement as well as root causes or barriers for areas below goals; designing and implementing interventions that will increase the quality of care and service delivered to members; and re-measuring plan performance to identify the effectiveness of the quality improvement interventions and initiatives.

Program Compliance with Regulatory and Accrediting Bodies
Our comprehensive QM Program is developed and administered in compliance with the standards established by NCQA, the Pennsylvania Department of Human Services (DHS), the Pennsylvania Department of Health (DOH), the Pennsylvania Insurance Department (PID) and the Centers for Medicare & Medicaid Services (CMS).

Annually, we complete Healthcare Effectiveness Data and Information Set (HEDIS) data collection and tabulation. HEDIS is administered by NCQA and is a standardized and comprehensive set of measures and reports that show how managed care plans compare regarding the care provided to members. Approximately 90 measures are reported over six domains: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Risk Adjusted Utilizations, Health Plan Descriptive Information and Measures Reported Using Electronic Clinical Data Systems. Examples of these measures include use, accessibility, and availability of services, how the plan manages preventive care for wellness and cancer screenings and how the plan manages health problems such as heart disease, diabetes, asthma and smoking. The data is an important part of measuring the quality of care provided for our members. Additionally, HEDIS scores impact our NCQA accreditation status.

Further compliance responsibilities are managed through our staff members who are designated as mandated reporters, as defined by the Pennsylvania Family Support Alliance (https://pafsa.org/frequently-asked-questions/), and as such must report suspected child abuse to the appropriate authorities.

Additionally, we must ensure that emergency department staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for Members under the care of the county Children and Youth Agency consistent with their obligations mandated in 18 Pa.C.S. §5106 and all applicable statutes. This includes

reporting to Adult Protective Services any suspected abuse or neglect of Members over the age of 18.

Provider Incentive program
Our provider P4P program comprises of two distinct incentive programs:

The “Quality Care Plus” (QCP) Program was implemented in July 2012 and consolidated several separate incentive plans into a single program for our provider network. This program was designed to recognize and reward our family practice, internal medicine, and pediatric physician offices.

The “Maternity Quality Care Plus” (MQCP) Program is a specialty incentive program designed to recognize and reward maternity care providers’ quality performance.

We collaborate with our larger provider groups to design our provider P4P program. We incorporate feedback received from our provider partners to design our program. In addition, we also analyze our NCQA HEDIS results, state specific mandates and priorities to identify improvement opportunities. We elect to give providers a 3-6 months’ notice prior to implementing QCP changes. This communication approach provides our network a period to positively impact their first payment cycle with those changes in place.

Every year, we share with our network a QCP and an MQCP program description manual, which describes the program, the requirements, the measures included, and payout targets.

Network Management staff meet with individual PCP and maternity practices to discuss the program, review report cards and formulate process improvement efforts to boost low performing measures. In addition, member-level detail reports identifying gaps in care are provided to practices to facilitate targeted outreach efforts.

Community Partnerships
We have built strong partnerships within the communities we serve. We work with our local school systems to provide health education to our youth on topics such as: Breakfast Basics, Anti-Bullying and/or Cyberbullying, Smoking hazards and cessation, Online Safety, Safe and Healthy Summers, and Asthma.

We have representation on multiple boards and committees and assists in the development of educational programs for members of the communities we serve throughout Pennsylvania. In recent years the types of boards and coalitions that we have served on include the following:

- Community Action Networks

- Community Resource Networks
- Concerned Black Men
- Early Head Start Programs
- Food Pantries
- Health Center Advisory Committee
- Homeless advocacies
- Immunization Coalitions
- Intercounty Collaborations
- Lead Poisoning Prevention Organizations
- Maternal and Baby Health Organizations
- Montgomery County Intermediate Unit Health Services Advisory Committee
- NAACP Coalition of Montgomery County
- Neshaminy Coalition for Youth
- Poverty Forum
- University of Pennsylvania Office of Government Affairs
- Voices for Children Coalition

In 2019, we opened our Community Wellness Center in West Philadelphia. Our center has on-site Member Relations, Customer Experience and Medicare Sales teams to assist our members. We provide resources and health and wellness programs that are open to the public and free for the entire family. Offerings include job training workshops, nutrition classes, fitness classes (Zumba, line dancing, yoga, etc.), and more.

Program Components
The QM program utilizes a variety of studies, quality indicators and routine performance monitors that provide an ongoing mechanism for quality improvement. Various performance measures are utilized to evaluate the QM program.

These performance measures include the following, and others:

- Topic-specific focused reviews based on established standards, parameters or guidelines
- Comprehensive medical record review of all primary care physician (PCP), Ob/Gyn and high-volume specialist sites at least every 24 months
- Preventive health/health status reviews (immunization, childhood, adolescent, adult, well elderly, obstetric)
- Population-based studies
- Regulatory programs such as HEDIS, Star and PA performance measures
- Internal quality of care measures
- Model of Care Compliance for Dual Special Needs Program (D-SNP)

- Clinical and/or service audits as mandated by DHS and/or PID
- Member complaints and/or grievances
- Annual member satisfaction survey (CAHPS)
- Physician access indicators
- Appointment availability indicators
- Annual provider satisfaction surveys
- Sentinel events monitoring
- Drug utilization review
- Inpatient quality of care referrals and Adverse events - Hospital Acquired Conditions (HAC), Other Provider Preventable Condition (OPPC) and Potential Serious Adverse Effects (PSAE)
- Over and underutilization reports
- Continuity and coordination of care monitoring
- Evaluation and oversight of all delegations and subcontractors' quality management programs, including dental and vision services
- Adverse events - Hospital Acquired Conditions (HAC), Other Provider Preventable Condition (OPPC) and Potential Serious Adverse Effects (PSAE)

A summary of our Quality Management annual program description and work plan is available on request by calling us. For more information, please visit Contact Information.

Note: Our specialists choosing to leave the network or otherwise becoming unavailable to members (for example, by limiting their practice) must notify us in advance of that change, so we can notify members under their ongoing care.

In keeping with NCQA quality standards, we require that specialists provide 60 days advance notification to us when:

- The entire practice terminates its participation with us
- Any single specialist terminates participation under his/her Health Plan contract
- Any single practitioner within a group practice, or the entire specialty group, leaves or becomes unavailable to members

Quality Initiatives

The Quality Improvement Committee (QIP) and our Health Plan Board of Directors have identified and prioritized activities on which to focus for the future. These initiatives reflect the goals and previous performance levels of our Health Plan, as well as the managed care rules and regulations of the DHS, PID, DOH and CMS. Please refer to the "Healthier YOU" section for a listing of our clinical quality programs. The clinical quality programs assist us to continually improve the health outcomes of our members.

Site Review Prior to Credentialing

Our staff performs site assessments of primary care providers. The purpose of the site visit is to review for factors under the Americans with Disabilities Act (ADA) accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the provider, if different from the building entrance. Site visits will be conducted by a designee of our Provider Relations Team.

The initial credentialing review process includes a review of medical records to assess performance regarding overall medical record keeping standards for primary care physicians including: pediatricians, family practice and internal medicine. That review is completed by our QM nurses. Sites are reviewed annually to determine if members have been seen; if so, the QM department, will request a redacted medical record to assess the medical record keeping standards of the provider site. It is preferred that they send that record electronically prior to the physical site visit being performed by the Network Management representative. Once the redacted medical record is received the QM nurses will conduct their review.

Site review results are forwarded to each practitioner/practice. All deficiencies identified during the site visit must be documented on the site visit tool and reviewed with the provider office staff. A plan of action to remediate must be documented and a re-review must occur within 30 calendar days. If the location fails the second site visit an additional 30 day remediation period will be allowed, at which time a third site visit must occur to review the defined deficiencies. If the location fails the third site visit, the location must be removed from our network until the provider remedies all identified deficiencies. If the provider requests to add that location again in the future, a full site visit will be required and any noted deficiencies must be corrected before that location can be added to our network.

Member Satisfaction Survey
We partner with an outside agency to perform the Consumer Assessment of Health Providers and Systems (CAHPS) survey in accordance with HEDIS and NCQA requirements. Members are specifically asked to rate quality of service, quality of care and satisfaction with their providers of care, and the health plan. After results are reviewed by the QM Department the results are presented to internal committees for review and formulation of initiatives to aid in improvement. Providers may be asked to participate in initiatives aimed at increasing customer service awareness.

Provider Satisfaction Survey
We conduct an annual satisfaction survey of the provider network to assess satisfaction with the plan. The survey tool also allows for comments and recommendations from the provider network. The responses provide a catalyst for an internal review of our programs and services, helping to identify areas of strength and opportunities for improvement. The results are reviewed by the QM Committee, a peer review committee that provides input on the findings and our strategies to improve satisfaction and services.

Provider Quality of Care Sanctions and Appeals

The following section provides an overview of possible provider sanctions and the appeal process associated with Quality Management initiatives and actions.

Quality of Care Level

Quality of Care levels are numerical codes used to categorize the severity of an event that may constitute a potential adverse effect. These codes are assigned during the investigation and review process by the QM department (levels 0 and 1) or the Credentialing Committee (> or = to a level 1). There are four levels currently used in this process. These are:

- Level 0 - No Quality of Care Concern(s) Identified
- Level 1 - Quality of Care Concern(s) Identified, with no risk of patient harm
- Level 2 - Quality of Care Concern(s) Identified, with potential for harm but not identified (no direct link/causation was established that the quality of care concern(s) identified caused patient harm).
- Level 3 - Quality of Care Concern(s) Identified, Potential for Patient Harm and/or Patient Harm Occurred

Quality of Care Sanctions

It is our goal to assure the provision of quality health care services in an efficient and economical setting. A provider may be subject to quality of care review and sanctions by us when a review of an individual incident or a trend of data reveals that a practitioner or provider is not in conformity with local standards of care or practice, quality management and utilization management criteria; has failed to adhere to policies and procedures established by us; or has failed to demonstrate improvement following a specific corrective action process.

- Quality of care sanctions for our providers will be determined on a case-by-case basis.
- Quality of care sanctions may apply to any service provided where a review indicates there was a deviation from the standard of care regarding diagnosis, treatment or expected outcome.

The appeal process applies to any provider who has received a quality of care sanction from us.

Responsibility and Authority

A Health Plan Medical Director will review all potential quality of care sanctions. Sanctions for quality of care will be reported to the Credentialing Committee and to our Vice

President, Chief Medical Officer (CMO). All sanctions that may lead to termination of a provider's Agreement with us are also discussed with the Senior Vice President Clinical and Provider Management, who reports to the President and Chief Executive Officer (CEO) of our Health Plan, prior to any termination action being taken.

Cases where a potential for immediate harm to members is identified will be reviewed with the Health Plan CMO or their designee who can act immediately to terminate health plan participation if patient welfare will be compromised by delay. An investigation of the facts and circumstances will take place prior to the termination action.

Sanction Process and Appeal Procedure
If, following review of the individual circumstance, we determine that the provider's treatment and care of a member is not in conformity with local standards of care and practice, quality management and utilization management criteria, or the provider has failed to adhere to policies and procedures established by us, then the Health Plan CMO or designee may issue sanctions. Sanctions may include but are not limited to:

- Closing the provider's panel to new members
- Removing all or part of the provider's panel
- Terminating the provider's agreement
- Transferring members to a new provider
- Imposing financial penalties

The sanction process will typically work as follows:

- The provider will receive a letter identifying the issue(s) and will be provided an opportunity to conform to the appropriate procedures and protocols within a specified time frame.
- Repeated instances of nonconforming behavior may subject the provider to a second letter and the provider will not be permitted to accept additional members until all issues are resolved to our satisfaction.
- Failure to conform thereafter will be grounds for immediate termination of the provider's agreement with us.

Notwithstanding the foregoing, if, in the sole discretion of the Health Plan, the provider's behavior is egregious, negligent, criminal, or threatens the ability of us to ensure quality health care to members, the provider agreement may be terminated immediately. In the event of such termination, the provider will not be permitted to accept additional members and the provider's current member panel will be advised that the provider is no longer a physician authorized to provide medical services to our members. Cases when there is a potential for immediate harm to members will be reviewed with our CQO or designee who can act immediately to terminate health plan participation if patient welfare

will be compromised by delay. An investigation of the facts and circumstances will take place prior to the termination action.

Appeal/Sanction Dispute
The provider may appeal/dispute the proposed quality of care sanctions by presenting a written explanation, dispute letter, to us, Attn: HPP Legal Affairs Dept., within 30 business days of the notice of action or sanction. The Dispute Letter shall detail the reason(s) such action or quality of care sanction should not be implemented.

If no Dispute Letter is received by us within 30 business days of the notice of action or sanction, then the proposed sanction will become final, and we will implement the sanction as soon as practical.

If the provider timely submits a Dispute Letter, we will appoint either a single hearing officer (not employed by us) or a multi-person Sanction Review Panel to hear the provider's dispute. A sanction hearing date will be scheduled within 60 days of our receipt of the provider's Dispute Letter.

At least 30 business days in advance of the sanction hearing, we shall notify the provider of the date, time, and location of the hearing, as well as the name(s) of the hearing officer or panel members, and the name(s) of any witnesses expected to testify on behalf of the Plan. The hearing will be coordinated by our Health Plan Legal Affairs department.

In the hearing notification letter, we shall notify the provider of his/her right to be represented at the hearing by an attorney or other representative, the provider's right to call, examine and cross-examine witnesses, his/her right to submit a written statement at the close of the hearing, and his/her right, upon timely notice given to us, to have a record made of the hearing at the provider's expense. The hearing notification letter will also notify the provider that if the hearing panel affirms our proposed sanction, the provider is required to pay the reasonable costs of the hearing incurred by us, including but not limited to any expert witness expenses, costs of transcripts and attorney's fees.

At least 10 business days in advance of the hearing, the provider must notify us in writing of the names of the provider's witnesses and all supporting documentation the provider intends to present at the hearing. Also, should the Provider wish to be represented by an attorney or other representative at the hearing, the Provider must also notify us of the representative's name at least 10 business days in advance of the hearing.

The hearing officer or panel shall make a written report of its decision and the basis thereof, within 30 business days of the sanction hearing date. We shall notify the provider of the hearing officer or panel's final decision within 30 business days after its receipt of the hearing panel's conclusion.

Regardless of whether a sanction hearing is held, those incidents that result in a limitation of a physician's clinical privileges for more than 30 business days, or result in a quality of care termination, are generally considered to be a reportable sanction. The reporting to the National Practitioners Data Bank and DHS when applicable is done by us.

Pharmacy Drug Utilization Review
Our pharmacy drug utilization program is coordinated with our quality assurance programs to achieve quality care through a disease management approach.

The pharmacy Drug Utilization Review Program (DUR) is designed to identify and correct potentially harmful prescribing patterns, enhance community-prescribing standards and detect patterns of fraud and abuse. The policy and procedures meet federal statute/regulations, 42 Code of Federal Regulations (CFR) 456, as well as NCQA guidelines. Our continuous quality improvement philosophy allows for annual evaluation and assessment of the program, resulting in the implementation of improved programs that are responsive to the needs of our members and providers.

The Prospective DUR system provides us with the ability to minimize the number of potentially dangerous conditions that result from improper drug utilization.

The system achieves this objective by:
reviewing prescription drug claims for therapeutic appropriateness prior to medication dispensing
using criteria that include the patient's medical history and clinical parameters
focusing on those members with conditions that place them at the highest level of risk for a potentially harmful outcome

The system evaluates each incoming drug claim when the pharmacist enters the information for the prescription with respect to the member's drug and medical history. The system identifies potential drug therapy problems. Monitoring is accomplished through an online alert message system that transmits a message in conjunction with claim adjudications that may present potential therapeutic problems. When appropriate, the pharmacist receiving this advice then takes additional steps to evaluate the order, such as calling the prescribing physician.

The following drug therapy problem types are evaluated:
excessive drug dosage (age-specific)
insufficient drug dosage (age-specific)
drug pregnancy contraindications
excessive quantity dispensed
early refill (over utilization)
late refill (underutilization)
drug age contraindications

drug to drug interactions
therapeutic duplications
drug to diagnosis contraindications
generic product availability

All criteria are rated using the following severity indicators:
cause serious harm to relatively few people (high risk and low incidence),
cause relatively minor harm to a large number of people (low risk and high incidence), and
significantly increase the cost of health care by increasing hospitalizations or other treatment modalities

In the event a medication requires prior authorization, a system alert message will appear, advising the pharmacist to call for prior authorization.

A claim that is submitted either online (or, if previously approved for paper, via paper claim) by a participating pharmacy and subsequently approved for payment that includes DUR messages is subject to post-payment audit and recoupment if written documentation is not maintained that pertains to the message(s) returned with the claim. If a message is returned saying that the approved claim has a dosage that exceeds standards developed by a national database company, and no notation is retrievable that documents a discussion between the pharmacist and the prescriber verifying the high dose, the claim is subject to reversal upon audit. Likewise, a claim paid but returned with duplicate therapy message is subject to reversal unless there is documentation demonstrating that the prescriber spoke with the dispensing pharmacist and approved the concurrent administration of both drugs involved.

Retrospective Drug Utilization Review
Retrospective Drug Utilization Review (RDUR) provides a focused member-specific review of a particular drug, therapeutic drug class or issue. The review identifies potential opportunities for improvements in the members' therapies or practitioners prescribing practices within the therapeutic class. The RDUR is designed to ensure ongoing periodic examination of pharmacy claims data, including other medical records as appropriate, through computerized drug claims processing and information retrieval systems. This is used to identify patterns of inappropriate or medically unnecessary care among members enrolled in the plan, or associated with specific drugs or groups of drugs. Retrospective review of providers' and members' drug utilization is performed to improve quality of care and product cost savings that cannot be realized through prospective DUR alone.

Examples that may be addressed by RDUR if concurrent and prospective DUR is not enough:

- FDA withdrawal of medications or safety warnings
- Manufacturer voluntary withdrawal of medications
- Appropriate generic use

- Clinical abuse/misuse
- Drug-disease contraindications
- Drug-drug interactions
- Inappropriate duration of treatment
- Incorrect drug dosage
- Use of formulary medications whenever appropriate
- Over and under utilization
- Therapeutic appropriateness and/or duplication
- Inappropriate use of medications with no diagnosis
- Importance of adherence and compliance to medication
- Inappropriate use of controlled substance

The RDUR program evaluates the appropriateness of therapy from a variety of perspectives, with a primary focus on ensuring safety and efficacy and a secondary focus on reducing unnecessary cost. Clinical pharmacists review flagged profiles based on product selection, dosage, quantity and duration. Our pharmacists review the clinical appropriateness of proposed interventions and communications with prescribing practitioners may be warranted. Depending upon the finding, our Pharmacy department may provide the prescriber and/or the member education as appropriate. This education may be targeted through specific member intervention letters or through the member newsletters and updates on our website. Our website will also be used to supply education and updates for all members and providers.

Chapter 10: Clinical Programs

Purpose: This chapter provides an overview of our clinical programs.

Topics: Important topics from this chapter include:

Clinical Programs—Medicaid, CHIP and Individual and Family Plans
Baby Partners
Pediatric Care Coordination
Adult Care Coordination
Clinical Connections

Medicare Care Coordination

- Duals Special Needs Plan

Clinical Programs—Medicaid, CHIP and Individual and Family Plans

Clinical Programs is a department that is responsible for care coordination services (also known as case management services) that promote self-management of health care needs and address the needs of the membership across the life continuum. Clinical Programs is comprised of special teams that offer a holistic approach of care coordination by addressing social, behavioral as well as physical health care concerns of the member.

Clinical programs available to our members include:
Baby Partners. (Medicaid, CHIP and Medicare members) A perinatal program that follows expectant mothers from the first notification of pregnancy through up to at least 84 days post-delivery and may refer mom or baby for continued care coordination if needs are identified.
Adult Care Coordination. (Medicaid and Individual and Family Plans) Assists adult members with multiple chronic conditions and/or social needs to obtain all the services that they may need to follow the health care plan of their PCP or Specialist.
Pediatric Care Coordination formerly Special Needs. (Medicaid, CHIP and Individual and Family Plans) Assists children with multiple health care concerns to obtain the health care services that they need with strong emphasis on fragile children and children with certain chronic conditions. These care coordinators are well versed in important childhood milestones as well as needed vaccinations and preventive care.
Clinical Connections. (Medicaid and CHIP) Provides discharge screenings, health risk assessment follow-up and disease education for members who are not associated with other Health Plan programs.

To refer members to any of our clinical programs please use the referral form on our website, email ClinicalConnections@jeffersonhealthplans.com **or call 215-845-4797 for providers and a representative will connect you to the appropriate program.**

How are members identified for our case management services?
Identification: We proactively identify members who may benefit from care coordination services based on a population stratification model that consists of benefit category, special needs indicator on the eligibility file, ER, inpatient, readmission utilization, severe and persistent mental illness, chronic conditions, care gaps and risk score that is calculated using a software product managed by our Health Care Economics (HCE) area.
Referrals: Members, providers, practitioners, regulatory agencies, Health Plan internal departments such as Pharmacy, Member Relations, Utilization Management, all may refer to any clinical program.
Interventions: Including telephonic outreach, mailings, face to face case management either in the home setting, virtually or community based.
Evaluation of the Effectiveness of the Program: Annually, we evaluate the effectiveness of the programs, based upon reduction in ER use, inpatient admissions and readmissions.

What is involved in Care Coordination?
Our services are in place to address the needs of the membership across the life continuum—prenatally through adult care needs. A critical component of this includes collaboration on member's identified goals and interventions between the member, families/designated member representative, the member's healthcare providers and community agencies as appropriate. The assessment tool that is used by staff integrates physical and behavioral health with psycho-social wrap around services to address social determinant needs. All clinical programs follow evidence-based guidelines and standards of care while being mindful of the member's cultural, linguistic and gender specific preferences. Care Coordinators assist members in following through with the treatment plan outlined by the member's primary care physician (PCP) and/or specialist. The goals of the program are to transition members to self-management and/or help them to achieve an optimal state of health. Interventions—which only follow a comprehensive evaluation of the member's health status, (including cognitive functions, psychosocial, vision and hearing needs and clinical history)—may include:

- Proactive assistance in scheduling PCP/Specialist appointments, dental and behavioral health care appointments as well as maternal home visiting programs as appropriate
- Assistance with PCP selection or other health care providers as requested
- Coordination of care for members in substitute care
- Integration of care plan goals and interventions with the member's specific Behavioral Health MCO care management team
- Transportation assistance (as needed)
- Support management of chronic conditions through condition education and medication adherence
- Proactive assistance in addressing care gaps specific to the member based on age, gender and chronic condition
- Review of discharge instruction and coordination of care post inpatient stay
- Coordination of home care services and durable medical equipment and other prior authorization needs
- Caregiver coordination (with member's consent)
- Assistance in addressing barriers to health that may include, but are not limited to, food resources and housing concerns
- Linkage to community resources for services such as utility services support and GED and employment opportunities
- Behavioral health referrals and coordination of needed services
- Assistance with medication delivery to ensure compliance
- Explanation of benefits including member rewards program and complaint and grievance filing if applicable
- Assistance with life planning needs
- Smoking cessation resource and program referral (when applicable)

- Dietary counseling/support, as well as food resources, in member's zip code
- Participation in interagency team meetings (as requested).

***Tip**: Providers may be eligible to participate in the Maternity Quality Care Plus (MQCP) incentive program. This program rewards maternity care practices based on the quality of care our pregnant members receive. Contact our Network Management staff for more details.*

Additional Provider Tips:
Providers who have Medicaid members (under the age of 21) assigned to their panels are required to track and outreach to members who are in need of EPSDT services or are not up to date on all EPSDT periodically scheduled needs.

New Medicaid members are required to have a complete physical exam within 45 days of enrollment unless under the care of assigned PCP.
CONNECT assists parents/ families in locating resources and providing information regarding child development ages birth to age 5 by calling 1-800 692-7288 or visiting www.connectpa.net.

Providers who have CHIP members assigned to their panels are required to track and outreach to members who are in need of services or are not up to date on all required needs.

Individual and Family Plans Care Coordination

Care Coordination services are available for the members who require assistance with accessing care, coordinating care, identifying community resources for SDOH, and educational guidance and support for their illness. Identified barriers, coordination to care and resources are managed by the Care Coordinator in partnership with their identified health care providers.

To refer members to any of our clinical programs please email ClinicalConnections@jeffersonhealthplans.com or call 1-866-500-4571, press prompt 2 for providers and a representative will connect you to the appropriate program.

Medicare Advantage Care Coordination

We make Care Coordination services available for our Medicare members who require assistance with accessing care, coordinating care, identifying community resources for SDOH, and educational guidance and support for their illness. The Care Coordinator evaluates the member's healthcare needs through a health risk assessment (HRA) for our Dual Special Needs Plans (DSNP) members. The HRA assists us to identify the medical, functional, cognitive, psychosocial, mental health and any social determinants of health care needs or barriers that may prevent our members from accessing needed care and

services. Identified opportunities and barriers, coordination and access needs are managed by the Care Coordinator. The Care Coordinator works closely with the member/caregiver (s) and provider to achieve agreed upon goals that will improve their health outcome.

Jefferson Health Plans Medicare Advantage Care Coordination is available for all Medicare Plans in Pennsylvania and New Jersey.

- Pennsylvania: Our Special and Pearl (HMO SNP) Plans – (Pearl is New! January 1, 2024), Prime, Complete and Giveback (HMO POS) Plans (Giveback is New! January 1, 2024)
- Pennsylvania: Our Flex and Flex Plus (PPO) Plans (New! January 1, 2024)
- New Jersey: Our Silver and Platinum Plans

Our Care Coordinators will:

- Complete a Health Risk Assessment Tool (HRAT) to identify a member's needs. HRAT's must be completed for all Medicare DSNP (Special and Pearl Plans) members.
- Assist members to understand and comply with their treatment plan outlined by the member's PCP and or specialist
- Assist with arranging transportation to healthcare appointments
- Ensure services are in place before, during and after a transition of care
- Provide preventive health reminders and disease specific education
- Coordinate behavioral health services
- Coordinate and collaborate needed Medicaid services provided by Community Health Choices (CHC) plans (DSNP)
- Address SDOH needs and refer to needed community resources such as housing, food, and transportation
- Discuss life planning that includes power of attorney, advance directives and living wills

Dual Special Needs (D-SNP) Medicare Plan members
As a Jefferson Health Plans Provider your responsibilities related to providing services to our Dual Special Needs Members include:

- Completing Annual Model of Care (MOC) Training. This MOC training describes the goals and objectives of our DSNP MOC program as well as your roles and responsibilities.
- You may access the MOC training via our required training webpage.
- You will be contacted via a letter by the Jefferson Health Plans Care Coordinator inviting you to attend an Interdisciplinary Care Team (ICT) meeting to review and discuss your patient's Individualized Care Plan (ICP).

- Attached to the ICT invite letter is your patients ICP may contact your patient's Jefferson Health Plans Care Coordinator at any time to change or update the care plan.

Chapter 11: Provider Practice Standards & Guidelines

Purpose: This chapter provides an overview of the current provider practice standards and guidelines used by us.

Topics: Important topics from this chapter include:

Access and appointment standards
Provider office practice standards

Overview

Providers that participate with us must adhere to certain standards and guidelines to remain a participating provider. This chapter provides documentation of these contractual requirements.

Access and Appointment Standard

The following table specifies the office access and appointment standards we require provider practices to meet.

Table 11A: Provider Access and Appointment Standards

Criteria	PCP	OBGYN	Specialist
Routine Office Visits	Within 10 business days	OB: Initial prenatal visit within 24 hours of identification of high risk by Jefferson Health Plans or maternity care provider or immediately if emergency exists. First prenatal visit (pregnant 1–3 months): Within 10 days First prenatal visit (pregnant 4–6 months): Within 5 days First prenatal visit (pregnant 7–9 months): Within 4 days GYN: Within 10 days OB/GYN: Within 5 days of effective date of enrollment	Otolaryngology, dermatology, pediatric endocrinology, pediatric general surgery, pediatric infectious disease, pediatric neurology, pediatric pulmonology, pediatric rheumatology, dentist, orthopedic surgery, pediatric allergy and immunology, pediatric gastroenterology, pediatric hematology, pediatric nephrology, pediatric oncology, pediatric rehab medicine, and pediatric urology: Within 15 business days All other specialists: Within 10 business days
Routine Physical	Within 3 weeks	N/A	N/A
Preventive Care	Within 3 weeks	N/A	N/A
Urgent Care	Within 24 hours	Within 24 hours	Within 24 hours
Emergency Care	Immediately and/or refer to ER	Immediately and/or refer to ER	Immediately and/or refer to ER
First Newborn Visit	Within 2 weeks	N/A	N/A

Patient with HIV Infection	Within 7 days of enrollment for any member known to be HIV positive unless the member is already in active care with a PCP or specialist regarding HIV status	N/A	Within 7 days of enrollment for any member known to be HIV positive unless the member is already in active care with a PCP or specialist regarding HIV status
EPSDT	Within 45 days of enrollment unless the member is already under the care of a PCP and the member is current with screenings and immunizations	N/A	N/A
SSI Recipient	Within 45 days of enrollment unless the enrollee is already in active care with a PCP or specialist	Within 45 days of enrollment unless the enrollee is already in active care with a PCP or specialist	Within 45 days of enrollment unless the enrollee is already in active care with a PCP or specialist
Office Wait Time	30 minutes (or up to 1 hour if urgent situation arises)	30 minutes (or up to 1 hour if urgent situation arises)	30 minutes (or up to 1 hour if urgent situation arises)
Weekly Office Hours	At least 20 hours per site	At least 20 hours per site	At least 20 hours per site
Maximum Appointments per Hour	6	N/A	N/A

Telephone Availability Standards

Telephone availability standards are closely monitored through our member satisfaction surveys, site reviews, and member complaints. These standards include:

- All PCPs must be available to members for consultation regarding an emergency medical condition 24 hours a day, seven days a week.
- After regular office hours, the PCP should return member calls within one hour of when the member called. Coverage may be shared with another PCP participating with us.
- If a PCP uses an answering service, the assigned service person must be capable of taking a message and contacting the physician directly and immediately.
- An appointment system for scheduling all routine visits is also a requirement. At a minimum, this includes an appointment book and written notice given to patients stating date and time of next appointment. Evidence of compliance with these minimum access standards is sought at the time of initial credentialing, at recredentialing, and at interim periods if non-compliant activity is noted.

- For any missed appointment, the PCP or specialist should make three attempts to contact the member about the missed appointment. At least one of such attempts must be a follow-up phone call. Documentation of the notices and telephone calls should be placed in the medical record.

The PCP or specialist should ensure that the average office waiting time does not exceed 30 minutes. When the physician encounters an unanticipated urgent visit or is treating a patient with a difficult medical need, the wait time should not exceed one hour.

The hours of operation of a provider must be convenient for and not discriminate against our members. Provider services need to be available 24 hours a day, 7 days a week, when medically necessary.

We use the Council for Affordable Quality HealthCare (CAQH) online provider application tool. It is required for you to maintain current and accurate information on CAQH and re-attest to the information in your CAQH application as required.

Medical Information Confidentiality

Issues of confidentiality concerning medical information are addressed in our Notice of Privacy Practices, among other areas. This notice is distributed to all of our members as required by the federal government. It describes how medical information about members may be used, and how members can access this information. This policy is also posted on our Privacy Practices webpage under "HIPAA Notice of Privacy Practices."

The HIPAA Notice of Privacy Practices includes:

- How we protect member health information
- Our privacy practice
- How we use or share information

Member Confidentiality

All Health Plan contracts with health care providers contain a provision titled "Confidentiality and Accuracy of Records." This provision states that the provider agrees to abide by all federal and state laws regarding confidentiality and disclosure and shall treat all enrollees' health and enrollment information, including any medical records or mental health records as confidential in accordance with the provisions of the Agreement, and comply with all applicable laws regarding the confidentiality and disclosure of such health and enrollment information. When disclosing member information, legal restrictions include those mandated by:

- The Pennsylvania Act 1998-68, the Quality Health Care Accountability and Protection Act, Section 2131 and the Department of Human Services regulations (5100.31 through 5100.39)

- Pennsylvania Act 148, the Confidentiality of HIV-Related Information Act
- The Code of Federal Regulations Title 42, Part 2: Confidentiality of Alcohol and Drug Abuse Patient Records
- Health Insurance Portability and Accountability Act (HIPAA)

It is our policy that:

Privacy of any information that identifies a particular member must be safeguarded. Information from, or copies of, records may be released only to authorized individuals, and providers must ensure that unauthorized individuals cannot gain access to or alter member records. Original records must be released only in accordance with federal or state laws, court orders, or subpoenas. Providers must have policies and procedures on safeguarding, releasing and office procedures on patients' confidential medical records.

Records and information must be maintained in an accurate, confidential, and timely manner.

Members must be given timely access to their records and information. (If requested, the provider must supply the member with a copy of his or her paper medical record, at no charge, unless the provider believes that supplying such record is not medically advisable.)

All federal and state laws regarding privacy, confidentiality and disclosure for mental health records, medical records, other health information and member information must be adhered to.

Provider Confidentiality

All of our Credentialing department policies specify that all provider information is maintained in strict confidence and that all provider files are maintained in a secured storage area and are shredded before disposal.

All health care information presented to the peer review committees (Utilization Management, Pharmacy and Therapeutics, and Quality Management) is blinded prior to presentation to the committee members to protect the identity of the individual health care provider.

Health care provider information will be disseminated as required by law in response to a court order or subpoena. This process is handled in conjunction with our Health Plan's Legal Affairs department and follows the rules established by state law. When disclosing provider information, legal restrictions include those mandated by:
Title IV of Public Law 910-660, the Health Care Quality Improvement Act of 1986
The Peer Review Protection Act

Confidentiality of Other Information
Our participating providers may not disclose (by oral, written, electronic or other means) any financial or other proprietary information except as required by the Department of Human Services, the Pennsylvania Insurance Department or by law.

Credentialing/Recredentialing

As part of our Quality Management program — as well as National Committee for Quality Assurance (NCQA), Department of Human Services (DHS), Department of Health (DOH), Pennsylvania Insurance Department (PID) and Centers for Medicare & Medicaid Services (CMS) guidelines—participating PCP, specialist, allied health, ancillary and hospital providers undergo an initial credentialing process. Practitioners are recredentialed every three years and they must show evidence of satisfactorily meeting our quality of care and service measures for their members.

Providers who wish to be credentialed by us must submit a complete application and a signed Provider Data Collection form to release information.
We require the use of the CAQH application but will also accept the Pennsylvania standard paper application. Other documents required to complete the credentialing process are as follows: Primary Source Verification (PSV) is completed in alignment with NCQA, DHS, CMS and our credentialing standards. Please visit our website for our credentialing standards.

The process for providers due for recredentialing is initiated three months prior to their recredentialing due date. We will use the CAQH application to verify and update information for recredentialing purposes. If a CAQH application is not on file, we will reach out to the provider to obtain an updated application.

Information that will be required and verified at the time of recredentialing is as follows:

- Signed and dated “Provider Data Collection” form, as applicable
- Signed and dated Provider Questionnaire and Attestation Statement.
- Current state medical license
- Current DEA certificate
- Recertification of board certificate, as applicable
- Official documentation of ongoing CME activity
- Current copy of professional liability insurance face sheet
- Malpractice history, if applicable
- Accreditation certificate (ancillaries and hospitals)
- Hospital privileges (need signed hospital attestation for a participating Health Plan hospital). All specialists need to have admitting privileges. PCPs can have covering arrangement with participating provider.

- Medical Assistance identification number (to obtain an active Medical Assistance identification number, visit the provider enrollment section of the DHS website at www.dhs.pa.gov.
- Sanctions screenings (MediCheck, OIG, SAM, and Security Administration Death Master File) Medicare (CMS) identification number
- NPI number (individual and billing), using NPPES

All PCP sites are required to meet handicap accessibility as mandated by the Americans with Disabilities Act (ADA). Verification of those requirements may be made by a site visit to the practice location or by another means defined by us. In addition, medical record audit will be completed upon initial participation into the network and at least every two years to assess compliance with medical record keeping practices. See appendix for ADA and medical record documentation standards.

Compliance with appointment availability standards will also be assessed. Quality review audits are completed every two years and are managed outside of the credentialing and recredentialing cycles. Concerns noted during these reviews are documented and addressed with the provider and could result in a corrective action plan (CAP).

The decision of the Credentialing Committee to accept or deny a practitioner into the network will be communicated in writing by our medical director. If a provider is denied, the reason for denial and information regarding the appeal process are noted in the denial letter.

We offer each practitioner the right to review any of the information submitted in support of their credentialing/recredentialing application. Additionally, the practitioner has the right to correct any erroneous information by supplying the corrected information in writing to the Credentialing department. The provider also has the right to appeal the decision of the Credentialing Committee.

In compliance with DHS, PID and CMS regulations, we will not employ or contract with any provider/individual (or with any entity that employs or contracts with such provider/individual) who is excluded from participating in Medicaid or Medicare for the provision of any of the following: health care, utilization review, medical social work and/or administrative services.

Process for Providing Credentialing and Re-Credentialing Status
Providers can check the status of their credentialing application by emailing the Credentialing Department at credentialing@jeffersonhealthplans.com. The Credentialing inbox is monitored daily and a response will be provided within 48 hours of receipt of the initial request.

Practice Changes

The Network Management department must be immediately notified in writing when any of the following occurs. All professional provider data changes, can be emailed to datavalidation@jeffersonhealthplans.com

- Additions/deletions of providers
- Change in payee information (W-9 required)
- Change in hours of operation
- Provider practice name change
- Telephone number change
- Site relocation
- Site location terminations
- Full practice terms
- Change in patient age restrictions

For ancillary providers including, Physical, Occupational and Speech therapy, email changes to the applicable email box below.

Credentialing@jeffersonhealthplans.com

- Site relocations or closures – (credentialing application and roster is required)
- NPI & Promise Id number changes

Contracting@jeffersonhealthplans.com

- Initial contract (roster and application required)
- Change in group/practice ownership
- Tax id change (W-9 form is required)

ProviderData@jeffersonhealthplans.com

- Additions/links/terms of hospital based/ facility based/ PT / OT/Speech providers (hospital-based profile or roster required)
- Change in payee information- W9 is required
- Change in hours of operation
- Telephone number change
- Change in age restriction

Tax ID or NPI changes require a W-9 form and can be emailed to contracting@jeffersonhealthplans.com.

* Providers should also check the DHS PROMISe system on a routine basis to confirm demographic data, including all service locations/revalidation dates to ensure information is current and have an active PROMISe ID.
Please visit the DHS webpage at PROMISe Enrollment (pa.gov) for requirements and step by step instructions.

Administrative Terminations
Providers who fail to maintain compliance with our credentialing standards will be presented at the next regularly scheduled Credentialing Committee meeting for discussion and decision making. These are the exceptions to this policy.

Administrative Terminations	
Circumstance	**Action upon Health Plan notification**
Loss of medical license	Provider will be terminated immediately from all lines of business.
Inactive PROMISe ID with the Commonwealth of Pennsylvania	Provider will be terminated immediately from our Medicaid network.
Inactive participation with CMS	Provider will be terminated immediately from our Medicare network.
Suspension or termination from participation in the Medicaid or Medicare programs	Provider will be terminated immediately from all lines of business.

We run monthly checks against licensure, DEA, malpractice, and board certification and will send letters to providers in advance of the expiration date of those credentials. If the credential is not renewed and able to be primary source verified prior to the expiration date, the provider will be terminated effective the day following the expiration date of the credential.

***Note**: In addition, we also utilize the System for Award Management (SAM) to access the General Service Administration (GSA) precluded list, the OIG system and the MediCheck system. These lists are reviewed during credentialing and recredentialing and twice a month for sanction activity. Any provider who is identified as being precluded will be immediately terminated by us according to the terms of their agreement with us.*

Voluntary Provider Terminations
Providers are required to provide us with 60 days notice from terminating from the network unless their participating provider agreement stipulates otherwise. This notice must be provided in writing and should be addressed to the notification contact stipulated in the participating provider agreement.

We are required to notify all impacted members of a pending provider termination at least 30 days prior to the effective date of termination. We encourage the provider to issue their own notification to their members when terminating from our network.

Role of the Primary Care Physician (PCP)
Some of our products require members to select a primary care physician (PCP) or gives members the option to select a PCP. The PCP is usually the starting point for a member to receive medical care and acts as the gatekeeper for all future care provided. It is important for the PCP to stay connected with all their members and encourage them to utilize the primary care services available to them.

While we expect that much of our members' needs can and will be addressed by their PCP, we also acknowledge the need for more specialized services and that the member's PCP will use his or her education, experience and best medical judgment to direct members out for additional care when needed. PCP referrals to a specialist are not required for Medicaid, Medicare and CHIP members.

We stress the need for members to stay connected to their PCP (e.g., in cases where they are receiving care from other medical professionals, including but not limited to prescription care), continue to maintain the relationship with their PCP, and ensure that their PCP has access to their most current medical condition and services received.

Access to PCP care is vitally important to maintaining the health of our members and, when possible, steering them away from the use of emergency rooms when their condition can more appropriately be managed in a PCP office environment. A PCP is required to provide access to care as outlined in the Access and Appointment Standards section of this chapter. In addition, a PCP must be accessible 24 hours per day, 7 days a week.

Each PCP must follow all periodicity schedules, use appropriate health assessments or documentation, and maintain an individual medical record for all patients. In addition, any PCP providing care to members up to age 18 must participate in the Vaccines for Children (VFC) program.

The PCP is responsible to assess the mental stability of their members and should direct care to behavioral health care services as appropriate. The PCP has a right to inform the member how to access mental health services and coordinate access to these services, when necessary.

The PCP is responsible for communicating effectively with members by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with Low English Proficiency (also known as LEP) when needed by the member as outlined in the Cultural Competency & Nondiscrimination chapter of this manual.

Advance Directives

Advance Directives are written documents designed to allow competent patients the opportunity to guide future health care decisions if they are unable to participate directly in medical decision making. The Patient Self-Determination Act requires that patients be informed about their right to participate in health care decisions, including their right to have an advance directive.

Our member handbook contains information concerning advance directives. Providers must document in a prominent part of a member's current medical record the presence or not of an executed advance directive and follow all applicable state and federal laws regarding the execution of these directives.

Each state has different regulations for the use of advance directives. Two common forms used for advance directives are the Living Will and the Durable Power of Attorney for Health Care Decisions. We require participating providers to document discussion of a living will or advance directive.

If you require more information regarding advance directives, there are several sources of information available, please visit Advance Directives in the Appendix.

Employee Screening Standards

Participating provider offices agree, under their contract with us, that all providers, employees, owners, agents, and managing partners within the provider office, prior to being hired and monthly thereafter, must be screened using PA MediCheck (and any other applicable state exclusion lists), the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), and the Excluded Parties List System (EPLS) on System for Award Management (SAM) databases. It is the responsibility of the employer to perform the sanction screenings on all employees within the Fraud, Waste & Abuse safeguards of participation in the Federal and State government programs.

Provider Office Practice Standards

On the following pages, you will find a table listing our mandatory and recommended Provider Office Standards. Please first note the Mandatory and Recommended Emergency Procedures.

Mandatory Standards

Staff members who are licensed or administer patient care must be CPR-trained and available during patient hours.

Emergency equipment and supplies must be present and appropriately maintained.

All primary care and specialty practices that administer injectable medications with a potential for anaphylactic reaction must maintain adrenaline or epinephrine, and an appropriate means and qualified staff to administer mechanical ventilation (e.g., ambu bag or resuscitation mouthpiece). Exceptions include offices connected to hospitals where CPR/code teams respond to medical emergencies.

Staff must be able to identify who is responsible and describe the frequency with which emergency supplies are checked for availability and expiration. Offices must schedule supply checks as a routine office procedure rather than as optional or random events.

Offices that perform stress tests must have a defibrillator. At minimum, there should be documentation of quarterly inspection.

For offices that have a defibrillator, the staff must be able to produce a record of daily defibrillator checks and communicate that staff have been trained on proper use of the equipment.

Other equipment and supplies should be available for practice location, specialty, patient population/environment and accessibility to advanced medical care.

If the practice performs cardiac stress tests, the following must be available:

- Calibrated defibrillator
- Banyan kit or Nitroglycerin
- IV Furosemide (Lasix)
- 50% Glucose
- Sodium bicarbonate
- Lidocaine
- Atropine
- Epinephrine (Adrenaline)
- IV setup
- Oxygen equipment
- Operating manuals

Operating manuals for equipment such as EKGs must be available, and the equipment must be maintained per the manual.

Recommended Emergency Procedures
Recommended emergency procedures include the following:
There should be written or verbal emergency procedures.
There should be periodic training for staff in emergency procedures.
The practice should have oxygen available, and personnel trained to administer it.

Office Practice Standards
The table shown below provides an overview of Office Practice Standards used by our provider network.

Table 11B: Office Practice Standards		
Standards	**Mandatory Requirements**	**Recommended Standards**
Infection Control	Infectious material is separated from other trash and disposed of appropriately Medical instruments used on patients are disposable or properly disinfected and/or sterilized after each use Needles and sharps are disposed of directly into rigid, sealed container(s) that cannot be pierced and are properly labeled	Standard precautions are reviewed with staff and documented annually The practice site has an OSHA manual Hand washing facilities or antiseptic Hand sanitizers are available in each exam room
Medication Management	Pharmaceuticals, including samples and needles/syringes, are stored in a secure location and away from patient access Controlled substances are in spaces with access restricted to authorized individuals A dispensing log is maintained for controlled substances Expiration dates of all medications, including vaccines and samples, are checked on a regular basis Prescription pads are controlled and kept secure from unauthorized use	Expired items are disposed of appropriately There is a separate refrigerated area for medications Refrigerator temperatures are logged daily

Fire Safety	Fire extinguishers are appropriately identified and properly maintained Exits are clearly marked and are unobstructed	There are functioning smoke detectors and/or building alarms
Office Layout & Design	The physical layout safeguards confidentiality of patient information Patient treatment rooms are designed to safeguard patient privacy There is one exam room per practitioner seeing patients at any given time	There is adequate seating in the reception area Patient education materials are available The practice site is clean, well maintained, uncluttered, well-lit, and free of danger areas
Office Layout & Design	The physical layout safeguards confidentiality of patient information Patient treatment rooms are designed to safeguard patient privacy There is one exam room per practitioner seeing patients at any given time	There is adequate seating in the reception area Patient education materials are available The practice site is clean, well maintained, uncluttered, well-lit, and free of danger areas

Physical Accessibility	The office meets the minimum standards of accessibility for those individuals with physical disabilities Or there are reasonable alternatives to accommodate those members with disabilities. Accommodations include home visits, access to other sites, additional bathroom facilities, portable bathroom facilities, other as approved by the Credentialing Committee Or the office has proof of ADA Title III exemption (U.S. Department of Justice 1-800-514-0301)	N/A
Patient Access to Appointments and Medical Advice	There is 24-hour coverage of the practice by comparably qualified physicians There is a defined system for medical record keeping There is a preventive health recall system to ensure timely member follow-up for preventive screenings	The practice has standard procedures regarding scheduling appointments (see "Access and Appointment Standards" in this chapter) The practice has a standard for a maximum patient load of 6 per hour, per provider There are written and/or verbal guidelines for telephone answering There is a recall system for missed appointments to include documentation in the medical record of 3 outreaches, 2 of which must be written notices

Written Key Policies and Procedures	▪ Patient confidentiality ▪ Release of patient information	N/A

These standards are to be used in conjunction with the guidelines for the Pennsylvania Site Visit Protocol, which were developed in coordination with the Pennsylvania Medical Society.

Preventive Care and Clinical Guidelines

All participating providers are expected to follow preventive health guidelines by taking an active role in the ongoing management of member care, including appropriate management of members with chronic conditions. Providers are also responsible for ensuring timely and age-appropriate preventive screenings as well as continuity and coordination of care across specialties and care settings.

Our Quality Management Committee periodically reviews preventive care standards and clinical guidelines for members and approves/updates them according to the most current guidelines published by nationally recognized medical and professional societies. Preventive care guidelines are available on our preventive care guidelines webpage, and the clinical guidelines can be found on our clinical care guidelines webpage.

Provider offices without internet access, or those that need extra copies of the guidelines, can call us at 1-888-991-9023. The copies will be printed out and mailed to the requesting provider office.

Conscience Rights

We respect the conscience rights of individual providers and provider organizations if these conscience rights are made known to us in advance and comply with the current Pennsylvania laws prohibiting discrimination based on the refusal or willingness to provide health care services on moral or religious grounds.

To provide options to our members, the provider will contact our Utilization Management department to arrange for alternative care for the member. Utilization Management will work with Network Management to identify an alternative provider who can offer the care to the member.

Reportable Conditions – PA-NEDSS

As a reminder, all hospitals, laboratories, providers, and public health staff are required by law to report certain conditions to the Commonwealth of Pennsylvania's Department of Health (PA DOH). This requirement is outlined in Chapter 27 (Communicable and Noncommunicable Diseases) of the Pennsylvania Code (28 Pa. Code § 27.1 et seq) which can be searched at pacodeandbulletin.gov, and on its 2003 addendum (33 Pa.B. 2439,

Electronic Disease Surveillance System), located on the official Pennsylvania Code website at https://www.pabulletin.com/secure/

Providers must report the required diseases/conditions to the PA DOH through Pennsylvania's version of the National Electronic Disease Surveillance System, known as PA-NEDSS. Please note that first- time users of PA-NEDSS must register on their website at https://www.nedss.state.pa.us/nedss/ to use the reporting tool.

Note: If you are a public health staff member (as defined by PA DOH), you and your supervisor must complete the PA-NEDSS Authorization Request Form to obtain access to PA-NEDSS. Contact the PA- NEDSS Help Desk at 717-783-9171 or via email at ra-dhNEDSS@pa.gov for the appropriate version of this form. Please visit the Appendix for additional PA-NEDSS resources.

Chapter 12: Provider Billing & Reimbursement

Purpose: This chapter provides an overview of provider billing requirements and reimbursement considerations.

Topics: Important topics from this chapter include:

- Provider Reimbursement
- PCP Referrals, Authorizations & Encounter Data
- Claim Billing Instructions

Overview

We provide services to individuals who are eligible for benefits through our participation in the HealthChoices Medical Assistance program (Health Partners Plans Medicaid), Medicare Advantage (Jefferson Health Plans Medicare Advantage), the Children's Health Insurance Program (Health Partners Plans CHIP or KidzPartners) and the Pennsylvania marketplace (Jefferson Health Plans Individual and Family plans).

Payments will be made for all of our products at the lesser of billed charges or per the payment terms indicated in the provider's individual contract. In either case, we consider such remittance to be payment in full.

Note: Do not bill Health Partners Plans Medicaid members for services.

Health Partners Plans Medicaid members are never responsible for paying participating providers any amount for covered medical services, other than approved copayment amounts as part of the member's benefit package.

If you are participating in the Medical Assistance Program you may NOT seek reimbursement from the member for a balance due unless it is for a non-compensable service or one beyond his/her covered limits and the member is told by the provider, in writing, BEFORE the service is rendered.

If the member is dually eligible (Medicare/Medicaid) or has other insurance coverage, and the claim is for a coinsurance or deductible amount, please be aware we reimburse these amounts up to the applicable contracted or statutory limits.

Provider Reimbursement

The following sections provide an overview and guidelines for the reimbursement methods and requirements utilized by us.

Fee-for-Service Providers

All specialists and PCPs on a fee-for-service agreement are compensated based on the then prevailing or contracted rates. For KidzPartners, this includes reimbursement for childhood immunizations. Examples of fee schedules are available on request through the Provider Services Helpline (see Chapter 1 for contact information.). ALL services must be reported to us on a CMS-1500 form or via electronic submission in an ASC X12N-837 P format, using current HIPAA-standard coding. All facility services must be reported to us on a UB-04 form.

Additional Compensation for PCPs (Medicaid Only)

For the Health Partners Plans Medicaid program, certain immunizations, pediatric preventive services and hospital visits to newborns are eligible for additional compensation to primary care physicians without further authorization from us. Reimbursement for these

immunizations and hospital visits is based on the completion and submission of the following form(s):

- EPSDT Encounter
  Providers should report the appropriate level Evaluation and Management CPT code, plus CPT code EP Modifier and all immunization CPT codes to properly report an EPSDT claim. Without this required coding, Encounters (claim services) will not be able to be reported to the Department of Human Services (DHS). If the encounter is unable to be reported, the provider may be subject to retraction of payments made for these services.
- Administration of immunizations when participating in the Vaccines for Children Program.

Missed Appointments (Medicaid Only)

According to Pennsylvania Department of Human Services Medical Assistance Bulletin 99-11-14, a provider is not permitted to bill a member for a missed appointment. According to the Centers for Medicare & Medicaid Services (CMS), a missed appointment is not a distinct reimbursable Medicaid service, but a part of the provider's overall cost of doing business. As such, it is included in the MA rate and providers may not impose separate charges on Medicaid recipients. State Medicaid programs, including Pennsylvania's MA Program, must comply with the CMS policy on this subject; therefore, MA enrolled providers who render services to MA recipients may not bill recipients for missed appointments.

PCP Referrals, Authorizations & Encounter Data

The following sections provide guidelines for referring members to specialist services, obtaining authorization for those services when necessary and accurately recording member encounters.

PCP Referrals: Medicaid and CHIP

PCP referrals are not required for Health Partners Plans Medicaid and KidzPartners (CHIP) members for any service, including influenza and pneumococcal vaccines and women's routine and preventive services (e.g., mammography screenings). It is extremely important for specialists to keep the member's assigned PCP informed of all care they are rendering to their member, so the PCP has the opportunity to best manage the member going forward. Having all current procedure and outcome information will be critical to the approach the PCP takes in managing the member.

It is the responsibility of the rendering provider to verify eligibility prior to rendering care to a Health Partners Plans Medicaid or KidzPartners (CHIP) member and to verify authorization requirements prior to rendering any procedure.

The PCP still drives member care. When coordinating care, the PCP should direct the member to a specialist who they believe can assist with the care needed. We realize that

PCPs may occasionally need to direct members to a non-participating provider for some need or service not available through a participating provider. However, we require prior authorization before services can be rendered by a non-participating provider. If the PCP does not obtain prior authorization, reimbursement will be denied to the specialist.

If a member is not eligible with Health Partners Plans Medicaid or KidzPartners (CHIP) on the date of service, the physician will not be paid. To be sure, log on to our Provider Portal or call us (see Chapter 1 for contact information) before the service is rendered.

The specialist is able to provide consultation and any additional services required to treat the condition for which the member was directed. If the additional services being ordered require prior authorization it is the specialist's responsibility to obtain the prior authorization.

If the specialist identifies the need to direct the member to another specialist, the PCP should be contacted to maintain a role in the member's care and should always be given the opportunity to communicate with all treating specialists related to the care of the member.

In accordance with Pennsylvania law and the Department of Human Services requirements, we will maintain procedures by which a member with a life-threatening degenerative or disabling disease or condition shall, upon request, receive an evaluation to determine if the member qualifies to select a specialist to act as his/her Primary Care Physician. This evaluation will include a written letter of medical necessity from the specialist and a determination by the Medical Director. If the specialist is designated as the primary care provider, he/she must be credentialed as a PCP.

PCP Referrals: Medicare Advantage and Individual and Family Plans

PCP referrals are not required for our Jefferson Health Plans Medicare Advantage or Individual and Family plan products. It is extremely important for specialists to keep the member's PCP informed of the care they are rendering, so the PCP has the opportunity to best manage the member going forward. Having all current procedure and outcome information will be critical to the approach the PCP takes in managing the member.

The PCP should coordinate care between the member and the specialist(s) who they believe can assist with the care needed. Jefferson Health Plans realizes that PCPs may occasionally need to direct members to a non-participating provider for some need or service not available through a participating provider. However, we require prior authorization before services can be rendered by a non-participating provider. If the PCP does not obtain prior authorization, reimbursement will be denied to the specialist.
The specialist is able to provide consultation and any additional services required to treat the condition for which the member was directed. If the additional services being ordered

require prior authorization it is the specialist's responsibility to obtain the prior authorization.

It is the responsibility of the rendering provider to verify eligibility prior to rendering care to a Medicare member and to verify authorization requirements prior to rendering any procedure.

If a member is not eligible with Jefferson Health Plans on the date of service, the physician will not be paid. To be sure, log on to our Provider Portal or call Jefferson Health Plans (see Chapter 1 for contact information) before the service is rendered.

Member Encounters

Our PCPs, specialists, Ambulatory Surgical Centers, ancillary and allied health providers must provide encounter data for professional services on properly completed CMS-1500 forms or electronic submission in an ASC X12N 837P format for each encounter with our member(s). All providers must submit this form within 180 days following the encounter date or payment will be denied. PCPs must report encounter data associated with EPSDT screens of Medicaid members within 180 days from the date of service.

Claim Billing Instructions

We are required by State and Federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure that the required data is captured, and that claims are processed in an accurate, timely manner.

Important Note for Medicaid Claims

We are required to submit to the Pennsylvania Department of Human Services (DHS), the Commonwealth's department responsible for administering Medicaid, all necessary data that characterizes the context and purpose of each encounter between a Medicaid enrollee and a physician/practitioner, supplier or other provider. State regulation requires services to Medical Assistance recipients be rendered by providers participating in Medicaid, except in emergent or urgent situations. It is the responsibility of all providers enrolled in Medicaid to ensure that the information they supply to DHS (e.g., address information) is correct and kept up to date. DHS uses encounter data to develop risk-adjusted ratings that tie to reimbursement for Managed Care Organizations (MCO). A provider's failure to submit complete, accurate and timely encounter data to us as required may result in actions such as payment delay or no payment at all, as well as possible exclusion from the network.

Billing Requirements and Guidelines

One of our goals is to ensure timely and accurate claims processing. To that end, this section is intended to provide guidance to Provider Billing Offices so that complete and precise medical claim filing for payment consideration can be accomplished. These

guidelines do not, however, supersede any regulatory or contractual requirements published in legally binding documents or notices.

Claim (encounter) data, specifically the diagnosis and treatment codes, is used by DHS to develop a risk-adjusted reimbursement rate. DHS will reimburse Medicaid MCOs according to the level of illness experienced by and service rendered to their members. As an extension, reimbursements to providers from Medicaid Managed Care Organizations will become dependent upon the quality of the data used in this reimbursement methodology. A provider's failure to submit to us complete and timely encounter data, coded to the highest level of specificity, will have costly long-term effects. It is important that providers file all claims and encounters as required. Failure to do so could result in possible exclusion from the network.

Preventable Serious Adverse Events
Medical Directors will not approve services that are deemed harmful to our members, are of inferior quality, or are medically unnecessary (as may be the case with a serious and clearly preventable adverse event). In addition, based on CMS guidelines, financial compensation for any and all services rendered as a result of, or increased by, a preventable serious adverse event will be withheld or recovered.

Initial Claim Submission Procedures
We have specific, established requirements for filing a notice of claim. These requirements include that the notice of a claim be valid and complete, furnished within a prescribed time, and be delivered to the correct business address. Failure to comply with any of these requirements shall constitute a bar to filing a claim and shall preclude payment. To be accepted as a valid claim, the submission must:

- Be submitted on a standard current version of a CMS-1500, CMS-1450/UB-04 or in the ANSI X12-837 electronic formats (current version). Claim forms should not be photocopied versions. Paper claims must be submitted on original Red and White forms.
- Contain appropriate, current information in all required fields
  Be a claim for a plan member eligible at the time of service
- Be a claim for a provider properly established on Jefferson Health Plans' processing system for the time period and location (site) billed
  Be an original bill
- Contain correct current coding, including but not limited to CPT, HCPCS, modifier, DRG, Revenue and ICD-10 codes
- Not be altered by handwritten additions or corrections to procedure/service codes and/or charges
- Be printed with dark enough ink to be electronically imaged if submitted as a paper claim

- Be received within 180 days from the date of service as measured by the date stamp applied by a Health Plan representative who has agreed to and has the authority to accept claims at our business address
  - or by the system receipt date if filed as a paper claim through the correct claim post office box
  - or by system receipt date after passing via an electronic data interchange gateway and through our claim validation front-end editing
- For providers reimbursed on a CMS Medicare payment methodology (e.g., OPPS, IPPS, CMS Fee Schedules), providers must follow CMS' published billing requirements and specifications when submitting claims to us. In addition to the requirements set forth in this Provider Manual, the Provider must also include all claims information required by traditional Medicare under the provider's applicable contracted payment methodology.

Provider Numbers and Set Up
All providers billing for services, whether participating or non-participating, must be established on the Jefferson Health Plans processing system with effective dates coinciding with the dates of services billed.

Non-Par Providers
Non-participating providers, whether rendering emergency services or prior authorized and approved treatment, must provide the following information to be established on our system:

- W-9 tax form
- Pennsylvania Medicaid Provider Identification Number (in-state, Health Partners Plans Medicaid providers only)
- State Medical License Number and Expiration Date
- NPI (National Provider Identification) Number
- Provider Specialty
- Specialist should declare their specialty
- Facility
  - Allied Health Provider
  - Ancillary Health Care Provider (Home Health, DME, Transportation)

Note: Non-participating provider services (except for emergency services) require prior certification by calling our Inpatient Services or Outpatient Services (see the Contact Information section in Chapter 1).

To be established as a non-participating provider, please send the required information listed above to:

Health Partners Plans/Jefferson Health Plans

Attn: Provider Database Maintenance Team
1101 Market Street Suite 3000
Philadelphia, PA 19107

Or

Fax to:
215-967-4486
Attn: Provider Database Maintenance Team

Participating Providers
Participating providers must be contracted and credentialed by us. For electronic claim submission Providers must bill with their individual and billing NPI numbers or their claims will be denied.

Claim Mailing Instructions
For paper claims, Health Plan (Medicaid, CHIP, Medicare (**HMO-POS and HMO SNP products**) and Individual and Family plans) claims should be mailed to:
Health Partners Plans/Jefferson Health Plans
P.O. Box 211123
Eagan, MN 55121

For Jefferson Health Plans **(Medicare PPO products)** claims should be mailed to:
Jefferson Health Plans
P.O. Box 21921
Eagan, MN 55121

Electronic Claims Instructions
Electronic Payor ID for Products (Medicaid, CHIP, Medicare HMO/DSNP, Individuals and Families, **# 80142**.
Electronic Payor ID for Medicare PPO claims, Effective 1/1/2024: # **RP099**

Claim Filing Deadlines
We allow 180 calendar days from the date of service or discharge date to submit and have accepted a valid initial claim.

A claim must be accepted as valid (as proven by entry into our claims processing system and assignment of a claim control number) to be considered filed. Paper claim submissions that cannot be entered into the claim processing system because of invalid member, provider or coding information are returned to the provider with a rejection notice (form letter or insert) explaining the reason for rejection.

Electronic claim submissions are rejected on electronic submission/error reports. The submission/error report(s) a provider's office receives depends on the billing service and/or electronic interchange vendor used. Because we currently use Smart Data Solutions (SDS) as the gateway for electronic submissions from other billing services and/or electronic interchange vendors, an acknowledgement of all claims accepted through SDS and submitted to us is generated, as well as a first level rejection report of those claims not passing SDS's edits. Once the edits are passed, our system edits for member, provider and coding information, and these edits generate a second level of acceptance and/or error reports. Providers should check with their billing service and/or electronic interchange vendor to fully understand how our specific information is being provided.

During the 180-calendar day initial filing period, a provider may resubmit a non-accepted (invalid or EDI rejected) claim as often as is necessary to have it accepted. It is the provider's responsibility to ensure their claims are accepted within the 180-day filing timeframe. Once an initial claim is accepted, any subsequent (repeat) filing, regardless of whether it is paper or electronic, will deny as a duplicate filing. The initial claim, however, will be processed.

- If the claim does not appear on an Explanation of Payment within 45 calendar days of submission as paid, denied or as a duplicate of a claim already under review, and no rejection notice has been received, the provider must pursue the claim status to ensure it was accepted.

Claim status can be confirmed by accessing our Provider Portal or by calling the Provider Services Helpline at **1-888-991-9023.** An inquiry does not extend or suspend the timely filing requirement.

If, after resubmission, another 45 calendar days pass without the claim appearing on the Explanation of Payment (even as a duplicate denial), the provider should contact us to discuss what could be preventing the claim from being accepted.

Claims that have been adjudicated (paid or denied) cannot currently be re-filed as though they were initial, unprocessed claims. Re-filing a previously adjudicated claim will cause automatic denial as a duplicate submission. To contest an incorrectly processed claim, see the Claims Inquiries and Reconsiderations section below.

Filing Period Exceptions

The only exceptions to the 180-calendar day filing period are:

- If the delay was caused by a third-party resource filing. Third-party resource claims must be submitted within 60 calendar days of the initial determination notification from the primary carrier. This includes submitting a primary carrier EOP to us for coordination of benefits.

- If our Enrollment department verifies a problem determining a member's eligibility.
- Non-par Medicare providers must submit claims within 395 days of the date of service.

Claim Form Filing Requirements
Claim form completion requirements for both CMS-1500 and UB-04 forms are displayed later in this chapter. Each field is listed by number and includes a description of the data needed along with an "R", "C" or "O" field code.

"R" (required). If the field is coded "R" (required) the data must be completed on every form submitted. If the field is not complete or contains invalid data, the claim will not be considered for payment.

"C" (conditional). If a field is coded "C" (conditional), the data is required only for claims submissions where the field is directly related to the billed services for that record type. However, if the information is not included but is applicable to the billed services, the claim will not be considered for payment. Only claims completed as outlined will be eligible for payment consideration.

"O" is optional. A field coded "O" is optional.

Common Reasons for Claim Rejections or Denials include but are not limited to:

- **Incorrect Member Identification number.**
  Do not use the Medicaid ACCESS card number when submitting claims. Use of this number will cause a claim rejection. Until DHS has assigned a permanent Medical Assistance number, newborn claims will be denied.
- **Incorrect Provider Identification number.**
  For electronic and paper claims a provider must use both the individual and the billing NPI number. If these numbers have not been established in our processing system it may cause a provider to appear as non-participating, thus requiring authorization for services. Without an authorization, or a valid legacy provider number all claims will be denied.
- **Authorization and claim service dates do not match.**
  Providers are responsible for communicating all service dates, beginning/admission through ending/discharge. If the scheduled service date is canceled or rescheduled, providers must call Inpatient Services or Outpatient Services to update the authorization to reflect the change. Any service dates not included in the authorization will be denied.

- **Invalid procedure and/or diagnosis codes.**
  Claims must be coded with the most current procedure and diagnosis codes at the highest level of specificity. Unless claims are properly and completely coded, they will be rejected if invalid or denied if obsolete.
- **Unlisted Procedure Codes.**
  Unlisted and miscellaneous codes do not provide the description of a specific procedure or service, we require that the service reported by the unlisted procedure code be identified when clinical information is provided.

For any unlisted procedure codes, please be sure to attach the following supporting documentation:

- Cover letter that is concise and outlines the procedure / service being reported with the unlisted procedure code.
- Operative report or office notes that describe services performed that support medical necessity of the procedure.
- Determine an appropriate comparable procedure and identify differences between it and the new procedure you have performed. Include these differences in your cover letter.

Providers should consider what type of information would best help us understand what exactly is being billed. If we have any further questions about the service or item, additional information may be requested.

Examples of unlisted procedure codes:

- 21299 Unlisted craniofacial and maxillofacial procedure
- 37799 Unlisted procedure, vascular surgery

Be sure to report the appropriate unlisted code for the category/type of procedure performed. For example, report an unlisted laparoscopy procedure of the esophagus with 43289 *Unlisted laparoscopy procedure, esophagus,* not *43499 Unlisted procedure, esophagus*.

- **Directing care to non-participating providers.**
  Except for emergency services, all non-participating providers require prior authorization. (Please call our Inpatient and Ancillary Services.) Without proper authorization nonparticipating provider claims will be denied.
- **Billing us as primary when other insurance exists.** Providers must verify coverage every time a member is seen for services. We can be contacted to review other insurance information on file. If we are billed before the primary carrier has made a determination, the claim will be denied.

- **Explanation of Payments/Benefits (EOP/EOB) from primary insurers not submitted for secondary payment.**
  We will only pay up to our allowable fee schedule or contracted rate, minus what the primary payer did or would have paid for example deductibles, co-payments, or co-insurance as demonstrated on the EOP attachment. The claim will be denied until the required EOP information is submitted. The primary EOP must be submitted to us within 60 days of being issued.
- **Member benefit limitation has been exceeded.**
  Certain benefit packages have limitation to the number of services allowed. We will only pay for those services covered under their respective benefit package and will only reimburse the allowable portion of the claim, i.e., coinsurance and deductible.

Electronic Data Interchange (EDI)
We offer providers the speed, convenience and lower administrative costs of electronic claims filing or Electronic Data Interchange (EDI). EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative costs. Effective March 14th, 2024, the plan uses Smart Data Solutions (SDS) as our claim's clearinghouse.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs.
  - EDI eliminates the need for most paper claim submissions.
- Faster transaction time for claims submitted electronically.
  - An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received by us. Many electronically submitted claims, because of the "clean data" embedded within the claim, can be auto-adjudicated.
- Validation of data elements on the claim form.
  - By the time a claim is successfully received electronically, information needed for processing has been pre-screened for required elements and, if passed, will be accepted as submitted. This reduces the chance of data entry errors that occur when completing paper claim forms.

For all claims (837 Institutional and 837 Professional) submitted electronically through the SDS clearinghouse, we can electronically return detailed status information through SDS.

The status message will show which claims were accepted, rejected and/or pending, and provide the amount paid on the submitted claim once it has been finalized. It is the Provider's responsibility to monitor all reports of electronic submissions to assure that claims are accepted. Please contact your billing software vendor for additional information regarding all available reports.

To take advantage of EDI, providers should contact their billing software vendor and request that our claims be submitted directly through the SDS claims clearinghouse. Or, billing software vendors may be able to submit claims through their current clearinghouse and request forwarding to SDS. (Providers who are already SDS submitters, but who do not receive SDS claim status reports, should contact their software vendor.) If you require assistance with electronic filing contact us at EDI@jeffersonhealthplans.com.

EDI Claim Filing Requirements
Our Payor ID Number is #**80142** for our Medicaid, CHIP, Medicare (HMO-POS and HMO SNP products) and Individual and Family Plans **is RP099** for our Medicare PPO products.

Claims transmitted electronically must contain all of the required data elements identified within the 837 (Professional and Institutional) Claim Filing Companion Guide found on our HIPAA Connect/EDI Claims webpage. SDS or any other EDI clearinghouse or vendor may enforce additional, allowable data record requirements.

In order to send claims electronically to us, all EDI claims must be forwarded through SDS. This can be completed through any EDI clearinghouse or vendor.

SDS validates against HIPAA-required Transaction Code Set edits, allowable SDS proprietary specifications, and allowable Health Plan specific requirements. Claims not meeting the required HIPAA or SDS edits are immediately rejected and sent back to the sender via the RPT 05 Provider Daily Statistics report. This report details the rejected claims and the error explanation. Claim records that do not pass these required edits are considered invalid and will be rejected as never received at the plan. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service.

SDS accepted claims are tracked on the RPT04 Daily Acceptance Report by the provider. This is a list of claims passed to Jefferson Health Plans, but not necessarily accepted by us. If there are providers or members not found, or other allowable edits due to invalid claim data, these claims may be rejected by us.

Providers should pay close attention to the RPT11 Unprocessed Claims Report because it is the notification report that identifies claims that are not accepted in our system. This report is a critical part of the workflow in that it contains the reason these claims were not accepted. Claim records that do not pass our required edits are considered invalid and will be rejected as never received at the plan. In these cases the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service.

Providers are responsible for verification that EDI claims are accepted by SDS and by us. Acknowledgement reports, claim acceptance reports, error reports for rejected claims,

and unprocessed claim reports that are received from SDS directly or other contracted billing or gateway vendors must be reviewed and validated against transmittal records daily.

If a provider is submitting claims through a billing company or single source (such as a hospital EDI Unit handling all specialty department billing), and that billing company or single source is combining all records into one daily file when sending electronic submissions to SDS, any acknowledgement or rejection reports may also be combined. It is the responsibility of the billing company or single source to separate those errors and work them with each respective provider or medical department. Our EDI team can see all errors that are reported on the RO59 Unprocessed Claim Report and that the rejection occurred but can do no more to help with the flow of information at the provider's end.

EDI Exclusions
Certain claims may not be submitted through electronic billing. The exclusions fall into two categories:

- Excluded Providers
  Providers or vendors who are not contracted with SDS (Their claims are not transmitted through SDS).
- Excluded Claims
  Claims requiring supportive documentation or attachments such as invoices (until further notice, these claims must be submitted on paper).

Early Periodic Screening, Diagnosis & Treatment Reporting (Medicaid)
Early Periodic Screening, Diagnosis and Treatment (EPSDT) reports are filed for all members from the time of birth until 21 years of age. Completion of a claim form documenting any encounter, whether the service is prepaid (capitated) or fee-for-service, is a mandatory requirement, not an option.

The PCP of a member under the age of 21 years should perform and report EPSDT screens and appropriate immunizations or make arrangements for EPSDT screens to be performed elsewhere. These screens must be in accordance with the schedule developed by DHS and recommended by the American Academy of Pediatrics. As per the EPSDT guidelines, providers must advise members to obtain the appropriate dental services, contact our Healthy Kids Unit (**1-866-500-4571**) to coordinate dental appointments and document the dental referral on the claim.

Our providers may use the CMS-1500 form or file an electronic claim to report EPSDT activity. Dental referrals (YD) should be keyed in the IOD field of the claim. We rely on receipt of thoroughly completed CMS-1500 forms to obtain useful aggregate information about overall delivery of preventive care.

To properly report an EPSDT claim, PCPs should report:

- The appropriate level Evaluation and Management CPT code with the modifier EP, plus CPT code EP Modifier.
- Age-Appropriate Evaluation and Management Codes (as listed on the current EPSDT Periodicity Schedule and Coding Matrix).

For the latest EPSDT Periodicity Schedule and Coding Matrix, please refer to the most recent DHS bulletin or visit our EPSDT/Bright Futures webpage. A copy of the EPSDT Periodicity Schedule and Coding Matrix is also in the appendix.

When making a dental referral a provider must submit a remark code of YD on the claims. If submitting a CMS1500 form the YD should be places in field 10D. If submitting electronically the YD code is placed in 2300NET01.

All EPSDT documentation is required as a permanent part of the member's medical record.

Benefits for Pregnant Women (Medicaid Only)
Certain limitations on the number of services or applicability of copayments do not affect pregnant women. Women who are confirmed to be pregnant are eligible for comprehensive medical, dental, vision and pharmacy coverage with no copayments or visit limits during the term of their pregnancy, and until 60 days postpartum. These services include expanded nutritional counseling and smoking cessation services. However, services which are not covered under a pregnant woman's HealthChoices Benefit Package (HCBP) are also NOT covered, even while pregnant. For a fuller description of the benefits for pregnant women, please see Benefits During and After Pregnancy in chapter 4.
To ensure that a claim is processed without a service limitation, providers must bill with a pregnancy indicator on the claim.

Notes on Copayments
Copayments for services are summarized in the benefits chapters. Services may not be denied to any Medical Assistance recipient on the basis of an inability to collect a copay at the time of service.

Copayments that are due but not paid should be indicated on the claims as follows:

Copayments that are due (but not paid)	
CMS-1500	Box 24H code **11**
UB92/UB04	Condition code/indicator, **Y3**
837-I	2300 Loop, HI, 01, qualifier **BG**, data element **Y3**. The condition code/indicator is **Y3.**

837-P	2300 Loop, NTE 01= **ADD** and NTE 02 = **VC11** to indicate copay not collected.
NCPDP	N/A

Physician Administered Drugs and Biologicals
In accordance with the Pennsylvania Department of Human Services Operations Memorandum (#10/2013-012), if a claim type is an 837P or 837 I Outpatient, and the payment is based upon a HCPCS code such as a J-code or Q-code, the drug must be submitted with the NDC code along with the units dispensed.

For all Health Plan products, Hospitals must follow CMS requirements for billing 340B modifiers under the hospital outpatient prospective payment system. All claims for drugs and biologicals purchased through the federal 340B Discount Drug Program must be billed on a separate claim line with the appropriate 340B modifier (i.e. "JG" or "TB"). Hospitals that participate in the 340B Program must maintain documentation in accordance with CMS requirements and comply with applicable reporting requirements.

Depending on the provider's contract with us, the reporting of 340B modifiers may impact fee schedule allowances or be collected for informational purposes only.

Coordination of Benefits
Coordination of Benefits (COB) procedures are used by insurers to avoid duplication of benefits when a person is covered under more than one insurance plan. A coordination of benefits clause in either plan prevents double payments by making one plan the primary payer of benefits. Our Medical Assistance plan is a **payer of last resort**, thus is secondary payer to all other forms of health insurance, Medicare, or other types of coverage.

Copayment, Coinsurance and Deductibles
Providers are advised NOT to collect any copayments, coinsurance, or deductibles at the time of service for a Health Partners Plans Medicaid member who has other coverage (making us the secondary payer). Providers must consider payment from all sources in accordance with their payer contracts before determining if there is ever any member liability. If we are the secondary payer, the member, as a Medicaid recipient, never has payment liability unless the service is a non-covered service, and the member has been notified in writing and in advance of the service of their liability for payment.

Note: Services may not be denied to any Medical Assistance based on inability to collect a copay at the time of service.

After the primary payer has made a claim determination, a secondary claim and the primary carrier's Explanation of Payment should be submitted to us for consideration. Please use the post office box established for claims with attachments. HIPAA required Transaction Code Standards apply to electronic secondary claims.

Once the Health Plan allowed amount is reached by payment from either/or both payers, the provider is considered "**paid in full**" under our contract or negotiated fee arrangements. No additional money (copayment, coinsurance, or deductible) can be collected from the member. Any money collected from the member that exceeds our allowable amount must be immediately returned to the member. To collect money from a member exceeding what is owed under a Medicaid contract or fee arrangement violates Medicaid regulations and Pennsylvania statutes.

Members enrolled in KidzPartners may not be enrolled in any other health insurance program. If a KidzPartners member presents with other active insurance a Provider should verify eligibility with the other payer, collect applicable copays and submit the claim to the other insurer. The Provider should notify us of the insurance by calling the Provider Services Helpline at **1-888-991-9023** or sending in the Explanation of Payment (EOP) from the other insurer. Our Enrollment department will determine the effective dates of the other insurance and contact the member if there is termination in coverage. Providers are prohibited from billing our dual eligible (Medicare-Medicaid) members for any Medicare cost-sharing for Part A & B services. Providers should bill any Medicare cost-sharing to the member's assigned Community HealthChoices (CHC) plan.

Preventive Pediatric Care Exception

With the exception of preventive pediatric care, if other coverage is available, the primary plan must be billed before we will consider any charges. Preventive pediatric care is paid regardless of other insurance.

Primary Insurance Explanation of Payment (EOP)

After all other primary and/or secondary coverage has been exhausted; providers should forward a secondary claim and a copy of the Explanation of Payment (EOP) from the other payer to us. Secondary claims may also be filed electronically following the HIPAA compliant transaction guidelines.

- A timely submission for a claim with other insurance reported is 60 days from the EOP paid date. Provider appeals must also be submitted within 180 days of the our denial date.
- When a claim is submitted without an Explanation of Payment (EOP), Denial Letter. Exhaustion of Benefits, Payout sheet, or other valid primary insurance documentation, the claim will be denied for lack of an EOP. Documentation submitted by the provider with incomplete or incorrect primary information such as member, provider, paid date, date(s) of service, services rendered, billed charges, payment, denial code(s) and denial reason(s) will be denied for incomplete EOP.

- When other insurance information is obtained from a provider, it should include the other insurance member identification number for outreach to the primary insurance to flag the member's record with the appropriate coverage information.

Coordination of Benefits Method
We will coordinate benefits to pay up to our Medicaid fee schedule allowable or otherwise contracted rate (for example, primary insurance coinsurance, deductible and/or co-payment) not to exceed our allowance. The total payment (ours and other carrier) must not exceed our allowance.

We will coordinate benefits as follows:

- If the primary insurer has paid up to or more than ourallowed amount, no additional payment will be made.
- The primary pays less than we would have paid as primary, we pay as secondary the amount applicable to the primary member's coinsurance, deductible and/or co-payment not to exceed the difference between our allowable and primary paid.
- The primary pays less than ours' and there is no member coinsurance/copayment and/or deductible, we pay as secondary up to our allowable (the difference between our allowable and primary paid).
- The primary denies the service for reasons other than failure to adhere to the carrier's timely filing or utilization management requirements, then we will consider the service as primary. Providers must comply with all of our applicable authorization requirements when we assume primary responsibility.

Provider Failed to Adhere to Guidelines
Claims that could have been paid by a primary carrier but were denied because the provider failed to adhere to that carrier's claim filing or utilization management requirements, will not be considered by us. Unless an allowed amount from the primary carrier is present on the Explanation of Benefits and payment was not issued because of reasons other than the provider's error, we will not assume the primary insurer responsibility.

If a primary payer denies payment due to the provider's failure to follow that Plan's utilization management processes or claim filing procedures, we will also deny that claim unless payment is required by regulation, statute, or contract. If we are required to issue payment even though the primary payer denies the claim, the most we are obligated to pay is the amount that would have been paid as secondary payer. If the claim is denied by both the primary payer and us, the member has no liability to pay copayment, coinsurance, or deductible.

Authorization Requirements for COB
Providers must comply with all of our applicable authorization requirements when we assume primary responsibility.

Third Party Liability (TPL)
Third Party Liability refers to another entity that is responsible for the payment of medical expenses. That entity is usually another health insurer but could be auto or casualty insurer responsible for coverage related to an accident.

Third Party Liability relates to automobile insurance and personal injury insurance coverage (homeowners, business liability insurance, etc.). Should a provider render services for injuries resulting from an accident, the automobile or other liability carrier(s) should be billed as primary. If we are billed and pays inappropriately as primary, the rights of recovery fall to DHS. The provider is required by regulation to return these incorrect payments to DHS.

Third Party Liability also relates to personal injury legal actions brought by a member against a liable party to recover losses. Providers should bill medical insurers for all services even if the member intends to bring a lawsuit. Providers should not hold bills expecting to file against any legal settlement or with insurers after judgment. If we are billed and pays as primary, and the member succeeds in their legal action, the right of subrogation to recover for medical losses falls to DHS. DHS may place a lien against any judgment handed down compensating the member, thus shifting the cost of the member's medical losses to the liable party.
Note: Members enrolled in KidzPartners may not be enrolled in any other health insurance program.

Third Party Liability Resource Information
The Pennsylvania Department of Human Services (DHS) provides us with Third Party Liability Resource information files on all Medical Assistance recipients. We use DHS's resource information as a base for other insurance coverage. If, however, evidence of other insurance is discovered and validated by us, this information will be added to oursystem and relayed to DHS. All information on our file is available to the providers by calling our Provider Services Helpline. If, while providing medical services, the provider learns about third-party resources that do not appear on the member's information file or that resources on the file are no longer effective, he/she is required to report the information to us.

Providers who receive payment from both us and a carrier who was primary to us, and find they are in an overpayment situation, should return our payment per Medicaid regulatory requirement. If we discover overpayment to a provider, the provider must comply with our recovery efforts.

Overpayments
Providers who participate with Health Partners Plans Medicaid must participate in the Medical Assistance (MA) Program. Providers who participate in Medical Assistance enter into a written provider agreement with the State of Pennsylvania and must adhere to the MA

Regulations. Under MA Regulation, (55 Pa. Code § 1101.69), a provider who is overpaid on a claim is obligated to reimburse the excess payment. This Regulation applies to money paid by the State or by us, as one of the state contracted MCOs. Providers who participate in KidzPartners (CHIP) must adhere to federal regulations relating to overpayments. Under Federal Regulations (42CFR489.21, 42CFR489.40 and 42CFR489.41), a provider who is overpaid is obligated to reimburse the excess payment.

There is no time limitation for requesting reimbursement of overpayments from providers receiving State or Federal Funds. Health Partners (Medicaid and CHIP programs), however, follows the same recovery time period guidelines for non-fraud related claims as are adopted by the DHS: two years from the date of payment notice.

Provider **known** overpayments should be returned to:

Health Partners Plans, Inc.
Attn: Finance-Cash Receipts
1101 Market Street, Suite 3000
Philadelphia, PA 19107

If we discover an overpayment, recovery will be initiated and will be reflected on the provider's current Explanation of Payment. If the amount owed to us by a provider exceeds the amount of money to be paid within a payment cycle(s), an Explanation of Payment(s) will generate a $0 payment. The Provider is responsible for tracking their own balance until the credit balance is cleared.

Retroactive Disenrollments and Recovery
Health Partners Plans Medicaid and KidzPartners (CHIP) members are occasionally retroactively disenrolled. When this occurs, any premiums paid to us are retracted by DHS or the Pennsylvania Insurance Department. Therefore, since we received no revenue to offset the member's medical expenses, we are under no obligation to pay for such services. When this happens, claim payments to providers will be retracted for services occurring within the retro-disenrollment period.

Correct Coding Intervention
We apply correct coding standards that integrate nationally accepted guidelines including Current Procedural Terminology (CPT) logic as documented by the American Medical Association, and Correct Coding Initiatives (CCI) and post-operative guidelines as outlined by the Centers for Medicare & Medicaid Services to review claim submissions.
Codes determined to be included in or incidental to another procedure will be replaced with the more comprehensive code. Invalid codes that have been superseded with a current code may be replaced. If, however, there is any doubt about how to correct the coding, the claim will be denied for invalid coding, allowing the provider to take corrective action and re-file

the claim. Pertinent modifiers must be used to communicate bilateral and repeated procedures performed on the same day.

Both the originally submitted code and the more accurate code will appear on the processed claim. The originally submitted code will have no payment. The new code will have payment, if appropriate. An explanation of the coding modifications will be clearly documented on the Explanation of Payment.

Interest Payment
Under Pennsylvania law (Act 68), we are required to pay 10% per annum interest on clean claims; uncontested portions of a contested claim that are not paid within forty- five (45) days of receipt; and after ninety days (90) days from date of receipt for a clean or not clean claim. A clean claim is defined as a healthcare service claim for payment that has no defect or impropriety. A defect or impropriety includes, but is not limited to, the lack of required substantiating information or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. Claims from a healthcare provider who is under investigation for fraud or abuse regarding those claims are outside the definition of clean claims.

Forty-five (45) days is measured on an initial submission from the date of receipt by the health plan to the date of the check issuing payment or the date of electronic fund transfer. If a paid claim is re-adjudicated, a new 45-day period begins on the date additional information prompting the re-adjudication is received by HealthPartners Plans. Only additional monies paid are subject to interest calculation. If a claim or portion of a claim is contested (not paid) by us, then overturned and paid, interest will be calculated on the amount subsequently paid, beginning from the date additional information prompting the re-adjudication was received by us.

Under Act 68, interest may be calculated and paid as a separate check issued outside the claim payment and remit process or may be included as part of the claim payment. Interest owed of less than $2.00 on a single claim does not have to be paid. If more than $2.00 interest payment is owed, but not received via the claim payment and remit or via a separate check within 30 days after claim payment, providers should contact the Provider Services Helpline. For more information, refer to the Contact Information in Chapter 1.

False Claims Act and Self-Auditing
Identifying and reporting fraud, waste and abuse is everyone’s responsibility. We take this very seriously and holds all employees, members, and providers accountable for reporting all concerns of fraud, waste and abuse.

Providers in our network are responsible for auditing themselves and reporting any findings that would have resulted in an overpayment or underpayment to them. You can find self-auditing protocols on the U.S. Department of Health and Human Services (HHS) website at

oig.hhs.gov/compliance/self-disclosure-info/protocol.asp, or on the Pennsylvania Department of Human Services (DHS) website at https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages /MA- Provider-Self-Audit-Protocol.aspx.

The Pennsylvania Medical Assistance (MA) Provider Self-Audit Protocol allows for providers to report non-fraudulent overpayments and to return that money without DHS seeking damages.

The Office of Inspector General (OIG) Provider Self-Disclosure Protocol allows providers to self-disclose fraud, and that the OIG has implemented some benefits for providers to do so: Potentially receiving a lower multiplier on single damages which would normally be required in resolving a Government-initiated investigation.

The False Claims Act is the single most important tool U.S. taxpayers have to recover the billions of dollars stolen through fraud by U.S. government contractors, including Medicare and Medicaid providers, every year. Under the False Claims Act, those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $13,946 - $27,894 per claim.

If you wish to report Medicare, Medicaid, CHIP, or any other potential fraud, waste, or abuse, or other suspicious activity, please call our Special Investigations Unit (SIU) Hotline at (**1-866-477-4848**), the CMS Medicare Hotline Number at **1-800-MEDICARE** (**1-800-633-4227**), or the Pennsylvania Department of Human Services Medicaid Hotline at 1**-844-DHS-TIPS** (**1-866-379-8477)**. Fraud, Waste, or Abuse can also be reported to JHP online at https://www.mycompliancereport.com/report?cid=JEFF

Both online and hotline calls can be made anonymously.

Hotline Information

Recipient Fraud: Including, but not limited to, someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits AND that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS/MCO card, forging or altering prescriptions, selling prescriptions/medications, trafficking SNAP benefits or taking advantage of the system in any way.

- *Provider Fraud*: Including, but not limited to, billing for services not rendered, billing separately for services in lieu of an available combination code; misrepresentation of the service/supplies rendered (billing brand named for generic drugs; upcoding to more expensive service than was rendered; billing

for more time or units of service than provided, billing incorrect provider or service location); altering claims, submission of any false data on claims, such as date of service, provider or prescriber of service, duplicate billing for the same service; billing for services provided by unlicensed or unqualified persons; billing for used items as new.

Claim Inquiries and Reconsiderations
The procedures for inquiring about the status of claims or to request reconsideration of a payment decision are provided in the section below.

Claim Inquiries
Providers can check claim status via our provider portal.

Providers can also use the telephonic option for all claim inquiries which are directed through us at
1-888-991-9023. Providers may verify the following over the telephone:

- claim status
- payment amount
- check date and number
- denial and denial reason

Claim Reconsiderations
A provider can request a reconsideration determination for a claim that a provider believes was paid incorrectly or denied inappropriately, whether the result of a provider billing error or a Health Plan processing error. Providers have three options to request a reconsideration of a claim.

- Provider Portal
- Written Correspondence
- Telephone

Whichever method is used, a claim reconsideration request must be received within 180 calendar days from the date of the Explanation of Payment (EOP) advising of the adjudication decision.

Claim reconsideration requests should include a copy of the EOP and documentation supporting the assertion that the claim was paid incorrectly or why the denial should be overturned. Other important points to remember:

- If the claim involves other insurance, information regarding the member's primary insurance coverage, including a copy of the primary EOP/EOB must be provided.

- If the claim was denied for lack of an authorization or services not matching the authorization, the provider must contact the appropriate utilization management area to address the authorization problem and, only when resolved, submit a claim reconsideration request. Denials such as these are not handled by The Claims Reconsideration department. The dispute with the authorization needs to be reviewed and handled by Utilization Management.
- If the claim was denied because the provider is non-participating and lacked authorization, and the provider believes he or she is participating, there may be a problem with credentialing. We must be contacted and this issue resolved before the claim can be reconsidered. Please contact us for assistance at **1-888-991-9023** to verify provider identification numbers. Claims denied because the requested authorization or level of care was not approved constitute a medical necessity disagreement.

Appeals for denials of Inpatient authorizations should be mailed to:

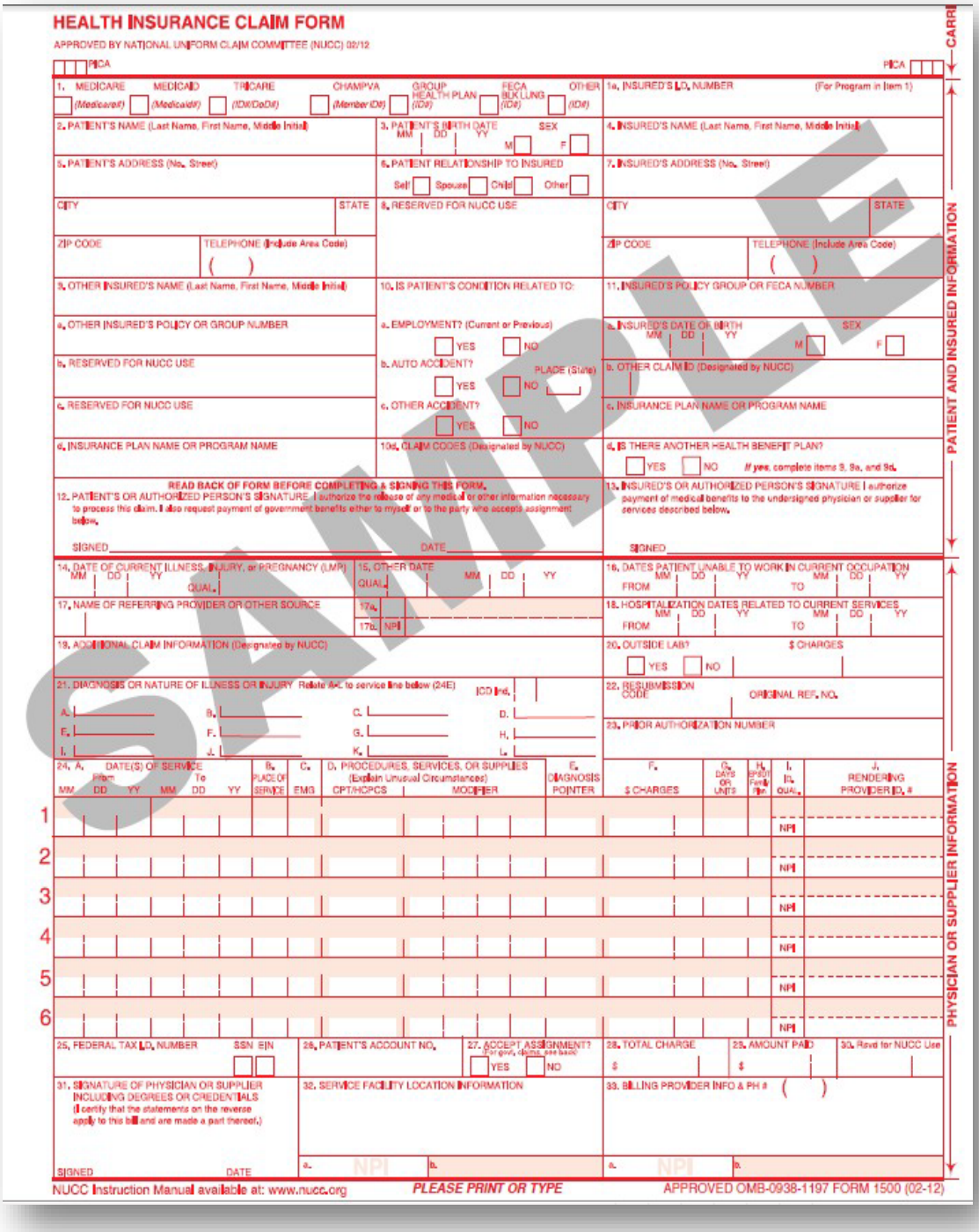
Health Partners Plans/Jefferson Health Plans
Attn: Inpatient Provider Appeals
1101 Market Street, Suite 3000
Philadelphia, PA 19107

All other written requests for reconsideration are directed through the Claim Services department. For prompt handling, reconsiderations should be submitted through the Provider Portal: https://www.healthpartnersplans.com/providers/provider-portals:

The provider will be advised of the claim reconsideration outcome, generally within 30-45 calendar days of the date the written request was received by Claim Services. Claims that are overturned and have payment issued will appear on the provider's EOP and no other notice will be provided. If the original denial is upheld, the provider will be sent a form letter advising of the right to dispute and appeal the outcome. For more information on the dispute and appeal process, please see Chapter 13-Complaints, Grievances & Appeals.

To request assistance with access to our provider portal, please follow the setup guidelines on the portal webpage.

Figure 12A: Sample CMS-1500 Form (Version 8-05 New Form)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRI

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 12B: Billing Requirements for CMS-1500 Form (Version 8-05 New Form)		
Field	**Field Description**	**R (Required) C (Conditional) O (Optional)**
1a	Jefferson Health Plans ID number	R
2	Patient name (last name, first name, middle initial)	R
3	Patient's birth date and sex	R
4	N/A (Same as field #2)	R
5	Patient complete address and telephone number	R
6	Patient's relationship to insured	R
7	N/A (Same as field #5)	C
8	Patient's status	C
9	Other insured information	C
10	Is patient condition related to: a. Employment? b. Auto accident? c. Other accident?	 R R R
11	Insured's policy group of FECA number	C
11a	Insured's date of birth	C
11b	Employer's name or school name	C
11c	Insurance plan or program name	C
11d	Is there another health benefit plan?	R
12	Patient's or authorized person's signature	R
13	Insured's or authorized person's signature	C
14	Date of current illness, injury, pregnancy	C
15	Date of same of similar illness	C

Figure 12B: Billing Requirements for CMS-1500 Form (Version 8-05 New Form)		
Field	**Field Description**	**R (Required) C (Conditional) O (Optional)**
16	Dates patient unable to work in current occupation	C
17	Name of referring physician	C
17a	Other referring ID number (must be reported with one of the NUCC qualifiers)	C
17b	NPI (the referring HIPAA NPI number)	C
18	Hospitalization dates related to current services	C
19	Medical License Number	R
20	Outside lab?	C
21	Diagnosis code(s) relate items to 24c by procedure line	R
22	Medicaid resubmission code (original DCN adjustments)	C
23	Prior authorization number	C
24a	Date(s) of service	R
24b	Place of service	R
24c	EMG	C
24d	Procedures, services, or supplies/modifiers	R
24e	Diagnosis pointer	R
24f	Charges	R
24g	Days or units	R
24h	EPSDT (family plan)	C
24i	Rendering provider other ID number (must be reported with one of the NUCC qualifiers)	C
24j	Rendering provider NPI ID number	C

Figure 12B: Billing Requirements for CMS-1500 Form (Version 8-05 New Form)		
Field	**Field Description**	**R (Required) C (Conditional) O (Optional)**
25	Federal tax ID number	R
26	Provider's patient account number	C
27	Accept assignment (assumed yes by Jefferson Health Plans contract)	C
28	Total charge	R
29	Amount paid	C
30	Balance due	C
31	Signature of physician or supplier	R
32	Service facility location information	C
32a	NPI number of the service facility location	C
32b	Other ID number (must be reported with one of the NUCC qualifiers)	C
33	Billing provider name, address, zip code, and phone number	R
33a	Billing/Group NPI	R
33b	Non-NPI—Other ID number (must be reported with one of the NUCC qualifiers)	O

Figure 12C: UB-04 Claim Form

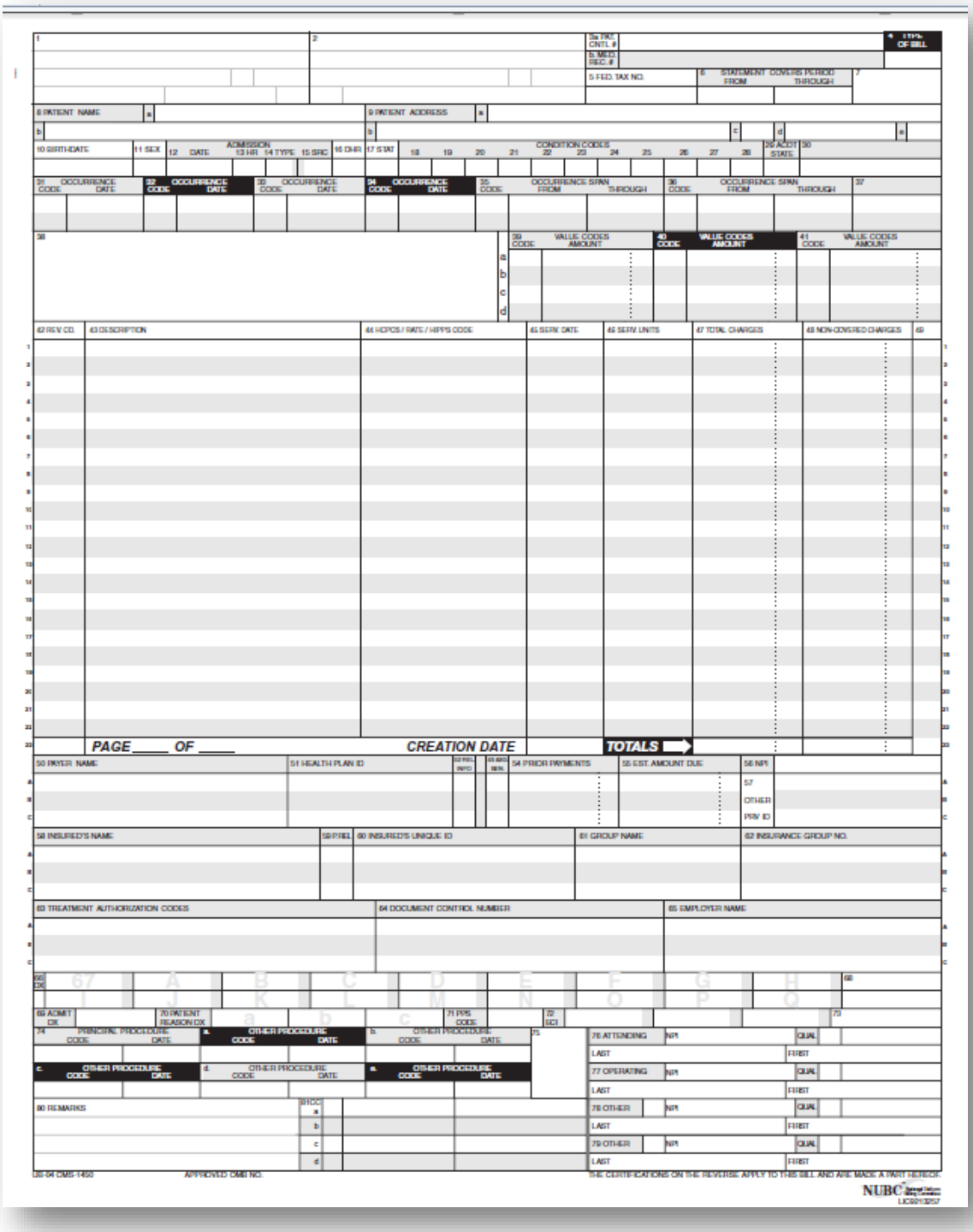


Figure 12D: Billing Requirements for UB-04 Claim Form ("R" is Required / "C" is Conditional / "O" is Optional)			
Field	**Field Description**	**Inpatient**	**Outpatient**
1	Provider name, address and telephone, county code	R	R
2	Pay-to name, address, pay-to ID	O	O
3a	Patient control number	R	R
3b	Medical record number	R	R
4	Type of bill	R	R
5	Federal tax number	R	R
6	Statement coverage period	R	R
7	Unlabeled	O	O
8a	Patient ID	O	O
8b	Patient name	R	R
9	Patient address and county code	R	R
10	Patient date of birth	R	R
11	Patient sex	R	R
12	Admission date of service	R	R
13	Admission hour	R	C
14	Type of admission/visit	R	C
15	Source of admission	R	R
16	Discharge hour	R	C
17	Patient discharge status	R	R
18-28	Condition codes	R	R
29	Accident state	C	C
30	Unlabeled	O	O
31-34	Occurrence code/date	C	C

35-36	Occurrence span code and dates	C	C

Figure 12D: Billing Requirements for UB-04 Claim Form ("R" is Required / "C" is Conditional / "O" is Optional)			
Field	**Field Description**	**Inpatient**	**Outpatient**
37	Unlabeled	O	O
38	Responsible party name/address	R	R
39-41	Value codes and amounts	C	C
42	Revenue code	R	R
43	Revenue description	R	R
44	CPT/HCPC Code, Modifier (if applicable) and Charge Amount	C	R
45	Service date	N/A	R
46	Units of service	R	R
47	Total charges by revenue code category	R	R
48	Non-covered charges	O	O
49	Unlabeled	O	O
50a	Payer name – primary	R	R
50b	Payer name – secondary	C	C
50c	Payer name – tertiary	C	C
51	Health Plan ID (Jefferson Health Plans Provider ID)	O	O
52	Release of information certification number	R	R
53a	Assignment of benefits - primary	R	R
53b	Assignment of benefits - secondary	R	R
53c	Assignment of benefits - tertiary	R	R
54	Prior payment - payer and patient (a-c)	C	C
55	Estimated amount due	R	R

56	NPI billing provider (HIPAA provider number)	R	R
57	Non-NPI - Other ID number billing provider (must be reported with one of the NUCC qualifiers)	O	O

Figure 12D: Billing Requirements for UB-04 Claim Form ("R" is Required / "C" is Conditional / "O" is Optional)			
Field	**Field Description**	**Inpatient**	**Outpatient**
58	Insured's name	R	R
59	Patient's relationship	R	R
60	Insured's unique ID (HPP/Jefferson Health Plans ID number)	R	R
61	Insured's group name, if applicable	C	C
62	Insured's group number	C	C
63	Treatment authorization code	R	R
64	Document control number	C	C
65	Employer name	C	C
66	DX version qualifier (ICDv)	C	C
67	Principal diagnosis code	R	R
67a-q	Other diagnosis	C	C
68	Unlabeled	O	O
69	Admitting diagnosis code	R	N/A
70	Patient's reason for visit code	C	C
71	PPS code - DRG code	R	C
72	External cause of injury code	C	C
73	Unlabeled	O	O
74a-e	Other procedure code/dates	C	C
75	Unlabeled	O	O

76	Attending NPI qualifier/ID number (first field NPI, second field qual + ID)	R	R
77	Operating physician NPI qualifier/ID number (first field NPI, second field qual + ID)	C	C
78	Other - qualifier/NPI qualifier/ID	C	C
79	Other - qualifier/NPI qualifier/ID	C	C

Figure 12D: Billing Requirements for UB-04 Claim Form ("R" is Required / "C" is Conditional / "O" is Optional)			
Field	**Field Description**	**Inpatient**	**Outpatient**
80	Remarks	O	O
81	Code-code-qualifier/code/value	C	C

R=Required C=Conditional

Explanation of Payment (EOP)

This statement reports fee-for-service payments to providers, including PCPs, specialists, ancillaries and hospitals. (It does not report payments for capitated services.) The EOP reports claim charges that are paid or denied, and the reason for the payment or denial. The EOP also shows any coordination of benefits payments, any adjustments or interest payments, as well as the provider NPI and Health Plan legacy identification numbers. Additionally, the EOP indicates claims that have been modified to reflect correct coding as determined by Correct Coding Initiative and/or American Medical Association guidelines.

Chapter 13: Complaints, Grievances & Appeals

Purpose: This chapter provides guidelines for understanding our complaint, grievance and appeal procedures.

Topics: Important topics from this chapter include:

Provider Disputes/Appeals
Provider Initiated Member Grievances and Appeals
Medicaid Member Complaint & Grievance Process
CHIP Member Complaint & Grievance Process
Medicare Member Grievance & Appeal Process
Individual and Family Plan Member Complaint and Grievance Process

Overview

We provide several types of appeals to providers who are dissatisfied with our decisions. Depending on the nature of the issue, providers may be able to choose between more than one available appeal avenue. This chapter of the Provider Manual describes appeal options. Appeal options include:

- Appeals of Inpatient Utilization Review
- Provider Quality of Care Sanctions and Appeals (see Chapter 9)
- Provider Dispute and Appeal Process. This process may not be used to appeal decisions that regard medical necessity, or provider sanctions.
- Provider-Initiated Member Grievances (Act 68)
- With the member's consent, a provider may appeal (grieve) a Health Plan decision on behalf of the member. A provider who pursues this appeal process may not additionally use the informal dispute resolution process described in Section V to appeal the same matter.

Provider Dispute & Appeal Process (Medicaid Only)

This Provider Dispute & Appeal Process is available only for the Health Partners Plans Medicaid plan and may not be used for any issues concerning medical necessity decisions, nor for provider sanctions (see Chapter 9 - Provider Quality of Care Sanctions and Appeals). This process allows for informal and formal processes for settlement of Provider Disputes and ensures equitability for all providers. Provider Appeal decisions are reported to the appropriate internal business areas. Provider terminations are reported to the Department of Human Services.

A Provider Dispute is a written communication to us from a Medicaid provider expressing dissatisfaction with a decision (other than a medical necessity decision or a provider sanction) that directly impacts the provider. The three matters that providers may bring through our Provider Dispute & Appeal process are as follows:

- Provider credentialing denial by the plan;
- Provider termination action by the plan; and
- Provider claim denials (for reasons other than medical necessity).

Providers are encouraged to follow the Claim Reconsideration process for quick resolution to billing and payment errors (see Chapter 12 - Claim Reconsiderations). Providers may, however, access the Dispute & Appeal Process for initial claim denials. If a provider chooses to use the Dispute & Appeal Process for initial claim denials, the Dispute & Appeal Process filing deadlines apply, and the Claim Reconsideration process is no longer available as a resolution process. Further, any initial claim denials presented through the Claim Reconsideration process that result in continued provider dissatisfaction may be presented through the Dispute & Appeal Process. The Dispute & Appeal Process filing deadlines apply.

The Provider Dispute & Appeal Process provides for the settlement of applicable issues as follows:

Disputes
Providers have the right to file a dispute regarding provider credentialing denial, provider termination, and claim denials (including denied payment for services already rendered). Providers have thirty (30) calendar days from the date of the written notice (credentialing denial, termination or claim denial) from Jefferson Health Plans to file a dispute. All disputes must be in writing and mailed to:

Health Partners Plans, Inc.
Attn: Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107

A provider representative (e.g., co-worker, friend, the provider's attorney, etc.) can assist the provider in filing a dispute. If a provider representative files a dispute on behalf of a provider, the provider must provide us with written authorization stating that said provider representative may act on the provider's behalf. The provider is given ten (10) calendar days to provide the proper authorization for said provider representation. The dispute process begins the date upon which the written authorization from the provider is received by our Complaints, Grievances & Appeals (CG&A) Unit.

1st Level Dispute Process (Informal)
The initial dispute is a 1st Level Dispute. After our Complaints, Grievances & Appeals Unit receives the request for the dispute process by the provider or the provider representative, we will initiate the 1st Level Dispute panel. The panel will consist of at least one person who has the authority, training and expertise to address and resolve provider dispute issues. The 1st Level Dispute panel has thirty (30) calendar days from the date of receipt of the 1st Level Dispute request to investigate and render a decision. The Complaints, Grievances & Appeals Unit has five (5) business days from the date of the 1st Level Dispute panel's resolution to forward the decision notification letter to the provider.

If the provider is dissatisfied with the decision, the provider may appeal the dispute to our 2nd Level Dispute (Internal Appeal) process.

2nd Level Dispute Process (Internal Appeal/Formal)
Following resolution of his/her 1st Level Dispute, a provider has the right to file a 2nd Level Dispute (Appeal). The 2nd Level Dispute (Appeal) by the provider is due within thirty (30) calendar days of the date of the 1st Level Dispute decision notification letter. All 2nd Level Disputes (Appeals) must be in writing and mailed to:

Health Parnters Plans, Inc.
Attn: Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107

The Complaints, Grievances & Appeals Unit will appoint a 2nd Level Dispute review committee that shall:

- include healthcare providers/peers not employed by us, comprising at least one-fourth (1/4) of the membership of the committee;
- include committee members who have the authority, training and expertise to address and resolve Provider Disputes (Appeals);
- have access to data necessary to assist committee members in making decisions; and
- document meetings and decisions of the committee.

Prior to the 2nd Level Dispute (Appeal) hearing, we will send a letter to the provider informing him/her of his/her right to appear before the 2nd Level Dispute (Appeal) panel. The provider's authorized representative (if applicable) also has the right to be present at the 2nd Level Dispute (Appeal) hearing. The provider must give the name of the provider representative to us at least two (2) business days prior to the 2nd Level Dispute (Appeal) hearing. Additionally, the same rules apply for appointing a provider representative as described above in this "Disputes" section.

The 2nd Level Dispute (Appeal) panel has thirty (30) calendar days from the date of receipt of the 2nd Level Dispute (Appeal) request to hold a hearing and render a decision. The CG&A Unit has five (5) business days from the date of the 2nd Level Dispute (Appeal) panel's resolution to forward the decision notification letter to the provider. The decision of the 2nd Level Dispute (Appeal) Committee is final and binding.

Provider Dispute & Appeal Process for Suspensions/ Terminations/Non-Renewal of Physician Contract (Medicaid & Medicare)
In-network providers that participate with both Medicaid and Medicare lines of business or Medicare Only and are suspended, terminated or denied re-credentialing have the following appeal rights:

First Level Provider Appeal

- An appeal must be filed in writing by the provider or the provider's representative (with written permission of the provider) in order for the Complaints, Grievances and Appeals Unit to process the request as a written appeal. We will send the provider an acknowledgment letter within five.
- (5) business days of receiving the Appeal.

- The provider will submit any material related to the appeal to us within ten (10) calendar days of the appeal.
- We have thirty (30) calendar days from the date the Appeal was received, to investigate, hold a Provider Appeal hearing and render a decision in the case.
- The majority of the Provider Appeal hearing panel members will consist of peers of the affected physician.
- We have five (5) business days after the Provider Appeal hearing panel makes the decision to forward a decision notification letter to the provider.
- If the decision is upheld, the provider has no further Medicare appeal rights, and the decision is final and binding.
- The provider can file a 2nd level appeal for the Medicaid line of business only. Please refer to the Medicaid 2nd Level Dispute Process (Internal Appeal/Formal) for further details.

Sanctions and Appeals
In certain situations, a provider may be subject to review and sanctions by our Quality Management Committee. The provider has certain appeal rights concerning these Quality Management Committee decisions. For more information, see Chapter 9 Provider Quality of Care Sanctions and Appeals.

Provider Complaint Procedure
A credentialed provider may initiate a complaint against us (for issues other than denial of credentialing, claims payment, or provider termination) by contacting the Provider Services Helpline at 1-888-991-9023 (see Chapter 1 for Contact Information). All provider complaints requiring follow-up action will be documented on a Provider Issue form. Each complaint must be addressed within seven (7) business days.

Binding Arbitration Hearing
The dispute will be referred to arbitration before a panel comprised of three (3) individuals. Both the provider and us will select one panel representative each, within 10 working days of receipt of the request for arbitration. The two panel representatives will then select a third panel representative to create the three-person arbitration board. If the two representatives cannot agree on the third representative within 14 days of the request for selection, the third panelist shall be drawn by lot from two candidates (one selected by the provider and one selected by us).

Upon selection of the third arbitrator, the arbitration board must issue its decision as expeditiously as possible in accordance with the procedures of the American Arbitration Association for handling such matters. Matters concerning level of care/placement decisions shall be reviewed and decided by the panel immediately. The arbitration proceeding will be

conducted according to the prevailing rules of the American Arbitration Association. The decision of the arbitration board shall be binding and subject to review by DOH.

The entire cost of the arbitration proceeding shall be borne by the losing party.

***Note**: We will not exclude a provider from its provider network because the provider advocated on behalf of a member in a utilization management appeal or another dispute with us over appropriate medical care. Additionally, we cannot terminate a contract or employment with a healthcare provider for filing a grievance on a member's behalf.*

Provider-Initiated Member Grievances (Medicaid and CHIP Only)

This information pertains to Health Partners Plans Medicaid and KidzPartners (CHIP) members. With the written permission of the member, providers have the right to appeal on behalf of the member. While a provider may request the member's written consent prior to treatment, he or she may not (as a condition of treatment) require that the member sign a document authorizing the provider to file a grievance.

Applicable regulations provide specific requirements and time frames that must be adhered to. When the member gives the provider permission to file a grievance or appeal, the provider must assure timely compliance with the requirements, since he or she has assumed the member's grievance and appeal rights. The member, however, may rescind consent at any time.
When the provider initiates a member grievance or appeal, he or she may not bill the member for the services that are the subject of the grievance until an external grievance review has been completed, or unless the member has rescinded the consent. Health Partners Plans Medicaid members may never be billed or balance billed for covered services.

In situations where the provider is prohibited from billing the member, or if the provider chooses to never bill the member for the services being grieved, he or she may drop the grievance. The provider must notify the member or the member's legal representative in order to do so.

A member may ask another person to serve as his/her representative in the appeal process. This person is then termed the "member's representative." If the representative is a healthcare provider, the provider must have the member's written consent to file/pursue a grievance or appeal. Documentation of member consent must be submitted with the request. A provider may obtain the member's written permission at the time of treatment. However, the provider must not require a member to sign a document authorizing the provider to file an appeal as a condition of treatment. Either the member or the member's legal representative may provide this consent.

The written consent giving a provider authority to file/pursue a grievance or appeal as the member's representative must contain each of the following:

- The member's name, address, date of birth, and plan identification number
- When the member is a minor or legally incompetent: the name, address and relationship to the member of the person signing the consent on behalf of the member.
- The name, address and identification number of the healthcare provider who is obtaining consent from the member.
- The name and address of the plan that will receive the grievance or appeal
- A description of the specific service(s) (whether coverage was provided or denied) that the consent will apply to.
- The signature and date of signature of the member, or (if a minor or legally incompetent) the member's legal representative; and the signature and date of signature of a witness.

The written consent must also include the following statements:

- The member or member's legal representative may not file a grievance or appeal about the service(s) listed in the consent form unless the member or member's legal representative rescinds the consent in writing. The member or member's legal representative has the right to rescind this consent at any time during the grievance or appeal process.
- If the provider fails to file the grievance or appeal, or does not continue to pursue the grievance or appeal through the second-level review process, the consent of the member or member's legal representative will be rescinded automatically.

The member (or the member's legal representative, if the member is a minor or legally incompetent) has read (or has been read) this consent document, and has had it explained to his/her satisfaction. The member or member's legal representative understands the information in the member's consent form.

A member may rescind his/her consent at any time throughout the grievance and appeal process. If the member rescinds consent, he/she may continue the grievance from the point at which consent was rescinded. A member may not file a separate grievance or appeal on the same matter. If a member files a grievance or appeal, he/she may, at any time during the grievance or appeal process, choose to give consent to a healthcare provider to continue the grievance or appeal on behalf of the member. A member's legal representative may similarly exercise these member rights.

Please note that, if a provider uses the following process, he or she may not also use the informal dispute resolution process described under Appeals of Inpatient Utilization Review Decisions to appeal the same matter.

Under Pennsylvania Code Title 28, chapter 9- 9.706 (c) (g), (c), once a healthcare provider assumes responsibility for filing a grievance, the healthcare provider may not bill the enrollee or the enrollee's legal representative for services provided that are the subject of the grievance until the external grievance review has been completed or the enrollee or the enrollee's legal representative rescinds consent for the healthcare provider to pursue the grievance. If the healthcare provider chooses never to bill the enrollee or the enrollee's legal representative for the services provided that are the subject of the grievance, the healthcare provider may drop the grievance with notice to the enrollee and the enrollee's legal representative in accordance with subsection (g).

Subsection (g) reads as follows:
(g) The provider, having obtained consent from the enrollee or the enrollee's legal representative to file a grievance, shall have 10 days from receipt of the standard written UR denial and any decision letter from a first, second or external review upholding the plan's decision to notify the enrollee or the enrollee's legal representative of its intention not to pursue a grievance.

Grievances (Medicaid and CHIP only)

When we deny, decrease, or approve a service or item different than the service or item requested because it is not medically necessary, a written grievance may be filed by the member, member's legal representative, or healthcare provider or other member's representative (with the appropriate written consent of the member) to request that we reconsider our decision. Specifically, a decision may be grieved that:

- Denies or provides limited authorization for a requested service, including its type or level.
- Reduces, suspends or terminates a service that was previously authorized.
- Denies the requested service and approves an alternative.
- Denies payment, fully or in part, for a service, based on lack of medical necessity.

Provider-Initiated Member Grievances
The member, or member's representative, or provider (with member's written consent) must file the grievance within 60 days from the date of receipt of notification about the decision. In order to initiate a grievance on behalf of a member, the provider must submit the member's written consent with the request for a grievance. This member consent may be obtained at the time of treatment. However, the provider must not require a member to sign a document authorizing the provider to file a grievance as a condition of treatment.

A provider appealing with consent of the member should send the written grievance to:

Health Partners Plans, Inc.
Attn: Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 1910

When a grievance is received, we issue a written confirmation to the member, the member's representative (if designated), and the provider (if the provider has filed the grievance with member consent). The letter will provide additional information about the grievance review process, including:

- Classification of the matter as a grievance versus a complaint. The member, member's representative, or provider may question this classification by contacting the Pennsylvania Department of Health.
- The right of the member to appoint a representative to act on his/her behalf at any time during the internal grievance process.
- The ability of the member, member's representative, or provider that filed the grievance (with member consent) to review information related to the grievance upon request. They may also submit additional information to us for consideration.
- The right of the member or member's representative to request that a Health Partner Plans staff member (who has not participated in the utilization management decision) help prepare the first-level grievance, at no charge.
- Notice that the member, member's representative, and provider will be given 10 days written, advance notice of the scheduled review, and that they have the right to attend and participate.

We will consider the member's access to transportation, as well as any disabilities or language barriers, and will make reasonable accommodation to permit the member, member's representative, and the provider to participate, in person, by conference call, or by videoconference. When the member, member's representative, or the provider cannot attend the review in person, we will provide the opportunity to communicate with the committee by other appropriate means, such as telephone and videoconference.

A committee made up of three (3) or more individuals whose members have not been involved in any prior decision and are not the subordinates of an individual involved in any prior decision regarding the grievance will provide the grievance review. A licensed physician or an approved licensed psychologist (practicing in the same or similar specialty that would typically consult on the healthcare services in question) will be a committee member. Other appropriate providers may participate in the review, but the licensed physician must decide

the grievance. At least one third of the grievance review committee may not be employees of ours or a related subsidiary or affiliate.

We will provide the member, member's representative, or provider that filed a grievance with member consent access to all information about the matter being decided. We will allow for written information or other additional material to be introduced in support of the grievance. The member, member's representative, or provider may directly voice the remedy or corrective action which they are asking of us.

Grievance review attendance is limited to these people:

- Review committee members who are not employees of ours
- Appropriate plan representatives
- The member or the member's representative(s), including legal representation and/or any attendant necessary for the member's participation in and understanding of the proceedings
- The provider who grieved the matter with the member's consent
- Any pertinent witnesses

All persons attending this meeting will need to identify themselves and their role in the grievance process for the member and any representatives for the member that are present. The committee will base the review decision on the materials and testimony presented during the review meeting only. Committee members may not discuss the case prior to the review meeting. Committee members must attend the review meeting in person or participate actively by telephone or videoconference (and have an opportunity to review any information introduced at the review meeting prior to voting), or they may not vote. An attorney may represent the committee's interests at the review meeting but may not argue the plan's position or represent its staff. A summary of the meeting's proceedings will be produced from an electronic recording. This summary will become part of the grievance record and will be included in the information the plan sends if there is a request for an external grievance review.

We will reach a decision and notify the member, member's representative, and provider within 30 days from receiving a grievance. A 14-day extension may be requested by the member, member's representative, or the provider who filed the grievance with written consent of the member. This notice will include the basis for the decision, and will explain how to request a Fair Hearing from the Department of Human Services (DHS) (ONLY applicable for Medicaid members, Fair Hearings are NOT available in the CHIP program), an external review of the decision by the Pennsylvania Insurance Department (PID) for Medicaid members, or an external review of the decision by the Pennsylvania Department of Health for CHIP members, or both a request for a Fair Hearing and a request for an external review of the decision for Medicaid members.

The notice will specifically include:

- A statement of the matter reviewed by the committee.
- The specific reasons for the committee's decision.
- Corresponding provisions that were the basis for the decision, and how to obtain copies of any documents used.
- The scientific or clinical judgment behind the decision.
- Information on how to file a Fair Hearing from the Department of Human Services (DHS), an external review of the decision by the Department of Health (DOH), or both a request for a Fair Hearing and a request for an external review of the decision.

Medicaid members may ask for an external review of the decision by the Pennsylvania Insurance Department (PID) within fifteen (15) days from receipt of the decision. The member may file a request for a DHS Fair Hearing within one hundred twenty (120) days from the mail date on the written notice of decision.

CHIP members may ask for an external review of the decision by the Pennsylvania Department of Health (DOH) within fifteen (15) days from receipt of the decision.

Expedited Grievances
If the member's life, health or ability to regain maximum function would be jeopardized by delay caused by the standard review process, an Expedited Grievance may be filed. The member, member's representative, or provider (with written consent of the member) may file this request by calling us.

To obtain an expedited review, we must be provided with written certification from the member's physician that the member's life, health, or ability to regain maximum function would be jeopardized by delay. This certification must include the physician's clinical rationale and facts that support his/her opinion. The certification must include the provider's signature. If the provider certification is not included with the request for an expedited review, we must inform the member that the provider must submit a certification as to reasons why the expedited review is needed and why the grievance cannot be processed within the standard thirty (30) day time frame.

The expedited grievance will be put into writing. A committee of three or more people, including a licensed doctor and a Health Plan member, will review the grievance. The licensed doctor will decide the expedited grievance with help from the other representation on the committee. No one on the committee will have prior involvement with the grievance. The expedited grievance process will follow the process described above under Provider-Initiated Member Grievances (Act 68 Process), with these exceptions:

- A 48-hour time frame of receiving the provider certification or seventy-two (72) hour timeframe of receiving the Member's request for an expedited review applies, whichever is shorter.
- If the member cannot attend the hearing in person due to the short time frame, the hearing may be held by telephone or videoconference. In this case, all information presented will be read into the record.
- If the member cannot be provided with a copy of the report of the same or similar specialist prior to the expedited hearing, we may read the report into the record at the hearing and provide a copy of the report to the member at that time.
- To allow us to conform to the time requirements of this section, it is the responsibility of the member, member's representative, or provider to provide information to the plan in an expedited manner.

We will conduct an expedited internal review and issue a decision within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Member. The decision notice to the member, member's representative or provider will state the basis for the decision and include any clinical rationale. It will also give the procedure for requesting an expedited external review and, if applicable, a DHS Fair Hearing. (Fair Hearings are not available in the CHIP program.) The member, member's representative or provider (with written consent of the member) has two business days from receipt of the expedited grievance decision to request an expedited external review. The member may file a request for a DHS Fair Hearing within one hundred twenty (120) days from the mail date on the written notice of our expedited Grievance decision.

If an expedited external review is requested, we will submit a request to the Pennsylvania Insurance Department (PID) for Medicaid members or Pennsylvania Department of Health (DOH) for CHIP members by fax and telephone within 24 hours of receiving a request from the member, member's representative or provider with member's written consent. The Pennsylvania Insurance Department (PID) or Pennsylvania Department of Health (DOH) will assign a certified review entity (CRE) to the case within one business day of receiving the expedited review request. The CRE will make a decision within two business days following its receipt of the case file.

Medicaid Member Complaints, Grievances, and Fair Hearings Process

Health Partners Medicaid Member Complaint & Grievance Process
Information pertaining to Health Partners Medicaid Member Complaint, Grievance and Fair Haring process can be found at:

https://www.healthpartnersplans.com/members/health-partners/using-the-plan/member-handbook

This information at this link pertains to (Medicaid) members ONLY.

KidzPartners Member Complaint & Grievance Process
Information pertaining to KidzPartners (CHIP) Member Complaint and Grievance process can be found at:

https://www.healthpartnersplans.com/members/kidzpartners/resources/member-handbook

This information pertains to KidzPartners members ONLY.

Jefferson Health Plans Medicare Advantage Member Grievance & Appeal Process

This information pertains to Jefferson Health Plans Medicare Advantage members ONLY.

Grievances
A Grievance means any complaint or dispute other than the one involving an organization determination, expressing dissatisfaction with any aspect of Jefferson Health Plans Medicare providers' operations, activities, or behavior, regardless of whether remedial action is requested.

Members have (60) calendar days from the date of the incident or the date the member receives written notice of a decision to file a grievance. Grievance requests must be filed orally or in writing with Jefferson Health Plans Medicare. A grievance can be filed on behalf of a member by a provider or other representative. The member's written authorization must be included with the grievance request.

For quality of care issues, a member may file a grievance with Jefferson Health Plans Medicare, or file a written complaint with CMS's contracted Quality Improvement Organization (QIO). If a quality of care complaint is filed with QIO, Jefferson Health Plans Medicare will work with the QIO to resolve the complaint.

Standard Grievance

Jefferson Health Plans Medicare Advantage will respond to a member's grievance within (30) calendar days. We may extend the 30-day review period by up to 14 days if requested by the member, or if we justify the need for additional information. If Jefferson Health Plans Medicare extends the 30-day review period, the member and the representative involved will be notified in writing of the reason for delay. A grievance decision notice will be issued no later than the expiration of the extension.

Expedited Grievance

Jefferson Health Plans Medicare must respond to a member's grievance within 24 hours in the following instances:

The grievance involves Jefferson Health Plans Medicare's decision to invoke an extension to the time frame required for an organization determination in response to a service request or reconsideration (appeal).

The grievance involves Jefferson Health Plans Medicare's refusal to grant the member's request for an expedited organization determination in response to a service request or expedited reconsideration (appeal).

Reconsideration (Appeal) Process
Providers must adhere to the Medicare appeals and expedited appeals procedures, including gathering/forwarding information on appeals as necessary and as described in the Code of Federal Regulations (42 CFR 422 Subpart M).

Reconsideration (Appeal) Request
A reconsideration consists of a review of an adverse Jefferson Health Plans Medicare determination notice. If the request is not filed in 60 calendar days, the member (or the members' authorized representative) may request that the reconsideration time frame be extended. The request for the reconsideration and extension of the time frame must be written, and must state why the request was not filed in a timely manner.

In order for Jefferson Health Plans to process a standard reconsideration (appeal) request for **service or payment** from a contracted plan provider on behalf of a member, Jefferson Health Plans must obtain an Appointment of Representation from the member, authorizing the medical provider to represent the member during the appeal process.

***Note**: Non-contracted providers may appeal on behalf of a member by obtaining an Appointment of Representation form. When acting as a representative of the member, a non- contracted provider is prohibited from participating as an independent party (appellant) to the appeal.*

Standard Reconsideration (Appeal) of Service Determination

Jefferson Health Plans Medicare Advantage will issue a written determination for a service reconsideration request as expeditiously as the member's health condition requires, but no later than 30 calendar days from the date we received the request for a standard reconsideration.

We may extend the 30-day time frame by 14 days. If Jefferson Health Plans Medicare Advantage extends the time frame, we will notify the member in writing of the reasons for delay and inform the member of his/her grievance rights if the member disagrees with our decision to extend the time frame.

When Jefferson Health Plans Medicare Advantage makes a reconsideration determination that upholds the initial denial, in whole or in part, we will prepare a written explanation and send the case file to

MAXIMUS as expeditiously as the member's health condition requires but no later than 30 days from receipt of the reconsideration request, subject to an additional 14-day extension.

MAXIMUS Federal Services/Part C
Medicare Managed Care Reconsideration Project
3750 Monroe Ave. Suite 702
Pittsford, New York 14534-1302
Phone: **1-585-348-3300**

Standard Reconsideration (Appeal) of Payment Determination

Jefferson Health Plans Medicare Advantage will issue a written determination for payment reconsideration requests no later than 60 days from the date we received the request for a standard reconsideration.

When Jefferson Health Plans Medicare Advantage makes a reconsideration determination that upholds the initial denial, in whole or in part, we will prepare a written explanation and send the case/file to MAXIMUS within 60 days of receipt of the reconsideration request.

Expediting Certain Reconsiderations
A member or a physician (contracted or not contracted) may request that Jefferson Health Plans Medicare Advantage expedite a reconsideration of a determination that involves our refusal to provide or pay for services that the member believes should be furnished or arranged for if the member believes that the continuation of services is medically necessary.

The expedited reconsideration (appeal) time frames will be applied in the following circumstances:

- A member requests reconsideration (appeal) because he/she missed the deadline to request QIO review of a non-coverage of an inpatient hospital care decision following his/her receipt of Notice of Medicare Non-Coverage (NOMNC).
- A member requests reconsideration (appeal) because he/she missed the deadline to file a Fast Track appeal request with the QIO following his/her receipt of a 2-day advance termination notice from a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) provider.
    - Contracted and non-contracted physicians may initiate an expedited reconsideration without appointment of representation or Waiver of Liability documents.

Plan's Refusal to Expedite a Reconsideration Request
If Jefferson Health Plans Medicare Advantage denies a member's request for expedited reconsideration, we will give the member prompt oral notice and subsequently deliver, within 3 days, a notice to the member explaining that the request will automatically be transferred to the 30-day time frame for standard reconsiderations. The notice will also inform the member of the right to file a grievance if he/she disagrees with the decision not to expedite as well as the member's right to resubmit a request for an expedited reconsideration with any physician's support.

Plan's Decision to Expedite a Reconsideration Request
Those requests made or supported by a physician will be accepted as expedited if the physician indicates that applying the standard 30-day time frame for conducting reconsideration could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Jefferson Health Plans Medicare Advantage will complete the reconsideration and give the member (and physician involved, as appropriate), notice of the decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request. We may extend the 72-hour deadline by up to 14 days. If Jefferson Health Plans Medicare Advantage extends the time frame, we will notify the member in writing of the reason for the delay and inform the member of his/her grievance rights if the member disagrees with our decision to extend the time frame.

If Jefferson Health Plans Medicare Advantage first notifies the member (and physician involved as appropriate) orally of a completely favorable expedited reconsideration, we will issue a written confirmation within 3 days. If our expedited reconsideration determination upholds the initial determination (denial), in whole or in part, we will submit a written explanation and the case file will go to MAXIMUS as expeditiously as the member's health condition requires, but no later than 24 hours from our determination. Jefferson Health Plans Medicare Advantage will concurrently notify the member (and the physician involved, as appropriate) that the case file has been submitted to MAXIMUS.

Medicare Part D Grievance and Redetermination (Appeal) Process
Appeal Process

Appeals must be requested within 60 calendar days after the date of determination. Jefferson Health Plans Medicare Advantage can give the member more time if there is a good reason for missing the deadline. Members/providers have the right to ask Jefferson Health Plans Medicare Advantage for an exception if they believe a drug that is not on the formulary should be covered or if the drug should be covered at a lower cost sharing amount. They can also ask for an exception to utilization management tools, such as a dose restriction or step therapy requirement. The physician must provide a statement to support the exception request.

Requesting an Appeal
Members, their prescribing physician, or their appointed representative may request an appeal. A relative, friend, advocate, attorney, doctor, or someone else can act for the member. Others may already be authorized under State law to act on behalf of the member.

Jefferson Health Plans Medicare Advantage can be reached at **1-800-901-8000**, October 1 – March 31: seven days a week, from 8:00 a.m. to 8:00 p.m. April 1 – September 30: Monday through Friday, from 8:00 a.m. to 8:00 p.m. If members have a hearing or speech impairment, please call us at **TTY 1-877-454-8477**.
Problem Resolution – Part D
The following is communicated to all Jefferson Health Plans Medicare Advantage members.

There are two kinds of appeals you can request:

Expedited (72 Hours) – You can request an expedited (fast) appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If the doctor who prescribes the** drug(s) asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates waiting for 7 days could seriously harm your health, **we will automatically expedite the appeal.**
- If you ask for an appeal without support from a doctor, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

Standard 7 Days – You can request a standard appeal. We must give you a decision no later than 7 days after we get your request.

What do I include with my appeal request?
You should include your name, address, Member ID number, the reason for your appeal, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescribing physician must indicate that all the drugs on any tier of our formulary would either harm your health or not be as effective to treat your condition as the requested off-formulary drug.

How do I request an appeal?

For an Expedited Appeal: You or your appointed representative should contact us by telephone or fax us at:

Phone: 1-866-901-8000 (TTY 1-877-454-8477)
Fax: 215-991-4105

For a Standard Appeal: You or your appointed representative should mail or deliver your written appeal request to:

Jefferson Health Plans
Attn: Complaints, Grievances & Appeals Department
1101 Market Street, Suite 3000
Philadelphia, PA 19107

What Happens Next?
If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with the decision, you will be notified of your appeal rights.

Contact Information:
If you need information or help, call us at: **1-866-901-8000 (TTY 1-877-454-8477).** Other Resources to help you:

Medicare Rights
Toll Free: **1-888-HMO-9050**

Center Elder Care Locater
Toll Free: **1-800-677-1116**
1-800-MEDICARE (1-800-633-4227)
TYY: 1-877-486-2048

Individual and Family Plan Member Grievance & Appeal Process

This information pertains to Jefferson Health Plans Individual and Family plan members ONLY.

Grievance – a complaint by a member or member's authorized representative concerning any aspect of the operations, activities, or behavior of the health plan, or its providers, regardless of whether remedial action is requested.

Here are a few instances in which You would submit a Grievance:

- Quality of Your medical care
- Respecting Your privacy
- Waiting times
- Customer Service of Jefferson Health Plans' staff or Provider staff
- Cleanliness of a Provider's office
- Dissatisfaction with contractual benefits
- Timeliness of Our actions related to coverage decisions and appeals

Adverse Benefit Determination - An Adverse Benefit Determination may be any of the following:

- A decision by the Plan or someone on behalf of Plan to deny a service or payment for a service. This decision is based on a review of the information provided and the request does not meet [Insurer's] requirements for:
  - medical necessity
  - appropriateness
  - the type of health care setting
  - the level of care
  - effectiveness of the service
- The service is considered to be experimental or investigational.
- The service is not covered by this policy.
- A cancellation of coverage determination by Jefferson Health Plans.

Final Adverse Benefit Determination – happens when Jefferson Health Plans' decision to deny an initial request is partially or fully upheld by Jefferson Health Plans' internal appeal process.

Internal Appeal – an Internal Appeal is a request by a member, a member's authorized representative, or a health care provider, with the written consent of the Member, to have the Plan reconsider a decision concerning an Adverse Benefit Determination, or the Plan's compliance with the surprise billing and cost-sharing protections under the No Surprises Act.

External Review – an External Review is a review by an Independent Review Organization of the Plan's decision to deny coverage for or payment of a service. You can request an External Review by contacting the Pennsylvania Insurance Department.

If you want to file a Grievance

Call Jefferson Health Plans' Member Services at:

- 1-833-422-4690 (TTY: 1-877-454-8477) and tell Jefferson Health Plans your Grievance, or

- Write down your Grievance and send it to Jefferson Health Plans by mail or fax, to:

  Jefferson Health Plans
  Member Appeals Department/CGA Unit
  1101 Market Street, Suite 3000
  Philadelphia, PA 19107
  215-991-4105 (fax)

You can also have someone else request a Grievance for you if you give that person your consent in writing to do so.

You can submit a Grievance to Jefferson Health Plans if it has been one year or less from the incident or action leading to the dissatisfaction. We will acknowledge receipt of your Grievance within 5 business days of receipt of your request. Your Grievance will be reviewed by a 1st Level Grievance Review Committee consisting of one Plan employee who had no previous involvement with your case. If your Grievance is concerning a clinical issue, a Plan Medical Director will make the decision on your Grievance. Jefferson Health Plans will send you a decision concerning your Grievance within 30 calendar days of receipt of your Grievance. The letter will also include information regarding how to file a 2nd Level Grievance with Jefferson Health Plans if you do not agree with our decision.

2nd Level Grievance

If you are not happy with the outcome of your 1st Level Grievance, you can request a 2nd Level Grievance from Jefferson Health Plans. You have 60 days from receipt of the 1st Level Grievance decision letter to request a 2nd Level Grievance. We will acknowledge receipt of your 2nd Level Grievance within 5 business days of receipt of your request. Your 2nd Level Grievance will be reviewed by a 2nd Level Grievance Review Committee consisting of 3 or more persons who have had no previous involvement with your case and who are not subordinates of the person who made the 1st Level Grievance decision. The 2nd Level Grievance Committee members will include Jefferson Health Plans' staff, with one third of the committee being Members or other persons who are not employed by Jefferson Health Plans. If your Grievance is concerning a clinical issue, a Plan Medical Director will serve on

the committee. You have the right to present your Grievance appeal to the committee. You may submit supporting materials both before and at the 2nd Level Grievance Review. Jefferson Health Plans will send you a decision concerning your 2nd Level Grievance within 45 calendar days of receipt of your 2nd Level Grievance request. The decision is final unless you choose to appeal to the Pennsylvania Insurance Department as described in the decision letter.

If you want to file an Internal Appeal:
Call Jefferson Health Plans' Member Services at:

- 1-833-422-4690 (TTY: 1-877-454-8477) and tell Jefferson Health Plans that you want to request an Appeal, or

- Write down your Appeal request and send it to Jefferson Health Plans by mail or fax, or

- If you received a notice from Jefferson Health Plans telling you Jefferson Health Plans' decision and the notice included an Internal Appeal Request Form, fill out the form and send it to Jefferson Health Plans by mail or fax.

  Jefferson Health Plans
  Member Appeals Department/CGA Unit
  1101 Market Street, Suite 3000
  Philadelphia, PA 19107
  215-991-4105 (fax)

Your provider can file an Internal Appeal for you if you give the provider your consent in writing to do so.

You can submit an Internal Appeal to Jefferson Health Plans if it has been 180 calendar days or less from your receipt of the denial letter from Jefferson Health Plans. We will acknowledge receipt of your Internal Appeal within 5 business days of receipt of your request. If you are currently receiving services, we are required to provide continued coverage pending the outcome of the Appeal. To continue receiving services, you must file your request for an Internal Appeal within 10 days of the date on the denial letter. Your Appeal will be reviewed by an Internal Appeal Review Committee consisting of 3 or more persons who have had no previous involvement with your case and who are not subordinates of the person who made the original determination. The Internal Appeal Review Committee members will include Jefferson Health Plans' staff, including a Plan medical director who is a matched specialist or a consultant who is a matched specialist who holds an active unrestricted license to practice medicine. A matched specialist or "same or similar specialty Physician" is a licensed Physician, Dentist or Psychologist who: is in the same or similar specialty as typically manages the care under review. One third of the Committee will be

Members or other persons who are not employed by Jefferson Health Plans. You will have an opportunity to submit supporting materials and testimony for your Appeal. In addition, if Jefferson Health Plans receives new or additional information after the initial adverse determination, we will provide this information to you for your review prior to the Committee Review. Jefferson Health Plans will send you a decision concerning your Internal Appeal within 30 calendar days of receipt of your Internal Appeal request. The letter will also include information regarding how to file an External Review with an Independent Review Organization if you do not agree with our decision.

If Jefferson Health Plans fails to issue a written decision concerning your Internal Appeal within 30 days following the date the Plan receives your request, and you or your authorized representative have not requested or agreed to an extension on your Internal Appeal, you may proceed to an external review.

Expedited Internal Appeal

If you or your doctor believes that your life, health, or ability to regain maximum function would be placed in jeopardy by waiting 30 days to get your decision on your Internal Appeal, you or your doctor can request an Expedited Internal Appeal. You may also request an Expedited External Review with an Independent Review Organization at the same time that you request an Expedited Internal Appeal. Upon receipt of your request, we will promptly inform you whether your request qualifies for expedited review or instead will be processed as a standard Internal Appeal. Your Expedited Internal Appeal will be reviewed by an Expedited Internal Appeal Review Committee consisting of 3 or more persons who have had no previous involvement with your case and who are not subordinates of the person who made the original determination. The Expedited Internal Appeal Review Committee members will include Jefferson Health Plans' staff, including a Plan medical director who is a matched specialist or a consultant who is a matched specialist, and one third of the committee being Members or other persons who are not employed by Jefferson Health Plans. You will have an opportunity to submit supporting materials and testimony for your Appeal. You may submit supporting materials both before and at the Expedited Internal Appeal Review Committee. Jefferson Health Plans will notify you of its decision concerning your Expedited Internal Appeal both orally and in writing within 48 hours of receipt of your Expedited Internal Appeal request. If you are not satisfied with outcome of your Expedited Internal Appeal you can request an Expedited External Review with an Independent Review Organization as outlined below.

External Review

If your request for a service was denied, you may have the right to file a request for independent external review of an Adverse Benefit Determination or a Final Adverse Benefit Determination. This independent external review would be done at no cost to you.

What other rights do I have?
You also have the right to a review of whether we have complied with the surprise billing and cost-sharing protections under the No Surprises Act.

For example, if you receive a covered health care service at an in-network facility, you may not be charged a bill for other than your in-network cost-sharing.

For more information on this, you can visit the Pennsylvania Insurance Department's website dedicated to this topic:

www.insurance.pa.gov/nosurprises.

How do I ask for an independent external review?
For more information on the independent external review process, you can visit the Pennsylvania Insurance Department's website at:

www.insurance.pa.gov/externalreview

To submit a request for either standard or expedited independent external review, you must submit a copy of your adverse benefit determination or final adverse benefit determination notice and a completed independent external review request form to:

Mail: **Pennsylvania Insurance Department**
Attn: Bureau of Managed Care
1311 Strawberry Square
Harrisburg, PA 17120

Fax: 717-231-7960

Email: RA-IN-ExternalReview@pa.gov

Phone: Consumer Services
1-877-881-6388

What happens next?
Once the Insurance Department receives your request, your eligibility for independent external review will be confirmed with us.

If your adverse benefit determination or final adverse benefit determination is eligible for independent external review, the Insurance Department will assign an Independent Review Organization and provide you with notice of the assignment and information on how you may submit information to support your position. The Independent Review Organization will

issue a decision to uphold, partially uphold, or overturn our decision based on the information provided by you and by us.

Contact Information
If you need information or help, call us at: 1-833-422-4690 (TTY: 1-877-454-8477). Other Resources to help you:

To ask for free legal help with your Grievance or Appeal, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org)
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Chapter 14: Medicare Compliance Requirements

Purpose: This chapter provides Jefferson Health Plans Medicare Advantage network providers with the information and resources they will need to understand and fulfill General Compliance Program and FWA requirements related to our Medicare Advantage products.

Topics: Important topics from this chapter include:

- First-Tier, Downstream and Related entities (FDRs)
- Compliance Program Requirements
  - Jefferson Health Plans Code of Business Conduct
  - Jefferson Health Plans Compliance Program
  - Code of Conduct and Compliance Policy Distribution Requirements
  - General Compliance Program and FWA Training Resources

Overview

This chapter provides a summary of Medicare Compliance Program requirements as they relate to Jefferson Health Plans Medicare Advantage network providers.

First-Tier, Downstream and Related entities (FDRs)

The Centers for Medicare & Medicaid Services (CMS) refers to our contracted partners as First-Tier, Downstream and Related entities (FDRs).

Examples of FDRs include:

- Field marketing organizations
- Agents
- Hospitals
- Providers
- Independent Practice Associations (IPA)
- Pharmacies
- Pharmacy benefit managers
- Claim administration vendors
- Fulfillment vendors
- Other vendors who help us deliver benefits

First Tier and Downstream Classification

Health care providers that are directly contracted with Jefferson Health Plans to provide Medicare healthcare services to Jefferson Health Plans Medicare Advantage enrollees are considered to be Jefferson Health Plans first tier entities, or FDRs (First Tier, Downstream, Related entities). For example, hospitals, health care facilities, provider groups, doctor's offices and clinical laboratories that are directly contracted with Jefferson Health Plans for its Medicare Advantage plans are considered to be Jefferson Health Plans First Tier Entities.

Parties that enter into written arrangements with the Jefferson Health Plans First Tier Entity examples mentioned above to perform Jefferson Health Plans Medicare Advantage related services are considered to be downstream entities.

Compliance Program Requirements

As a Medicare Advantage plan sponsor, Jefferson Health Plans must ensure that FDRs performing delegated administrative or health care service functions related to its Medicare Advantage program are familiar and comply with General Medicare Compliance Program and Fraud, Waste and Abuse requirements described in the Jefferson Health Plans Code of Business Conduct (COBC) and Medicare Compliance Program documents.

Jefferson Health Plans complies with CMS Code of Conduct and Compliance Policy distribution requirements. FDRs can access Jefferson Health Plan's Code of Business Conduct (COBC) and Medicare Compliance Program documents through the following links and Jefferson Health Plans webpages:

Code of Business Conduct (COBC)
Compliance Program
Delegated Vendor Information
Provider Webpage

In order to fulfill General Medicare Compliance Program requirements, Jefferson Health Plans Healthcare Provider First Tier Entities must:

- Adopt and Comply with Jefferson Health Plans COBC and Compliance Policies or have their own materially similar versions.
- Ensure that Jefferson Health Plans Code of Business Conduct and Compliance Program documents or their own materially similar versions are distributed to all personnel involved with Jefferson Health Plans Medicare Advantage business (including downstream entity personnel, when applicable) within 90 days of contracting, upon revision and annually thereafter.
- Submit Jefferson Health Plans Provider Compliance Attestation annually.
- Provide evidence of Code of Conduct and Compliance Policy distribution to Jefferson Health Plans upon request.

Note: Jefferson Health Plans maintains the ultimate responsibility for fulfilling the terms and conditions of its contract with CMS. CMS may hold Jefferson Health Plans accountable for the failure of its FDRs to comply with Medicare program requirements and in turn Jefferson Health Plans will hold its providers and FDRs to all of these applicable requirements.

General Compliance Program and FWA Training Resources

Jefferson Health Plans FDRs must ensure that all personnel assigned to perform Jefferson Health Plans Medicare Advantage services know:

- How the compliance program operates and;
- How to identify and report issues of Medicare Advantage Program non-compliance and Fraud, Waste and Abuse (FWA).

While this may be accomplished through Code of Conduct and Compliance Policy distribution, FDRs may also conduct General Compliance Program and FWA training with their employees as needed or upon Jefferson Health Plans assignment.

The following resources provide General Compliance and FWA information and content that may be incorporated into FDR training materials and curriculums:

Jefferson Health Plans Code of Business Conduct (COBC)
Jefferson Health Plans Compliance Program

CMS MLN website:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining

Chapter 15: Member Rights and Responsibilities

Purpose: This chapter provides a description of the member's rights and responsibilities for our Medicaid, Medicare, CHIP and Individual and Family lines of business.

Topics: Important topics from this chapter include:

Member Rights & Responsibilities

- Health Partners Plans Medicaid and KidzPartners (CHIP)
- Jefferson Health Plans Medicare
- Jefferson Health Plans Individual and Family Plans

Health Partners Plans Medicaid and Health Partners Plans CHIP/KidzPartners Member Rights and Responsibilities

Health Partners Plans Medicaid and KidzPartners (CHIP) members have the right to know about their Rights and Responsibilities. Exercising these rights will not negatively affect the way they are treated by us, its participating providers or other State agencies. Our members also have the right to make healthcare decisions without feeling as though we are restraining, isolating, influencing, bullying, punishing or retaliating against them.

We, and our network of providers, do not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.

Below is a statement of the rights provided to our members. These rights must be honored by us, our network providers and their staff.

Member Rights

Members have the right:

- To be treated with respect, recognizing their dignity and need for privacy, by our staff and network providers.
- To get information in a way that they can easily understand and find help when they need it.
- To get information that they can easily understand about us, its services, and the doctors and other providers that treat them.
- To pick the network health care providers that they want to treat them.
- To get emergency services when they need them from any provider without our approval.
- To get information that they can easily understand and talk to their providers about their treatment options, without any interference from us.
- To make all decisions about their health care, including the right to refuse treatment. If they cannot make treatment decisions by themselves, they have the right to have someone else help them make decisions or make decisions for them.
- To talk with providers in confidence and to have their health care information and records kept confidential.
- To see and get a copy of their medical records and to ask for changes or corrections to those records.
- To ask for a second opinion.
- To file a grievance if they disagree with our decision that a service is not medically necessary.
- To file a complaint if they are unhappy about the care or treatment they have received.

- To ask for a DHS Fair Hearing.
- To be free from any form of restraint or seclusion used to force them to do something, to discipline them, to make it easier for the provider, or to punish them.
- To get information about services that we or a provider does not cover because of moral or religious objections and about how to get those services.
- To exercise their rights without it negatively affecting the way we, DHS, , and network providers treat them.
- To create an advanced directive. See Section 6 of the Member Handbook for more information.
- To make recommendations about the rights and responsibilities of our Members.

Member Responsibilities
Members also have responsibilities, including the duty to work with their health care service providers. Here are some suggestions for our Members to ensure that Members and providers work together:

- Provide, to the extent they can, information needed by their providers.
- Follow instructions and guidelines given by their providers.
- Be involved in decisions about their health care and treatment.
- Work with their providers to create and carry out their treatment plans.
- Tell their providers what they want and need.
- Learn about our coverage, including all covered and non-covered benefits and limits.
- Use only network providers unless we approve an out-of-network provider.
- Get a referral from their PCP to see a specialist.
- Respect other patients, health plan staff, provider staff, and provider workers
- Make a good-faith effort to pay their co-payments.
- Report suspected or actual fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

Jefferson Health Plans Medicare Advantage Member Rights & Responsibilities

Member Rights
We have informed our Members that as a Jefferson Health Plans Medicare member, they have certain rights, including:

- We must provide information in a way that works for the Member (such as in languages other than English, in Braille, in large print, or other alternate formats).
- To be treated with fairness and respect at all times.

- We must ensure timely access to covered services and drugs.
- We must protect the privacy of personal health information.
- We must give information about the plan, our network of providers, and covered services.
- This includes:
- Information about coverage and the rules that must be followed when using our coverage.
- Information about why something is not covered and what can be done about it.
- We must support the Member's right to make decisions about their care. This includes:
- Having the right to know treatment options and participate in decisions about health care.
- Having the right to give instructions about what is to be done if a Member is not able to make their own medical decisions.
- Having the right to make complaints and to ask us to reconsider decisions we have made.

If members believe they are being treated unfairly or their rights are not being respected:

- If it is about discrimination, call the U.S. Department of Health and Human Services Office of Civil Rights at **1-800-368-1019** or TTY **1-800-537-7697**, or call your local Office for Civil Rights.

If it's not about discrimination, call Member Relations at the numbers below:

Health Partners Plans Medicaid Member Relations

- 1-800-553-0784 (TTY 1-877-454-8477)
- 24 hours a day/7 days a week

Health Partners Plans CHIP/KidzPartners Member Relations

- 1-888-888-1211 (TTY 1-877-454-8477)
- 24 hours a day/7 days a week

Jefferson Health Plans Medicare Advantage Member Relations

- 1-866-901-8000 (TTY 1-877-454-8477)
- From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday.

Jefferson Health Plan Individual and Family Plans Member Relations
1-833-422-4690 (TTY 1-877-454-8477)
From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday

- Call the State Health Insurance Assistance Program, Apprise, at 1-800-783-7067.

- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048

Member Responsibilities
Members also have some responsibilities as a member of the plan, including:

- Becoming familiar with covered services and the rules that must be followed to get these covered services.
- Tell us if of any other health insurance coverage or prescription drug coverage in addition to our plan.
- Tell their doctor and other health care providers that they are enrolled in our plan.
- Help their doctors and other providers help them by giving them applicable information, asking questions, and following through on their care.
- Be considerate of providers and respect the rights of other patients.
- Pay what is owed for their Medicare coverage and the services received.
- Give notice when they move.

Members can call us at the phone numbers below s for help if they have questions or concerns.

Health Partners Plans Medicaid Member Relations
1-800-553-0784 (TTY 1-877-454-8477)
24 hours a day/7 days a week

Health Partners Plans CHIP/KidzPartners Member Relations
1-888-888-1211 (TTY 1-877-454-8477)
24 hours a day/7 days a week

Jefferson Health Plans Medicare Member Relations
1-866-901-8000 (TTY 1-877-454-8477)
From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday

Jefferson Health Plans Individual and Family Plans Member Relations

1-833-422-4690 (TTY 1-877-454-8477)
From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday

Jefferson Health Plans Individual and Family Plans

Member Rights and Responsibilities

- Jefferson Health Plan members have the right to know about their Rights and Responsibilities. Exercising these rights will not negatively affect the way they are treated by Jefferson Health Plans, its participating providers or other State agencies. Our members also have the right to make healthcare decisions without feeling as though Jefferson Health Plans is restraining, isolating, influencing, bullying, punishing or retaliating against them.

- Jefferson Health Plans and its network of providers do not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.
- Below is a statement of the rights provided to our members. These rights must be honored by Jefferson Health Plans, our network providers and their staff. It is your obligation and duty as a Jefferson Health Plans provider to adhere to and comply with these standards and upholding our Members Rights.

Member Rights
Members have the right:

- To be treated with respect, recognizing their dignity and need for privacy, by Jefferson Health Plans staff and network providers.
- To get information in a way that they can easily understand and find help when they need it.
- To get information that they can easily understand about Jefferson Health Plans, its services, and the doctors and other providers that treat them.
- To pick the network health care providers that they want to treat them.
- To get emergency services when they need them from any provider without Jefferson Health Plans' approval.
- To get information that they can easily understand and talk to their providers about their treatment options, without any interference from Jefferson Health Plans.
- To make all decisions about their health care, including the right to refuse treatment. If they cannot make treatment decisions by themselves, they have

the right to have someone else help them make decisions or make decisions for them.
- To talk with providers in confidence and to have their health care information and records kept confidential.
- To see and get a copy of their medical records and to ask for changes or corrections to those records.
- To ask for a second opinion.
- To file a grievance if they disagree with Jefferson Health Plans' decision that a service is not medically necessary.
- To file a complaint if they are unhappy about the care or treatment they have received.
- To be free from any form of restraint or seclusion used to force them to do something, to discipline them, to make it easier for the provider, or to punish them.
- To get information about services that Jefferson Health Plans or a provider does not cover because of moral or religious objections and about how to get those services.
- To exercise their rights without it negatively affecting the way DHS, Jefferson Health Plans, and network providers treat them.
- To create an advanced directive. See Member Handbook for more information.
- To make recommendations about the rights and responsibilities of our Members.

Member Responsibilities

- Members also have responsibilities, including the duty to work with their health care service providers. Below are the responsibilities we share with our Members to ensure that Members and providers work together:
- Provide, to the extent they can, information needed by their providers.
- Follow instructions and guidelines given by their providers.
- Be involved in decisions about their health care and treatment.
- Work with their providers to create and carry out their treatment plans.
- Tell their providers what they want and need.
- Learn about Jefferson Health Plans coverage, including all covered and non-covered benefits and limits.
- Use only network providers unless Jefferson Health Plans approves an out-of-network provider.
- Respect other patients, health plan staff, provider staff, and provider workers.

Chapter 16: Appendix

Purpose: This chapter includes valuable information regarding a variety of topics and resources.

Topics: Important topics from this chapter include:

DHS Domestic Violence Initiatives
CMS-1500 Place of Service Indicators
Protections for Individuals Limited English Proficiency (LEP)
2024 Preventive Benefit Schedule
Healthy Kids Program Periodicity Schedule & Coding Matrix
Our Medical Record Documentation Standards
Americans with Disabilities Act (ADA)
Additional contact information

DHS Domestic Violence Initiatives

We support the Pennsylvania Department of Human Services (DHS) initiatives for victims of domestic violence.

The Massachusetts Medical Society has developed a system of action steps that should be taken whenever domestic violence is suspected. These steps are:

R= Routinely Screen Female Patients
A= Ask Direct Questions (so the patient can answer "yes" or "no")
D= Document Your Findings
A= Assess Patient Safety
R= Review Options & Referrals

For more information on RADAR and other screening tools, go to:
Department of Human Services:
(https://www.dhs.pa.gov/Services/Assistance/Pages/Domestic-Violence.aspx)
Pennsylvania Medical Society (www.pamedsoc.org or 1-800-228-7823)
National Domestic Violence Hotline (https://www.thehotline.org/ or 1-800-799-7233)

CMS-1500 Place of Service Codes

Please visit https://www.cms.gov/Medicare/Coding/place-of-service-codes/ for the list of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes.

Limited English Proficiency (LEP)

Providers should visit the websites below for tips on how to effectively communicate using interpreters:

- "Interpret Tool: Working with Interpreters in Clinical Settings," DHHS Office for Minority Health, Language Access Resources. www.acf.hhs.gov/sites/default/files/otip/hhs_clas_interpret_tool.pdf
- "Working With an Interpreter: Roles of an Interpreter and the Triadic Interview," DHHS Office for Minority Health, Language Access Resources. www.acf.hhs.gov/sites/default/files/otip/hhs_clas_working_with_an_interpreter.pdf

Additional Information

To help providers learn more about culturally and linguistically appropriate health care, we recommend review of the following material:

- "A Physician's Practical Guide to Culturally Competent Care," sponsored by DHHS Office of Minority Health. This is a free, self-directed training course for physicians and other health care professionals with a specific interest in cultural competency in the provision of care. Continuing Medical Education (CME/CE) credits are available. Access the website at https://cccm.thinkculturalhealth.hhs.gov/

Call the Provider Services Helpline at 1-888-991-9023 for more information.

2024 Preventive Benefit Schedule

PREVENTIVE CARE SERVICES FOR ADULTS

VISITS	
Preventive exams **Services that may be provided during the preventive exam include but are not limited to the following:** • **High blood pressure screening** • **Behavioral counseling for skin cancer** • **Obesity Screening** • **Unhealthy drug use screening**	**One exam annually for all adults**
SCREENINGS	
Abdominal aortic aneurysm (AAA) screening	**Once in a lifetime for asymptomatic males aged 65 to 75 years with a history of smoking**

Colorectal cancer screening	**Adults aged 45 to 75 years using any of the following tests:** • **Fecal occult blood testing: once a year** • **Highly sensitive fecal immunochemical testing: once a year** • **Flexible sigmoidoscopy: once every five years** • **CT colonography: once every five years** • **Stool DNA testing: once every three years** • **Colonoscopy: once every 10 years**
Depression screening	**Annually for all adults**
Hepatitis B virus (HBV) screening	**All asymptomatic adults at high risk for HBV infection**
Hepatitis C Virus (HCV) screening	**All asymptomatic adults**
High Blood Pressure Screening	**Adults aged 18 years or older with increased risk once a year** **Adults aged 18 to 39 years with no other risk factors once every 3 to 5 years** **Adults aged 40 years once a year**
Human immunodeficiency virus (HIV) screening	**All adults**

Latent tuberculosis infection screening	**Asymptomatic adults ages19 years or older at increased risk for tuberculosis**
Lipid disorder screening	**Adults 40 years of older once every 5 years**
Lung cancer screening	**Adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years**
Syphilis infection screening	**All adults at increased risk for syphilis infection**
Unhealthy alcohol use screening and behavioral counseling interventions	**Screening for all adults not diagnosed with alcohol abuse or dependence or not seeking treatment for alcohol abuse or dependence** **Behavioral counseling in a primary care setting for individuals with a positive screening result**
THERAPY AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	**All sexually active adults**
Behavioral interventions for weight loss	**Behavioral intervention for adults with a body mass index (BMI) of 30kg/m^2 or higher**
Exercise interventions for the prevention of falls	**Community-dwelling adults ages 65 years and older with an increased risk of falls**
Intensive behavioral counseling interventions to promote a healthful diet and physical activities for	**Adults ages 18 years and older diagnosed as overweight or obese with known cardiovascular disease risk factors**

cardiovascular disease prevention	
Nutritional counseling for weight management	6 visits per year
Tobacco use counseling	All adults who use tobacco products
Work-up and follow-up services for pre-exposure prophylaxis for the prevention of HIV	Adults at high risk for HIV infection
MEDICATIONS	
Low dose aspirin	Adults aged 50 to59 years for the primary prevention of cardiovascular disease and colorectal cancer
Pre-exposure prophylaxis for the prevention of HIV infection	Adults at high risk for HIV infection
Prescription bowel preparation	Adults ages 45 years and older when used in conjunction with a preventive colorectal cancer screening procedure (that is, flexible sigmoidoscopy, colonoscopy, virtual colonoscopy)
Statin	Adults ages 40 to 75 with no history of cardiovascular disease, with one or more risk factors for cardiovascular disease and a 10-year cardiovascular disease event risk of greater than 10%
Tobacco cessation medication	All adults who use tobacco products

IMMUNIZATIONS
Adult Immunization Schedule: **https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf**

PREVENTIVE CARE SERVICES FOR FEMALES, INCLUDING PREGNANT FEMALES

VISITS	
Prenatal care visits **Services that may be provided during the prenatal care visits include, but are not limited to the following:** • **Preeclampsia Screening**	**For all pregnant females**
Well-woman visits **Services that may be provided during the well-woman visit include but are not limited to the following:** • **BRCA-related cancer risk assessment** • **Discussion of chemoprevention for breast cancer**	**At least annually**

• Intimate partner violence screening • Primary care interventions to promote and support breast • Recommended preventive preconception and prenatal care services • Urinary incontinence screening	
SCREENINGS	
Anxiety screening	All females
Bacteriuria screening	All asymptomatic pregnant females at 12 to 16 weeks' gestation or at the first prenatal visit, if later
Counseling interventions to prevent perinatal depression	Pregnant of postpartum females at increased risk for perinatal depression without a current diagnosis of depression 20 sessions over a 70 week period
BRCA-related cancer risk assessment, genetic counseling, and BRCA mutation testing	Genetic counseling for asymptomatic females with an ancestry associated with the BCRA gene mutations, personal history or family history or a BRCA-related cancer BRCA mutation testing, as indicated, following genetic counseling

Breast cancer screening (2D or 3D mammography)	**All females aged 40 years and older**
Cervical cancer screening (Pap test)	**Ages 21 to 65: Every three years** **Ages 30 to 65: Every 5 years with a combination of Pap test and human papillomavirus (HPV) testing, for those who want to lengthen the screening interval**
Chlamydia screening	**Sexually active females ages 24 years and younger or older sexually active females who are at increased risk for infection**
Diabetes mellitus screening after pregnancy	**Females with a history of gestational diabetes who are currently not pregnant and who have not been previously diagnosed with type 2 diabetes mellitus**
Depression screening	**All pregnant and post-partum females**
Gestational diabetes mellitus screening	**Asymptomatic pregnant females after 24 weeks of** **gestation or at the first prenatal visit for pregnant females identified to be at high risk for diabetes**
Gonorrhea screening	**Sexually active females ages 24 years and younger or older sexually active females who are at increased risk for infection**

Hepatitis B virus (HBV) screening	**All pregnant females or asymptomatic adolescents and adults at high risk for HBV infection**
Human immunodeficiency virus (HIV screening	**All pregnant females**
Human papillomavirus (HPV) screening	**Ages 30 and older: Every five years** **Ages 30 to 65: Every five years with a combination of** **Pap test and HPV testing, for those that want to lengthen the screening interval**
Osteoporosis (bone mineral density) screening	**Every two (2) years for females younger than 65 years who are at increased risk for osteoporosis** **Every two (2) years for females aged 65 years and older without a history of osteoporotic fracture or without a history of osteoporosis secondary to another condition**
RhD incompatibility screening	**All pregnant females and follow-up testing for females at higher risk**
Syphilis screening	**All pregnant females at first prenatal visit**

	For high-risk pregnant females, repeat testing in the third trimester and at delivery Females at increased risk for syphilis infection
Tobacco Use Counseling	All pregnant females who smoke tobacco products
Unhealthy alcohol use screening and behavioral counseling interventions	Screening for all pregnant females Behavioral counseling in a primary care setting with a positive screening results
MEDICATIONS	
Breast cancer chemoprevention	Asymptomatic females aged 35 years and older without a prior diagnosis of breast cancer, ductal carcinoma in situ, or lobular carcinoma in situ, who are at high risk for breast cancer and at low risk for adverse effects from breast cancer chemoprevention
Folic acid	Daily folic acid supplements for all females planning for or capable of pregnancy
Low dose Aspirin	Aspirin for pregnant females who are at high risk for preeclampsia after 12 weeks of gestation

MISCELLANEOUS	
Breastfeeding supplies/support/counseling	
Reproductive education and counseling, contraception, and sterilization	**All females with reproductive capacity**

PREVENTIVE CARE SERVICES FOR CHILDREN

VISITS	
Pre-birth exams	**All expectant parents for the purpose of establishing a pediatric medical home**
Preventive exams **Services that may be provided during the preventive exam include but are not limited to the following:** **Behavioral counseling for skin cancer prevention** **Blood pressure screening** **Congenital heart defect Screening** • Counseling and education **provided by healthcare providers to prevent initiation of tobacco use** • Developmental surveillance • Dyslipidemia risk	**All children up to 21 years of age, with preventive exams** **provided at:** • **3-5 days after birth** • **By 1 month** • **2 months** • **4 months** • **6 months** • **9 months** • **12 months** • **15 months**

Assessment • Hearing risk assessment for children 29 days or older • Height, weight, and body mass index measurements • Obesity screening Psychosocial/behavioral assessment	• 18 months • 24 months • 30 months • 3 years-21 years: annual exams
SCREENINGS	
Alcohol, tobacco, and drug use screening and behavioral counseling intervention	**Annually for all children aged11 years and older** **Annual behavioral counseling in a primary care setting** **for children with a positive screening result for drug or** **alcohol use/misuse**
Autism and developmental screening	**All children**
Bilirubin screening	**All newborns**
Chlamydia screening	**All sexually active children up to age 21 years**
Depression screening	**Annually for all children aged 12 years to 21 years**
Dyslipidemia screening	**Following a positive risk assessment or in children where laboratory testing is indicated**
Gonorrhea screening	**All sexually active children up to age 21 years**

Hearing screening for newborns	**All newborns**
Hearing screening for children 29 days or older	**Following a positive risk assessment or in children where hearing screening is indicated**
Hepatitis B virus (HBV) screening	**All asymptomatic adolescents at high risk for HBV infection**
Human immunodeficiency virus (HIV) screening	**All children**
Iron deficiency Screening	**All children**
Lead poisoning screening	**All children at risk of lead exposure**
Newborn metabolic screening panel (For example, congenital hypothyroidism, hemoglobinopathies {sickle cell disease}, phenylketonuria {PKU})	**All newborns**
Syphilis screening	**All sexually active children up to age 21 years**
Vision screening	**All children up to age 21 years**
ADDITIONAL SCREENING SERVICES AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	**Semiannually for all sexually active adolescents**

Obesity screening and behavioral counseling	**Screening is part of the preventive exam for children ages 6 years and older.** **Behavioral counseling for children ages 6 years and older with an age- and sex-specific body mass index (BMI) in the 95th percentile or greater**
MEDICATIONS	
Fluoride	**Oral fluoride for children aged 6 months to 16 years whose water supply is deficient in fluoride**
Prophylactic ocular topical medication for gonorrhea	**All newborns within 24 hours after birth**
MISCELLANEOUS	
Fluoride varnish application	**Every three months for all infants and children starting age of primary tooth eruption to 5 years of age**
Tuberculosis testing	**All children up to age 21 years**

IMMUNIZATIONS (NOTE: FOR AGE 19 TO 21 YEARS, REFER TO THE ADULT SCHEDULE LISTED ABOVE)
Children Immunization Schedule:

https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

Healthy Kids Program Periodicity Schedule & Coding Matrix

For the latest EPSDT Periodicity Schedule and Coding Matrix please refer to the most recent DHS bulletin, titled "*Revisions to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule (99-15-07)*". Please visit our EPSDT/Bright Futures webpage to view Early and Periodic Screening and Diagnostic Treatment (EPSDT), and for the most current EPSDT Periodicity Schedule and Coding Matrix guidelines.

All sexually active patients should be screened for sexually transmitted infections (STI). All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first). Please our preventive care guidelines webpage.

Dental Periodicity Schedule: Per the American Academy of Pediatric Dentistry, please visit Periodicity of Examination, Preventive Dental guidelines.

Our Medical Record Documentation Standards

Consistent and complete documentation in the medical record is an essential component of quality patient care. Our standards have been developed using the standards of the NCQA, DHS, PID, CMS and the Pennsylvania Medical Society guidelines for documentation. Following are the standards against which the medical record is measured.

- Each page in the record contains the patient's name or ID number
- Each record contains appropriate biographical or personal data
- Each author is identified on each entry
- All entries are dated
- The record is legible to someone other than the writer
- There is a completed problem list
- A listing of medications is easily found and lists all medications currently used
- Allergies and adverse reactions to medications are prominently noted
- There is a pertinent history and physical exam
- Lab and other studies are ordered as appropriate
- Working diagnoses are consistent with findings

- Plans of action and treatment are consistent with findings
- There is evidence of patient teaching
- There are dates for return visits or other follow-up plans
- There is documentation and follow-up of "no-shows"
- Problems from previous visits are addressed
- There is evidence of appropriate use of consultants
- There is continuity and coordination of care between PCPs and specialists
- Consultant summaries, lab and imaging study results, and surgical procedure summaries reflect PCP review
- Care appears medically appropriate for the diagnosis or conditions
- There is a completed immunization record
- Preventive services are appropriately used
- There is documentation of discussion of a living will or advance directives
- There is documentation of discussions about domestic violence and safety at home. Please visit the appendix for additional Domestic Violence resources.
- Phone calls to and from the patient are documented
- Evidence of hospital discharge summary in medical record
- Evidence of review of hospital discharge by physician
- Evidence of communication between home care agency and physician in medical record

Additional Medical Records Requirements

- All records shall be maintained in an accurate and timely manner in accordance with the record-keeping procedures, applicable laws, regulations, and regulating entity requirements, including, but not limited to the DHS, DOH, PID, and/or CMS requirements related to medical records. All medical records must be legible, signed, and dated and must be maintained for ten (10) years from last date of service or as required by federal law. Payer and the provider agree that until the expiration of ten (10) years after the furnishing of any service pursuant to this Agreement, or until any ongoing audits by the following entities are completed, whichever is longer, Payer and the Provider shall make available, upon written request of DHS, the Commonwealth, the Secretary of Health and Human Services or the Controller General of the United States, or any of their duly authorized representatives, copies of this Agreement and any books, documents, records, medical records, other patient care documentation, and other data that is

necessary to certify the nature and extent of revenues, expenditures, and other financial activity arising in connection with this Agreement.

- The provider will abide by all Federal and State laws regarding confidentiality and disclosure of medical records or other health information.
- The provider must safeguard the privacy of any information that identifies a particular member and have procedures for how information will be shared and disclosed within and outside of the provider's office. Providers will ensure that medical information is released only in accordance with applicable Federal or State law or pursuant to court orders or subpoenas.
- The provider shall make, at his or her own expense, all records (i.e., any books, contracts, medical records, patient care documentation) available for audit, review or evaluation by all regulatory entities and its designated representatives or federal agencies in such detail as is reasonably necessary for the determination of the member's eligibility for medical services and for utilization management and quality improvement. Access shall be provided either onsite at the Health Plan or at the provider's office during normal business hours or through the mail or secured fax. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within 15 calendar days of such request and at no expense to the requesting entity.
- Each member is entitled to have timely access to his or her medical records in accordance with federal and state laws. Members also have a right to have a copy of their medical record. Members may be charged a nominal fee to have medical records copied. Members can call our Member Relations at **1-800-553-0748** (Health Partners Plans Medicaid, **1-888-888-1211** (Health Partners Plans CHIP/KidzPartners) or **1-866-901-8000** (Jefferson Health Plans Medicare Advantage) for help. They can also call their physician's office directly. The Member Relations staff will advise members that they must sign a release form to obtain their medical record or have a copy sent to a new doctor. Providers cannot charge the member for a copy of his or her medical record sent directly to another provider.

Jefferson Health Plans Medicare Advantage is a Health Maintenance Organization (HMO) with Medicare, Pennsylvania State Medicaid and Children's Health Insurance Program (CIHP) contracts. Enrollment in Jefferson Health Plans Medicare Advantage depends on contract renewal.

Americans with Disabilities Act (ADA)

Section 504 of the Rehabilitation Act of 1973 states that "No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of . . . handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." Section 504 applies to programs or activities that receive Federal financial assistance. Title II of the ADA covers all the services, programs and activities conducted by public entities (state and local governments, departments, agencies, etc.), including licensing. For more information regarding the ADA, go to the U.S. Department of Health and Human Services website at www.hhs.gov.

We require practitioners to abide by ADA requirements.

- Handicapped parking spaces with curb cuts, if applicable
- Handicapped accessible restrooms
- Access ramps where applicable
- Access ramps to entrance of the building
- Access ramps to provider office, if different entrance than building (e.g., hospital)

If a practitioner's site does not meet ADA standards, there are reasonable alternatives to accommodate those with disabilities. These include:

- Home visits
- Access at another site that meets ADA requirements
- Bathroom facilities elsewhere in the building that meet ADA requirements or portable bathroom facilities

Additional Contact Information

The below listing includes contact information for other organizations of interest to participating providers.

Behavioral Health Services

- *Medicare Advantage:* **1-800-424-3706** (Magellan)
- *CHIP:* **1-800-424-3702** (Magellan)
- Medicaid:
  - Visit https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/BehavioralHealth-MCOs.aspx

Vendor Information

- Avesis (Dental)..... **1-800-952-6674**
- Davis Vision..... **1-800-999-5431**
- ECHO Health (Electronic funds transfer and remittance advice)..... **1-888-834-3511**
- ECHO website..... http://view.echohealthinc.com
- eviCore (radiology and PT/OT/ST and other authorizations)..... **1-888-693-3211**
- Medical Assistance Transportation Program (MATP) County Contact List
  - http://matp.pa.gov/CountyContact.aspx

Claims Submissions

Please note that Health Partners Plans/Jefferson Health Plans recommends electronic claims submissions.

- EDI (Electronic Data Interchange) Support ..... EDI@jeffersonhealthplans.com

Our Payor ID (Medicaid, CHIP, & Medicare Advantage (**HMO-POS and HMO SNP products**) and Individual and Family plans)..... **#80142**

- Claims Submissions
  Jefferson Health Plans
  P.O. Box 211123
  Eagan, MN 55121

Jefferson Health Plans Payor ID Medicare (**PPO products**)..... **RP099**

- Claims Submissions
  Jefferson Health Plans
  P.O. Box 21921
  Eagan, MN 55121

Claims Reconsiderations

Claims reconsideration requests can be submitted through the HealthTrio provider portal- https://www.healthpartnersplans.com/providers/provider-portals

Patient Safety Reporting Hotline

- Use for confidential reporting of preventable, serious adverse events.....

1-855-218-2314

DHS Toll-Free MA Provider Compliance Hotline

- MA Provider Compliance Hotline (8:30am to -3:30pm)…….**1-866-379-8477**

Report Medicare, Medicaid, CHIP or other potential Fraud, Waste or Abuse, or Suspicious Activity

- Our SIU Hotline (reports can be made anonymously)……1-866-477-4848 or online at https://www.mycompliancereport.com/report?cid=JEFF
- The CMS Medicare Hotline……**1-800-MEDICARE (1-800-633-4227)**
- The Department of Human Services Medicaid Hotline….**1-844-DHS-TIPS** (**1-866-379-8477)**

PA-NEDSS

- PA-NEDSS New User Guide…….
  https://www.nedss.state.pa.us/nedss/FILES/V15/New%20User%20Guide.pdf
- Listing of PA reportable conditions…….
  https://www.health.pa.gov/topics/Reporting-Registries/Pages/Reportable-Diseases.aspx
- Pennsylvania Code website……https://www.pabulletin.com/index.asp

Advance Directives

- American Academy of Family Physicians……..www.aafp.org
- Patient information…….www.familydoctor.org
- American College of Physicians……..www.acponline.org
- American Medical Association……www.ama-assn.org

Additional Resources

- Pennsylvania Department of Human Services (DHS) Department of Human Services
  P.O. Box 2675
  Harrisburg, PA 17105-2675

- Women, Infants and Children (WIC) Nutrition Program **1-800-WINS (1-800-942-9467)**

- Pennsylvania Health Law Project

Philadelphia Office:
Corn Exchange Building

123 Chestnut St., Suite 400
Philadelphia, PA 19106
Phone: **215-625-3990**
Fax: **215-625-3879**

Harrisburg Office:
118 Locust St.
Harrisburg, PA 17101-1414
Phone: **717-236-6310**
Fax: **717-233-4088**

Pittsburgh Office:
100 Fifth Ave.
Suite 900
Pittsburgh, PA 15222
Phone: **412-434-4728**
Fax: **717-236-6311**