



Ancillary Annual Orientation and Training (AAOT)

October 23, 2024

Welcome!
Please read the participation tips below.



There is no sound until the webinar begins.



Webinar will be recorded. Participation in webinar is agreement to recording.



All participants phones have been **muted** except for the presenter.



Technical issues: Use chat, select David Kane from panelist from the Webex chat dropdown.




Questions: Please use the **Q&A Panel** when asking questions.

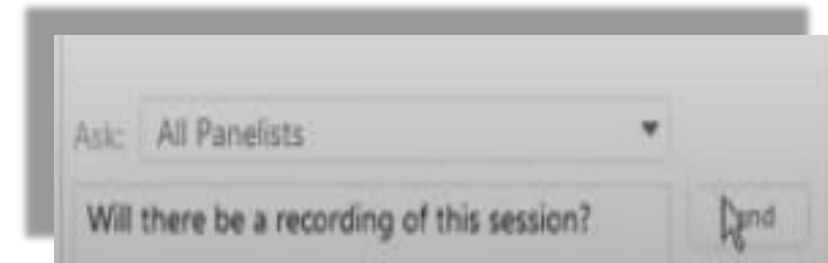
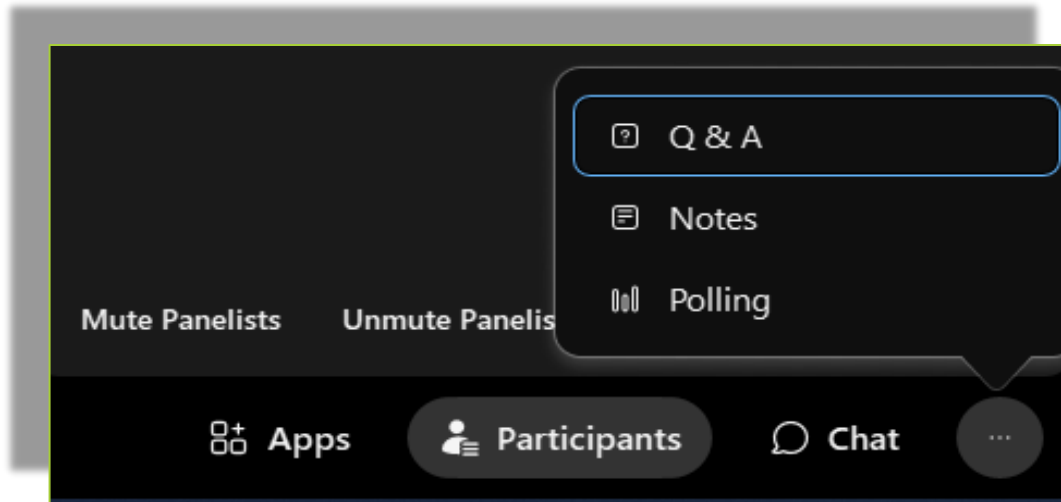


Any questions we are unable to address today, will be answered following the presentation.

Q&A Panel

As an attendee, you can ask questions using Q&A Panel.

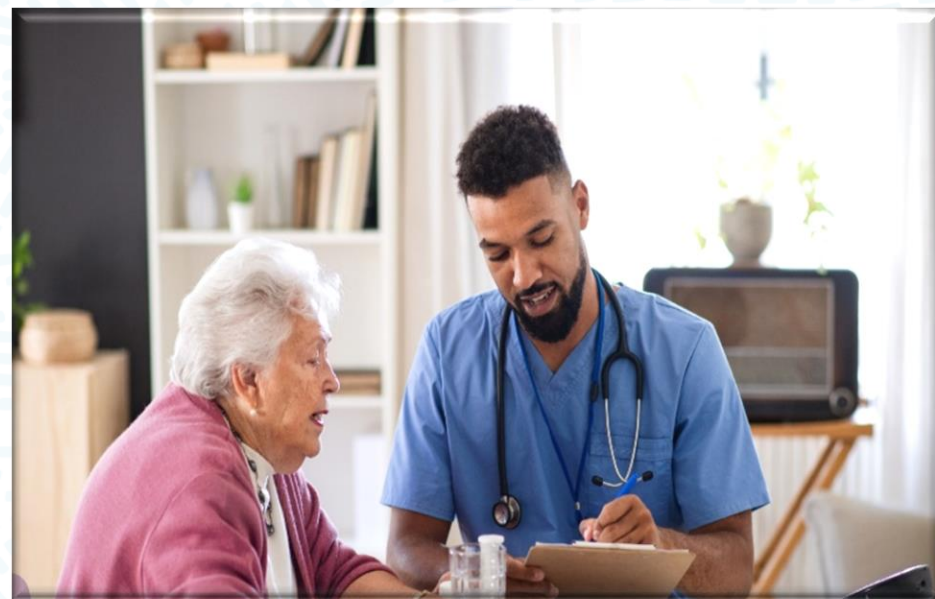
1. To open the Q&A panel, you need to click on the ellipses at the bottom right of the screen for 'More Panels' and click on Q&A. 
2. Select "All Panelist" from the drop-down menu. This will ensure questions are not missed.
3. Type your question in the message box.
4. Click "Send."





Jefferson Health Plans is a not-for-profit Pennsylvania-licensed Managed Care Organization (MCO) providing comprehensive healthcare coverage in Pennsylvania and New Jersey.

Our focus is on improving health outcomes through a wide range of initiatives that support member compliance and help to eliminate barriers to care.

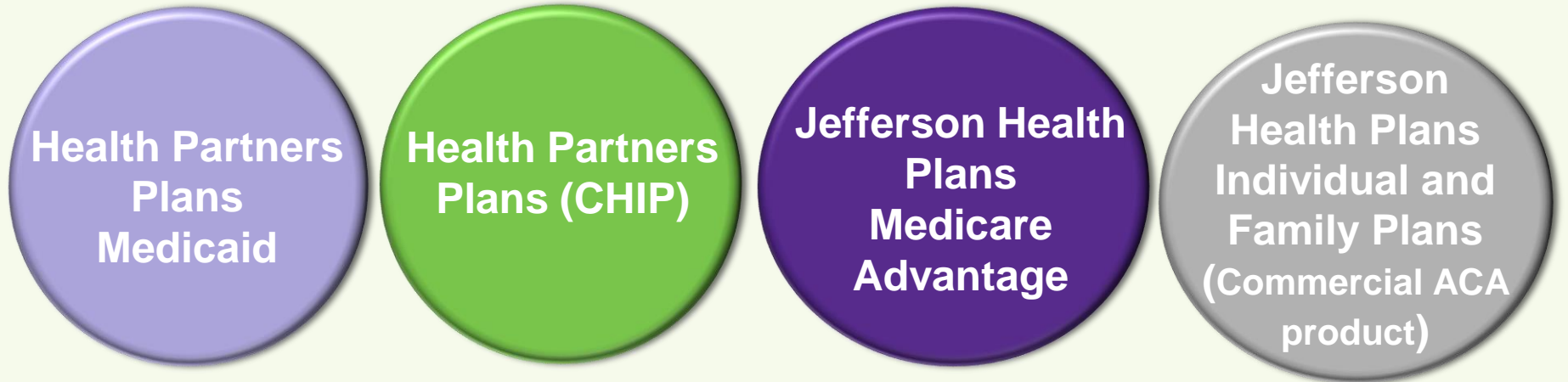


Thank you for being part of our provider network and helping us to improve the health outcomes of our members.

Agenda

- Product Overview
- Claims
- Credentialing
- Utilization Management and Prior Authorization
- Home Care and Other Services
- Complaints, Grievances and Appeals
- Online Tools and Resources
- **An attestation link will be provided at the conclusion of the webinar**

Product Overview



*Coverage for people of all ages

Health Partners Plans Medicaid Benefits

Our members have \$0 copays in 2024 for covered Medicaid physical health services and prescription drugs.

Jefferson Health Plans provides all the benefits of Medicaid, including:

- Primary care doctor and specialist office visits
- Hospital services
- Lab services
- Prescriptions
- Routine dental care for children and adults
- Checkups and immunizations and for children and adults
- Routine eye exams for children and adults
- Glasses and/or contact lenses for all children (two pairs of glasses or contacts, or one pair of each, covered yearly)
- Health Partners members aged 21 years and older are eligible to receive one pair of eyeglasses or contact lenses a year.

Additional Benefits

- Teladoc®, 24-hour medical help line for assistance when you need it
- Fitness center memberships
- Nutrition education and counseling
- Wellness Partners; a health and wellness initiative with free events for the community
- Baby Partners program
- Care Management programs
- Member events and education

Health Partners Plans CHIP Benefits

Health Partners Plans CHIP is available to children up to age 19 at low or no cost, based on household income, and is offered in all counties within Pennsylvania.

Health Partners Plans CHIP covers:

- Doctor and well-childcare visits
- Prescriptions
- Dental checkups and cleanings, and orthodontics (including braces when medically necessary)
- Eye exams and eyeglasses
- Mental health and substance abuse services
- Nutrition counseling
- Fitness center membership
- And much more!

Jefferson Health Plans: Medicare Advantage Plan Portfolios

HMO

- *Strong HMO offering for members that qualify for an LIS or are willing to pay a premium for lower cost sharing and MOOP*
- *Positioned to perform strongly in Eastern PA region with robust network*
- *Aligned to Jefferson Health System and positioned to perform strong in Jefferson core footprint*

State	Product(s)
PA	<ul style="list-style-type: none"> • Complete (\$0) • Prime (\$40.90) • Give Back (\$0) +\$125 Part B
NJ	<ul style="list-style-type: none"> • Silver (\$0) • Platinum (\$30)

PPO

- *Ideal landing spot for members that want to be outside base service area.*
- *Positioned to perform strongly within and outside of Jefferson core footprint on with robust network*

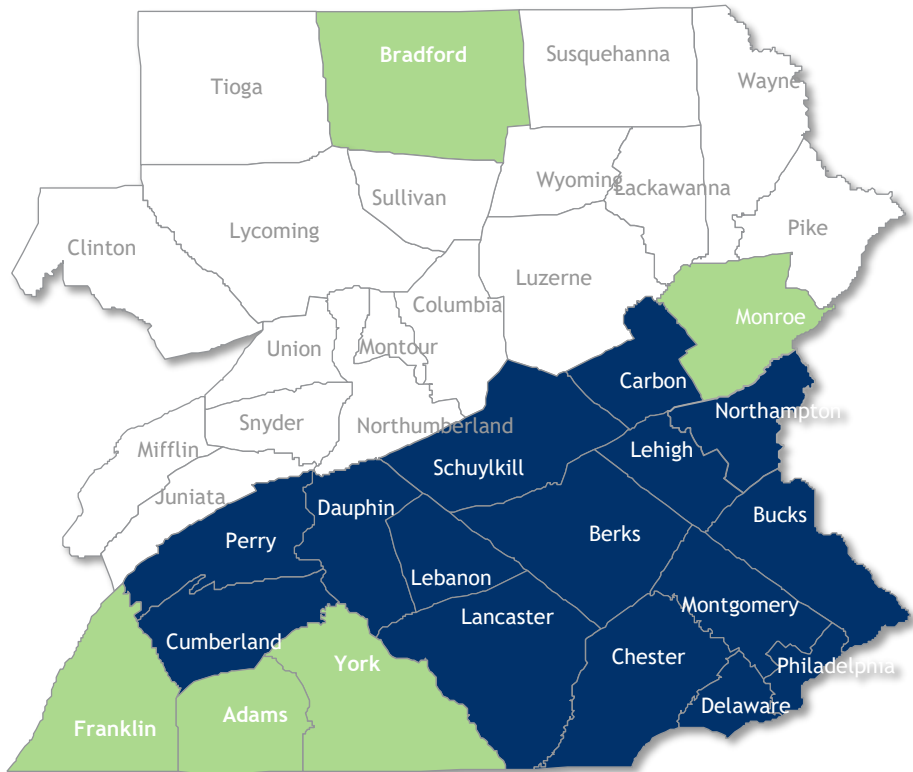
State	Product(s)
PA	<ul style="list-style-type: none"> • Flex (\$0) • Flex Pro (\$20) • Flex Plus (\$37)
NJ	<ul style="list-style-type: none"> • Choice (\$0) • Choice Plus (\$35)

DSNP

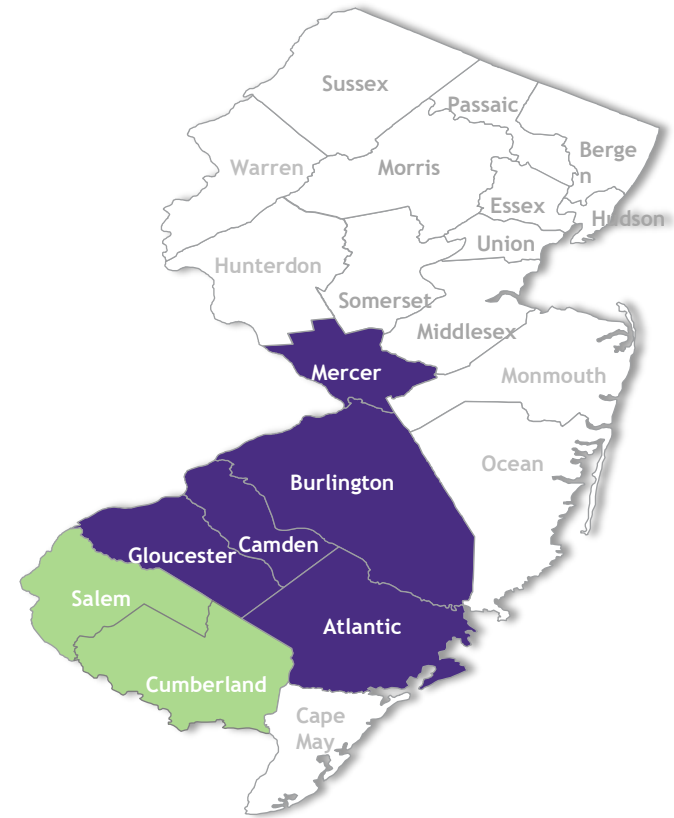
- *Members qualifying for Dual Eligible SNP plans*
- *Members looking to maximize the value of their health insurance products*

State	Product(s)
PA	<ul style="list-style-type: none"> • Special • Dual Pearl
NJ	N/A

2025 Medicare Advantage - Expansion markets



- 2024 Service Area
- 2025 Expansion counties (all products)



- 2024 Service Area
- 2025 Expansion counties (all products)

Note: Current view is not JHP full-service area, additional counties could be available

Individual and Family Plans- ACA Portfolio in Pennsylvania

HMO

- 3 Bronze plans (1 new plan launch for 2025)
- 3 Silver plans (Term'd 3 Off-X plans for 2025)
- 3 Gold plans (1 new plan launch for 2025)

Jefferson Health Plans HMO Portfolio:

3 Bronze Plans:	<ul style="list-style-type: none"> • \$0 Deductible • Total • Value
3 Silver Plans:	<ul style="list-style-type: none"> • \$0 Deductible • Balanced • Total
3 Gold Plans	<ul style="list-style-type: none"> • \$0 Deductible • Total • Value

NEW: PPO




- 3 Bronze plans
- 6 Silver plans
- 3 Gold plans

Jefferson Health Plans PPO Portfolio:

3 Bronze Plans:	<ul style="list-style-type: none"> • \$0 Deductible • Total • Value
3 Silver Plans:	<ul style="list-style-type: none"> • \$0 Deductible • Balanced • Total
3 Gold Plans	<ul style="list-style-type: none"> • \$0 Deductible • Total • Value

Individual & Family Plans (ACA) – 2025 Footprint



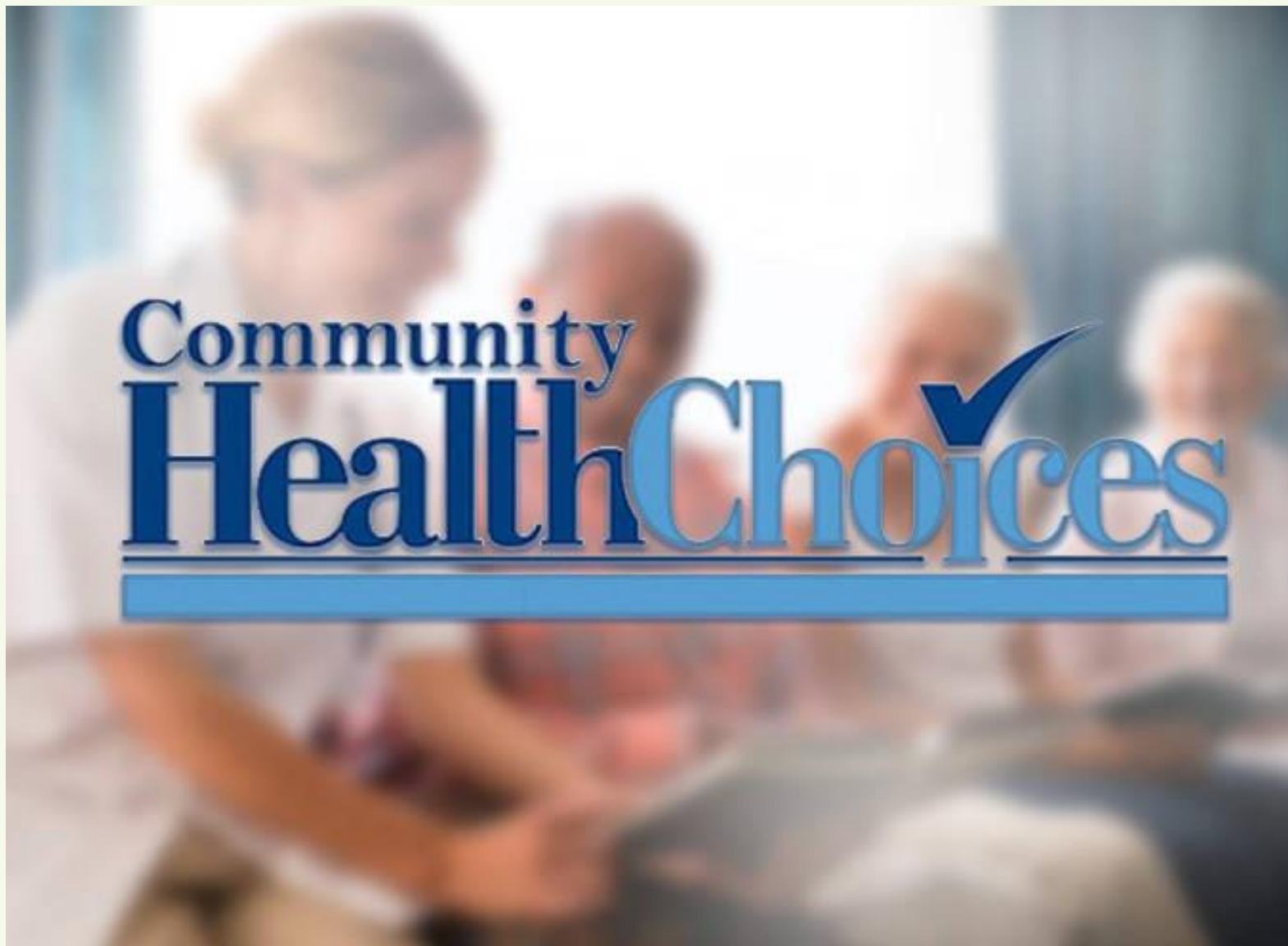
-  Existing service area (will continue to only offer HMO product)
-  Expanded service area for both HMO and PPO
-  Expanded service area for HMO

Specialist Referrals

- Specialist referrals are not required for any of our plans. Our members are permitted to “self-refer” for specialist care.
- It is extremely important for specialists to continue to keep a member’s assigned PCP informed of all care they render to the member.



Community Health Choices



Community HealthChoices

Community HealthChoices (CHC) plan beneficiaries are 21 or older and have both Medicare and Medicaid, or receive long-term support through Medicaid. There are three CHC plans:

- PA Health & Wellness (Centene)
- AmeriHealth Caritas (Keystone First CHC/AmeriHealth Caritas Pennsylvania CHC)
- UPMC

Keep in Mind

- Jefferson Health Plans members eligible for CHC were notified by the state that they must enroll with a CHC plan.
- Pennsylvania auto-enrolled members into one of the three plans if they did not choose a plan.
- As a participating provider, you can provide services to Jefferson Health Medicare members even if they are enrolled in a CHC (Medicaid) plan.
- You do not need to be participating with CHC plans to provide services to Jefferson Health Plans patients.
- Medicare is the primary payer and drives the care.
 - Medicaid benefits are accessed after Medicare benefits have been exhausted.
 - Our Care Coordinator can assist you with coordinating services between Medicare and Medicaid.
 - Medicaid is always the payer of last resort.
- Providers can submit claims to the CHC plans regardless of their contracting status with the CHC plans.

Resources and Links

- [CHC Fact Sheet](#)
- [Adult Benefit Package](#)
- [Long-Term Services and Supports Benefits Guide](#)
- [Coordination With Medicare](#)
- [Populations Served By CHC](#)
- [Eligibility Verification System \(EVS\)](#)



Special and Dual Pearl (HMO SNP) Plan Reminders

- Special and Dual Pearl plan members have both Medicare and Medicaid coverage.
- Special plan members are also referred to as Dual Special Needs Plan (DSNP) members.
- You **do not** need to be participating with Medicaid Community HealthChoices plans to provide services to a Jefferson Health Plans Medicare Advantage member.
- Providers can submit claims to the CHC plan regardless of their status with the CHC plan.

Claims



Clearing House: Smart Data Solutions

- **Smart Data Solutions** (SDS) is fully connected to accommodate Electronic Data Interchange (EDI) claim submissions for our two Payor IDs.
- Providers may sign-up through the SDS provider portal by emailing SDS directly at stream.support@sdata.us.



Smart Data Solutions

- When submitting to Smart Data Solutions, include the following information:
 - First Name
 - Last Name
 - Email
 - Phone
 - Organization name, NPI, and Tax ID
 - The Jefferson Health Plans Payor ID(s) listed on the previous slide.



If you have any questions, please contact the Provider Services Helpline at 1-888-991-9023 (Monday to Friday, 9 a.m. to 5:30 p.m.)

2025 Product ID Cards

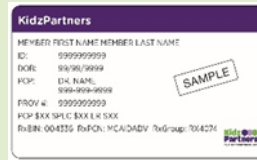
Health Partners Plans Medicaid



(9-digit ID starting with all numerical digits)

Payor ID: #80142
Paper Claims Submissions:
Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121

Health Partners Plans CHIP



(10-digit ID starting with a “3” or a “9”)

Payor ID: #80142
Paper Claims Submissions:
Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121

Jefferson Health Plans Medicare Advantage

*to be identified in the plan name on the card

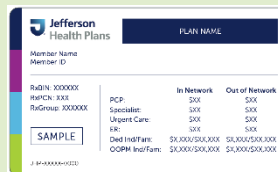


(7-digit ID number starting with a “5”)

HMO: Payor ID: #80142
Paper Claims Submissions:
Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121

PPO: Payor ID: #RP099
Paper Claims Submissions:
Jefferson Health Plans, PO BOX 21921 Eagan, MN 55121

Jefferson Health Plans Individuals and Families

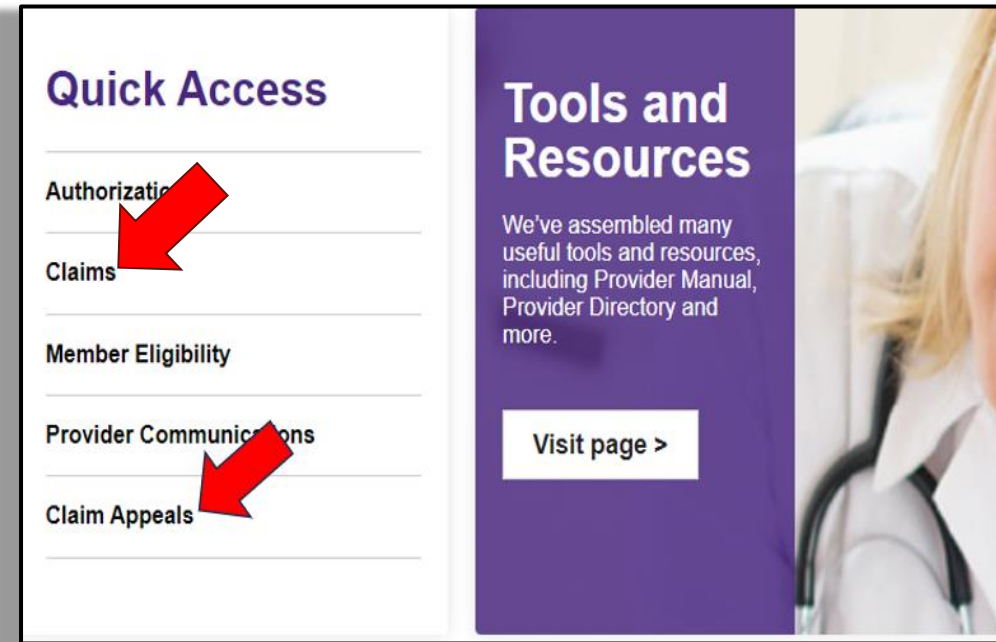


(12-digit ID, starting with a “J”)

Payor ID: #80142
Paper Claims Submissions: Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121

Claims Status and Reconsideration

- The [Provider Portal](#) can be used to check the status of a claim, or to request a reconsideration determination for a claim that may have been paid incorrectly or denied inappropriately. Reconsiderations must be made timely by the requestor.
- When requesting a reconsideration, **please be sure to have the claim number available to initiate your request.**



eLearning course: [Timely Filing Protocols and the Reconsideration Process](#)

Timely Filing and Other Claims

Timely Filing

Initial Submissions: 180-days from Date of Service or Discharge Date

Reconsiderations: 180-days from the date of Jefferson Health Plans' Explanation of Payment (EOP)

Coordination of Benefits: 60-days from date of other carriers (EOP)

Behavioral Health Claims

Must submit to Behavioral Health MCO

For latest listing of BH-MCO's by county, please visit [DHS HealthChoices Behavioral Health-MCO](#)

Health Partners Plans CHIP and Jefferson Health Plans Medicare contracts with Magellan Behavioral Health

Dental Claims

• **Avēsis** (Dental): 1-800-952-6674, www.myavesis.com/providers/

Vision Claims

• **Davis Vision:** 1-800-773-2847, www.davisvision.com/eye-care-professionals

Claim Payment Policy

[Policy Bulletin Library](#) provides reimbursement rules and billing guidelines necessary to ensure timely and appropriate payment

Transportation Claims

The Explanation of Payment (EOP) outlines the adjudication of your claims.

- Denial reason codes will appear at the line level and claim level of your EOP with the full description of the denial at the bottom of the EOP.
- Here is an example of a common transportation denial reason code: **P197**

Explanations		
Administered by	Code	Description
HealthPartnersPlans	PI97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- PI97 may appear on your EOP if the mileage payment is considered inclusive to the trip itself.
- If you have any additional questions about mileage/trip claims, please refer to provider contract.
- For information on Ambulance policy, please visit our [Policy Bulletin Library](#)

Encounter Data



Participating 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 a Jefferson Health Plans member.



For professional claims, providers who are registered as home health providers, hospice providers, certified nutritionists, DME, X-ray clinics and renal dialysis providers must include the referring provider on their claim submissions. The data can be submitted in the referring provider loop (2310A) or the ordering provider loop (2420E), whichever is appropriate to your claim situation.

Coordination of Benefits

- Health Partners (Medicaid) is the payor of last resort; therefore, is secondary payor to all other forms of health insurance coverage (e.g., Medicare). With the exception of preventive pediatric care, if other coverage is available, the primary plan must be billed before Jefferson Health Plans will consider any charges.
- 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 payor to Jefferson Health Plans. Secondary claims may also be filed electronically following the HIPAA compliant transaction guidelines.
 - For more information, visit our [Provider Manual Chapter 12: Provider Billing & Reimbursement](#)

Qualified Medicare Beneficiary (QMB)

- QMB program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries.
 - The law prohibits Medicare providers from collecting Medicare Part A and B coinsurance, copayments and deductibles from those enrolled in the QMB program.
 - For more information, visit [The CMS MedLearn Matters article](#)

Balance Billing Dual Eligible Members: Medicare/Medicaid

- Fully Dual Eligible beneficiaries are not directly responsible for their appropriate cost share amounts. These charges are payable by Medicaid (the CHC plan).
- Medicaid (CHC) will remain the payer of last resort.
- Providers may not balance-bill participants when Medicaid, Medicare or another form of TPL does not cover the entire billed amount for a service delivered.
- Please note that Jefferson Health Plans Special (HMO SNP) members are fully dual eligible.



Credentialing



Pathways for Provider Contracting, Application & Demographics Changes

- Ancillary providers including Physical, Occupational and Speech Therapy, email changes to the applicable email box below:

Credentialing@jeffersonhealthplans.com

- Site relocation- 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 or NPI 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

Key Takeaways

- Our goal is to process all credentialing applications within **60 days**, providing all requirements are submitted timely.
- We are required to verify and update your information every 90 days. Our directories are fed by the information you supply.
- It's so important that the state enacted the "No Surprise Act" to ensure directory accuracy.
- For initial contract, roster and application the providers can use the recruitment link below- <https://www.healthpartnersplans.com/providers/join-our-provider-network/provider-recruitment-form>

Revalidation of Medical Assistance Providers

- All providers must revalidate their MA enrollment (including all associated service locations - 13 digits) every 5 years. Providers should log into PROMISE to check their revalidation date and submit a revalidation application at least 60 days prior.
- Providers should check the Pennsylvania Department of Human Services (DHS) PROMISE system on a routine basis to confirm demographic data, including all service locations and revalidation dates to ensure information is current and have an active PROMISE ID. Please visit the DHS website for requirements and step-by-step instructions.
- Enrollment (revalidation) applications located at:
 - www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994

Utilization Management and Prior Authorization



Utilization Management

- Our UM department is committed to providing members with the most appropriate medical care for their specific situations.
- UM's decisions are based on medical necessity, appropriateness of care and service, the existence of coverage, and whether an item is medically necessary or considered a medical item.
- Jefferson Health Plans does not provide financial incentives for utilization management decision makers that encourage denials of coverage or service or decisions that result in under-utilization.
 - For more information, visit our [Provider Manual Chapter 8: Utilization Management](#)

Prior Authorization Submission: Jefferson Health Plans & Evicore



- Services performed in-office
- Short procedure units
- Ambulatory surgery centers
- Clinics
- Hospital outpatient departments.



- Cardiology Studies/Procedures
- Interventional Pain Management
- Joint & Spine Surgery
- Oncology
- Advanced Radiology services
- **Therapy services (PT, OT and ST)***

***Health Partners Plans CHIP does not require prior authorization for therapy services**

Prior authorizations are processed either through our **Provider Portal** or **eviCore**, depending on the type of service. Please refer to our [Prior Authorization Management Tools](#) to determine the appropriate submission type.

Prior Authorization Submission: Pharmacy

- 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 Jefferson Health [Prior Authorization](#) webpage.
- To request a prior authorization, the physician or a member of his/her staff should contact **Jefferson Health Plans' 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



Prior Authorization Process

- Providers should obtain prior authorization at least 7 days in advance for elective (non-emergent) procedures and services.
- Requests will be processed according to state and federal regulations.
- Failure to comply with this guideline may result in the delay of medically non-urgent services.

The screenshot displays a web interface for searching authorization requests. At the top, it is titled "Authorization Search Requests". Below the title, there are three search filters: "Patients" with a dropdown menu showing "Select a patient" and a search icon; "Requesting Provider" with an empty search box and a search icon; and "Servicing Provider" with an empty search box and a search icon. Underneath these are "Request Number" (empty search box) and "Date Range" (two date pickers showing "01/21/2024" and "02/21/2024"). The "Requested Service" section includes checkboxes for "Outpatient", "Home Care", "Transport", "Specialist", "Admission", "Dental", "Approved", "Pended", "Partially Approved", "Denied", and "Rejected", all of which are currently checked. At the bottom, there are three buttons: "Search Requests" (highlighted in purple), "Load", and "Save".

Prior Authorization Process cont.

- Providers may be contacted for discharge/transition planning for disenrolled members in some circumstances. Jefferson Health Plans will participate in this planning for up to 6 months from the initial date of disenrollment, unless the member chooses a different plan.
- For elective admissions and transfers to non-participating facilities, PCP, referring specialist or hospital must call the Jefferson Health Plans Inpatient Services Department @ 1-866-500-4571.
- For more information, visit our [Provider Manual Chapter 8: Utilization Management](#)



Jefferson Health Plans
Provider Manual

Chapter 8: Utilization Management

Provider Portal- Prior Authorization Process

HPP
Health Partners Plans

[Contact Support](#)

Provider Login

Enter your credentials

Username [Forgot your username?](#)

Password [Forgot your password?](#)

Log in

Need to register?
Register a new user or provider office.

Register

Provider Portal - Submitting Authorizations

1. Go to HPPlans.com/ProviderPortal to access Provider Portal Connect and log in.
2. From the Home screen, click Office Management > Authorizations or Quick Access > Authorizations.
3. The New Requests dropdown opens the Auth Submission dashboard.
 - Outpatient for DME, outpatient scheduled or elective procedures
 - Admission for acute care facility, hospital, or post-acute facilities
 - Home Care for home care services
 - Transportation request

The screenshot displays the Health Partners Plans Provider Portal interface. At the top, there is a navigation bar with links for 'Provider Directory', 'Resources', 'Patient Management', and 'Office Management'. The 'Office Management' dropdown menu is open, showing options like 'Eligibility', 'Claims', 'Code Lookup', 'Document Manager', 'Claim Appeals', and 'Authorizations'. The 'Quick Access' section highlights 'Authorizations' and 'Claims'. The 'Tools and Resources' section provides information about available resources. The main content area is titled 'Authorization' and includes a search bar for request numbers, a 'New Request' dropdown menu with options for 'Outpatient', 'Admission', 'Home Care', and 'Transportation', and a summary of current requests: 248 Approved, 182 Pending, 6 Partially Approved, and 20 Denied. There are also links for 'Advanced Search', 'Saved Searches', and 'Custom Templates'.

Provider Portal - Submitting Authorizations

4. Start patient search by clicking magnifying glass.
5. Search Current Patients by Member ID, First Name, Last Name
6. Locate and add patient
 - Make sure you select the appropriate patient from the search results.
 - Please make sure member has an active status for the dates of service. If not, you will receive an error during submission “The selected patient is not an eligible member as of the start date of this request”.

Authorization / Search Requests
Outpatient Request Submission

If you are not able to locate the Requesting Provider in the drop down box, please use the same provider you selected for the Servicing Provider. Please identify requesting provider in the clinical information submitted with the auth request.

Patient
*Search Current Patients

Select a patient

Diagnosis
*Search and select a diagnosis

Requesting Provider
*Requesting Provider

Servicing Providers
*Servicing Providers

Search Current Patients

Member ID	First Name	Last Name
<input type="text" value="ab1214300"/>	<input type="text" value=""/>	<input type="text" value=""/>

Search Current Patients ✕

Modify Search ▾

Pig, Peppa		
Patient ID	ab1214300	Birthdate 10/15/2014
Effective Dates	4/15/2022-	<input type="button" value="+ Add"/>

1 - 1 of 1

Provider Portal - Submitting Authorizations

- 7. Diagnosis** is typically the diagnosis from the acute stay. Search for a diagnosis by entering ICD code or at least two characters and select one or more diagnosis codes.
- 8. Requesting Provider** is the provider/case manager from acute care facility requesting the service for patient. Search and select the requesting provider.
- 9. Servicing Provider** is the facility that will be servicing the member. Search for a servicing provider by Last Name or Provider NPI, type, zip code, and/or specialty. You can also choose to include out of network providers by checking the box.

Note: More than one servicing provider can be entered. For example, requests can require both servicing facility and servicing provider.

Diagnosis
*Search and select a diagnosis

E66.01 | ICD10CM | MORBID SEVERE OBESITY DUE TO EXCESS CALORIES

Requesting Provider
*Requesting Provider

DUMMY pcp 2
DUMMY pcp 2
(HRD00028732_HRD0004992LOC005)
NPI: 9999999992
Test PCP Group 7
901 Market St
Philadelphia, PA, 19143-5137

Servicing Providers
*Servicing Providers

TEST HOSPITAL
TEST HOSPITAL
(HRD00003325LOC001)
NPI: 9999999998
Test Facility Group 5

Provider Portal - Submitting Authorizations

10. Service Details

- Service is the type of service
- Location of the requesting facility.
- Level of Service either Retrospective or Standard
- Service Units is the duration of the request
- Start Date and End Date for the event

Service Details

* Service: Outpatient Surgery X * Location: Ambulatory Surgical Center X * Level of Service: Standard X

* Service Units: 1 Days * Start Date: 08/15/2022 * End Date: 08/15/2022

- ## 11. Requested Procedures
- search for a CPT, HCPCS or Revenue code for procedure code by entering numeric code or at least two characters and select one or more procedure codes.

Procedure Code Information for each procedure, enter Quantity, Start Date and End Date.

Requested Procedures

* Procedure Code: [Search Box]

43775 | CPT | LAPS GSTRC RSTRICTIV PX LONGITUDINAL GASTRECTOMY

* Quantity: 1 * Date Range: 09/14/2022 - 09/14/2023 Modifiers: [Search Box]

Provider Portal - Submitting Authorizations

12. Paperwork - add clinical documents

- a. Click “+ Add paperwork” and the new document line appears below.
- b. Click “Submit”

Paperwork

*Report Type

Notes ×

Clinical Notes Test 1.pdf ×

Delete

*Report Type

Medical Record Attachment ×

Medical Records Test 1.pdf ×

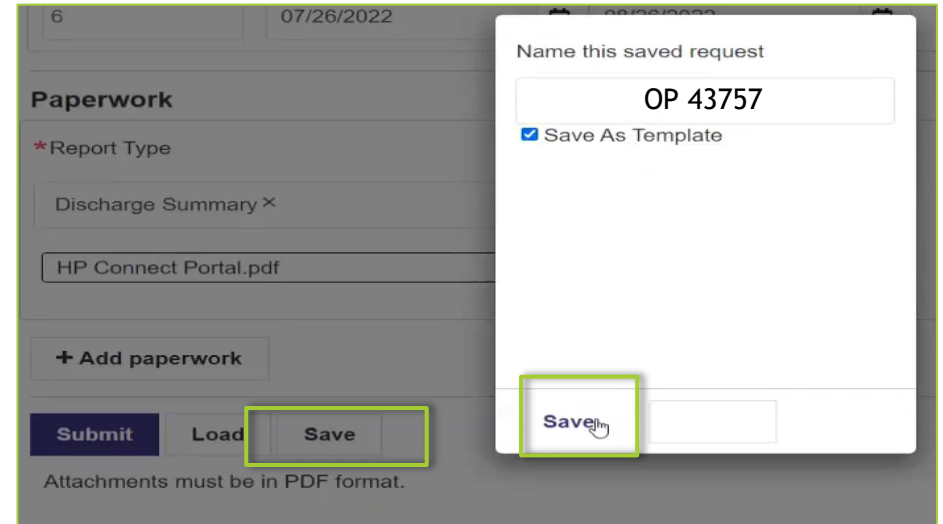
Delete

+ Add paperwork

Submit Load Save

Provider Portal - Submitting Authorizations

- **Save Templates Requests**, providers can save the request to use the template for similar requests which appears in Custom template from the Dashboard.
 - Saves all fields, except dates of service and paperwork.
- A message appears in the upper right corner. This item has been successfully saved to your custom templates; except for dates of service and paperwork.



This item has been successfully saved to your Custom Templates list. Please note, attached files and service dates are not saved as part of custom template.

Provider Portal - Submitting Authorizations

Request Detail

13. Authorization Request Number may take up to 24 hours to be returned in the portal. If you are not seeing a request number within 24 hours, please call Jefferson Health Plans' Health Care Management at: 215-967-4690 and follow the prompts for your authorization type (Precert, DME, Homecare, etc.).

- The authorization number format includes 2 letters and a series of numbers.
 - Portal Outpatient - PO56464
 - Portal Inpatient - PI01010158476

Authorization / Search Requests
Request Detail Print

Outpatient Request
Pending

Patient Catwmen, Secret	Member ID ab1214942	Birth Date 5/8/1981	Request Number	Submitted On 7/29/2022
-----------------------------------	-------------------------------	-------------------------------	-----------------------	----------------------------------

Confirmation Number
10

Diagnosis
Diagnosis Codes
E66.01 Morbid (severe) obesity due to excess calories

Requesting Provider

Provider DUMMY, 2DUMMY (HRD00028732_HRD0004992LOC005)	Provider NPI 9999999992	Address 901 Market St Philadelphia, PA, 191435137
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Servicing Providers

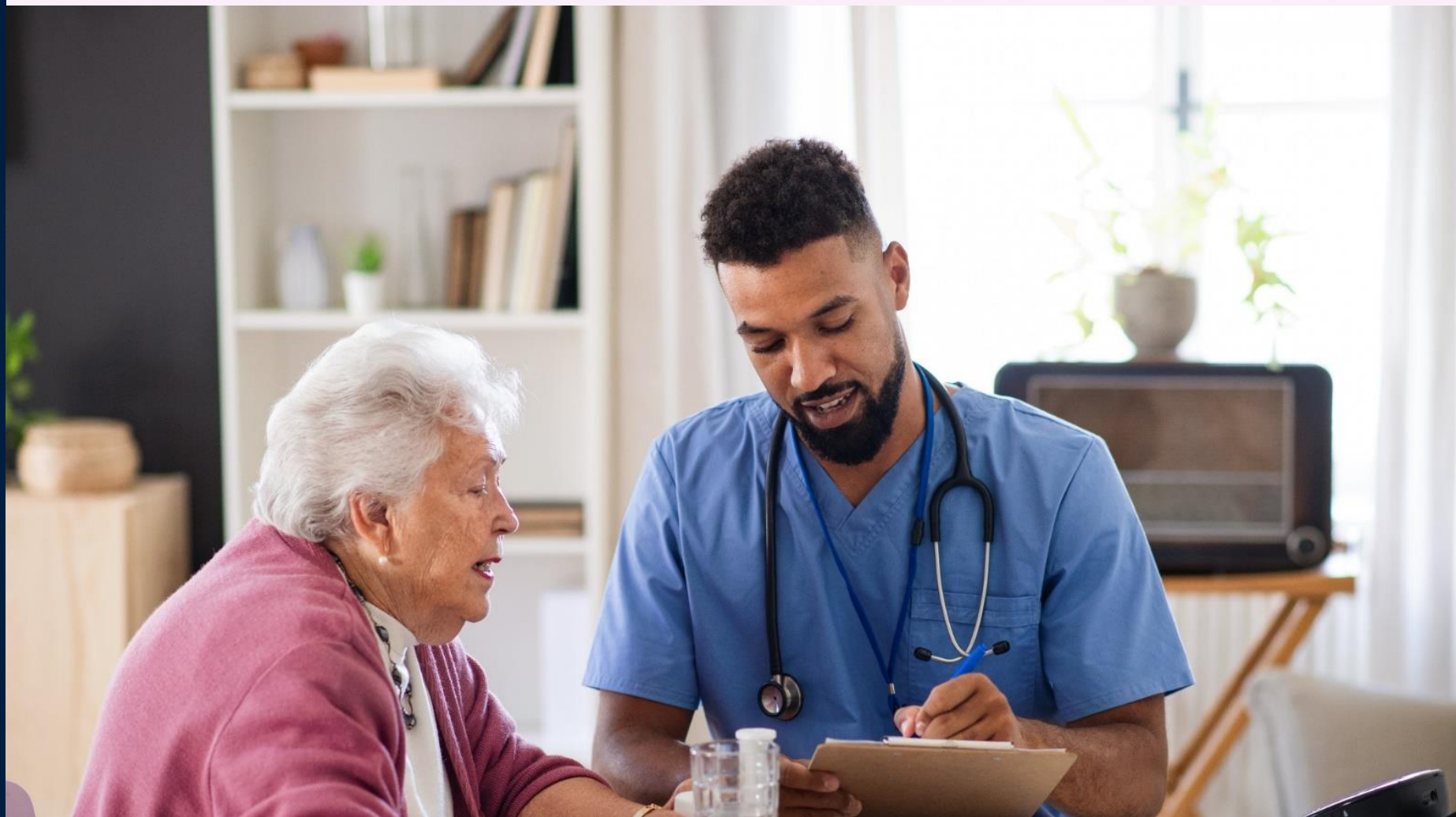
THIRDTEST HOSPITAL See More v

Provider Portal - Submitting Authorizations

- **Advanced Search Request** screen the provider has the option to view the details of a specific request, or they can modify the search to return different results.
 - When you conduct a search, you have the option of saving the search criteria as a pre-defined, 'favorite' search.
 - With one click on saved search, search results are instantly returned using your saved search criteria.
- **Custom templates** must change member, dates and applicable paperwork.
- To watch a demonstration and learn more about Provider Portal authorization and claims process, please click [here](#)
 - View Claims - 19:35
 - Reconsideration - 25:05

The image displays three overlapping screenshots of the Provider Portal interface. The top screenshot shows the 'Search Requests' screen with search filters for Patients, Requesting Provider, and Servicing Provider, and a 'Save' button highlighted. The middle screenshot shows the 'Outpatient Request Submission' form with fields for Patient, Diagnosis, Requesting Provider, and Servicing Providers, with a 'Save' button highlighted. The bottom screenshot shows the 'Authorization' dashboard with a 'New Request' button, search filters, and a 'Custom Templates' dropdown menu highlighted.

Home Care



Home Care

- Home Health services include Skilled Nursing (RN, LPN), Home Health Aide (HHA), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and Social Work (SW) visits.
- Requests must include a valid order for home health services and include supporting clinical documentation.
- Medicare Home Care servicing providers are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries within 5 business days once care has ended. Please visit [cms.gov](https://www.cms.gov) for information.



Home Care Prior Authorization Requirements

- Home health agencies are encouraged to use the [Provider Portal](#) to submit all prior authorization requests.
- Providers have 5 business days from Initial start of care to submit requests to be considered timely.
- All ongoing homecare requests are expected to be submitted *before* services are rendered
- We make every attempt to provide determinations as quickly as possible when all required documentation is received timely

Medicare has **14 days** to render a determination for all standard pre-service request.

Medicaid has **2 business days** to render a determination for all standard pre-service requests.

Medicaid has **30 calendar days** to render a determination on all retrospective requests.

Home Care Documentation

Mandatory Home Care Documentation Requirements

- **Orders** - Signed and dated (verbal) orders that include services dates/frequency
- **Referrals** - Signed and dated for the home care evaluation and/or start of care following a hospital or post-acute discharge
- **Clinical Discharge Summary** - from the inpatient stay
- **Visit notes** - (ongoing request)
 - Wound care notes
 - Therapy notes
- **Plan of care (485)** - Signed and dated by the overseeing provider in **30 days** of the start of care (SOC) and certification period

Home Care/ Home infusion Verbal Order

This impacts Health Partners Plans Medicaid, Health Partners Plans CHIP, and Jefferson Health Plans Medicare Advantage members.

Mandatory DHS and CMS Home Care Verbal Order requirements:

- The orders must be signed and dated with the date of receipt.
 - All verbal orders must have the name of the ordering/certifying practitioner along with the name and credential of the person taking the verbal order documented clearly.
 - Verbal orders may be signed by a registered nurse, supervisor, or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker).
 - For Medicaid/CHIP, verbal order can be taken by a Registered Nurse, qualified therapist, or pharmacist(home infusion)
- For services furnished based on a physician or allowed practitioners* (MD, DO, NP, PA, CNS, Certified Midwife, DPM) orders, the orders may be accepted and put in writing by person authorized to do so by applicable state and federal laws and regulations.
 - Verbal orders **must** be countersigned and dated by the physician or allowed practitioner (NP, PA, CNS, Certified Midwife) within 2 weeks.
 - *Practitioners required to write prescriptions within their scope of practice

Home Care Order Requirements

DHS and CMS Home Care Order requirements:

- Signed orders are required for all Home Health care service requests.
- The Plan of Care will be clearly signed and dated within **30 days** of the Start of Care (SOC) and be submitted.
- Orders/certification is for the same services related to the diagnosis.
- New orders are required for new services or a change in diagnosis and management.

• This constitutes a valid order:

- Obtained from a physician (MD, DO) or allowed practitioner *(NP, PA, CNS, Certified Midwife, DPM)
- hospitalist referral, prescription, discharge instructions, plan of care/485, letter of medical necessity, electronic referral etc. A referral does not remove the requirement for the POC (485)
- Written orders must have the date, time and credentials of the certifying practitioner

*Practitioners required to write prescriptions within their scope of practice

Home Care Utilization Review Process

- Jefferson Health Plans Medicare Advantage follows CMS guidelines as it relates to the Home Care Utilization review process for Medicare Advantage members
 - The full overview of these requirements can be found in the provider manual (Chapter 8- Utilization Management) or on our website: [Medicare Home Care Utilization Review Process | Health Partners Plans](#)

Home Infusion



Home Infusion - Medicaid

- Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively.
- Obtained from a physician (MD,DO) or practitioner (NP, PA, CNS, Certified Midwife, DPM)
 - Written orders must have the date, time and credentials of the certifying practitioner
- Prior Authorization is required for all Biologics, **nursing and supplies do not require authorization when services are performed by a par provider
- Non-par providers require prior authorization for home infusion Biologics, intravenous feedings, nursing and supplies.
- All requests are reviewed for Medical Necessity
- The frequency and duration of the administration of the medication must be within accepted standards of medical practice or must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.
- For home Chemotherapy, request can be submitted [Evicore](#) site or by calling 1-888-444-6178.
- Request can be submitted [Provider Portal](#) or Medicaid Ancillary fax 215-967-4491.

Home Infusions - Medicare Medical Part B

- Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively.
- Prior Authorization is required for J and B codes; nursing and supplies do not require authorization when services are reasonable and necessary.
- Injectables (Home Infusion Therapy) are covered under the part D pharmacy benefit. For more information, please visit [Prior Authorization](#).
- Where these services are reasonable and necessary the medication being administered must be accepted as safe and effective treatment of the patient's illness or injury, Must be a medical reason the medication cannot be taken orally.
- The frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.
- For home Chemotherapy, request can be submitted [Evicore](#) site or by calling 1-888-444-6178
- Infusion request can be sent to [Provider Portal](#) or Medicare ancillary fax 267-515-6633

Integra - Durable Medical Equipment (DME)



Integra - DME Medicaid & Medicare

DME Medicaid and Medicare requests must include:

- Complete signed order by certifying practitioner (NP, PA, DO, MD, CNM, DPM, etc.)
- Correct CPT/HCPC codes for all DME items requested with dates of service
- All request must include
 - DME provider name, NPI number of company supplying the equipment
 - Supplier Contact name and phone/fax number
 - Supporting clinical and signed orders
- DME requires prior authorization for all purchase items greater than \$500 and all DME rentals
- Providers are highly encouraged to submit all standard DME requests provider portal.
 - As a last resort, please use the [DME Authorization Request Form](#) and fax to 215-849-4749 (Medicaid) or 267-515-6636 (Medicare)

Exclusive to Medicaid or Medicare:

Medicaid: All miscellaneous codes require prior authorization

For more information, visit our website at [Prior Authorization](#)

Medicare: A face-to-face is required when applicable per Medicare guidelines (e.g., oxygen recertification)

Oxygen Certification Requirements

Mandatory DHS and CMS Oxygen Certification Requirements

- Initial requests for Oxygen must include a complete signed order from MD/DO/Certifying Practitioner.
- A complete order consists of:
 - Diagnosis code ICD10
 - Description of Equipment ordered CPT/HCPC code
 - Directions for Use of Equipment (e.g., flow rate, frequency)
 - Date of prescription/date of physician's signature
 - Signature AND printed name of physician prescriber
 - Physician's license number or NPI
 - Physician prescriber must be enrolled in PA Medicaid when the prescription was written
 - Provider printed information on the prescription must match the provider signature

Oxygen Certification Requirements

The continued need for Oxygen must be certified every 6 months (Medicaid) or every 12 months for Medicare as applicable. Re-certification can be a prescription or a Certificate of Medical Necessity (if a prescription, must be complete). A prescription is needed every year, in addition to the recertification requirement. Medicare requirements and criteria are based on NCD/Noridian LCD L33797. Medicare: A face-to-face is required when applicable per Medicare guidelines.

Shift Care
(Skilled
Nursing,
Home Health
Aide Services,
Medical Day
Care)



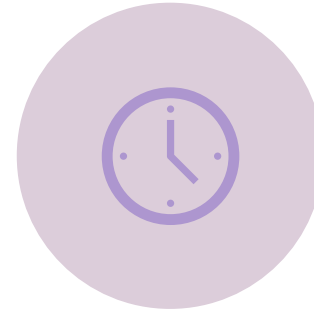
Shift Care/Medical Day Care



Requests submitted via provider portal or fax to 267-515-6667 ([Shift Care Authorization Form](#))



Letter of medical necessity (LOMN) is signed and dated, and is required from certifying practitioners (NP, PA, DO, MD, CNM, DPM, etc.)



Specific number of hours per day/week/duration



Work verification if hours are being requested for the legally responsible relative to attend work

Electronic Visit Verification (EVV): HHAeXchange

- HHAeXchange is the EVV vendor for Jefferson Health Plans.
- EVV is required for all shift care home health aide visits. **EVV is required for ALL home health visits.**
- Providers have **60 days** to accept members in HHAeXchange once authorization is approved.
- Providers are required to report all missed shifts weekly to Jefferson Health Plans.
- For assistance with HHAeXchange, email support@hhaexchange.com.

HHAEExchange

- Contact HHAEExchange for claims submission related issues and assistance with setting up an account.
- Providers have **60 days** from the authorization approval date to accept the member in the portal.
- If the provider has multiple locations, be sure to accept the member into correct location that will be servicing and later submitting a claim for the member.
- Allow **24 hours** for an approved authorization to appear in the HHAEExchange portal.
- For claims EOP disputes, please contact Jefferson Health Plans' Provider Services Helpline at 1-888-991-9023.

Electronic Visit Verification (EVV): Verification Points

Regarding EVV, claims will be rejected if they fail to meet one of the 6 required verification points below.

1. The type of service provided
2. The name of the individual receiving the services
3. The date of service delivery
4. The location of service delivery
5. The name of the individual providing the service
6. The time the service begins and ends

Non-Emergent Transportation



Behavioral Health Non-Emergent Transportation Medicaid, Medicare & CHIP



Behavioral health non-emergent (stretcher) transportation does not require prior authorization for all lines of business.



Health Partners (Medicaid) ambulance providers must have an active PROMISE ID# and all claims must include a behavioral health ICD-10 diagnosis code.



All behavioral health transports must be for a level of transport appropriate to the documented need for a Jefferson Health Plans member to a behavioral health facility.

Non-Emergent Transportation

Medicaid

Prior authorization is **not** required for Non-Emergent transportation requests from a par or non par provider.

Medicare

Prior authorization is **required** for Non-Emergent transportation requests from a par provider.

CHIP

Not a covered benefit

Home Health Services and Non-Emergent Transportation Facsimile

Home Care and
Home Infusion

Fax: 267-515-6633 (Medicare)

Fax: 215-967-4491 (Medicaid)

Durable Medical
Equipment
(DME)

Fax: 267-515-6636 (Medicare)

Fax: 215-849-4749 (Medicaid)

Shift
Care/Medical
Daycare

Fax: 267-515-6667

Non-emergent
Transport

Fax: 267-515-6627

Skilled Nursing
Facility/
Pediatric
Skilled Nursing
Facility



Skilled Nursing Facility - Medicare

- Prior authorization for post-acute skilled nursing admissions is required.
- All eligible Jefferson Health Plans Medicare members must meet CMS guidelines and evidence based clinical criteria.
- All request are subject to a secondary review by a Medical Director.
- The services are reasonable and necessary for the treatment of a patient's illness or injury; i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.
- The documentation must be submitted timely with clinical and therapy clinical within 48 hours of request. The requested services are appropriate in terms of duration, quantity, and that the services promote the documented therapeutic goals.
- Medicare does not have a custodial care benefit; however, dual enrolled (DSNP) members may be eligible under their secondary payer (Medicaid CHC).

Skilled Nursing Facility - Medicare continued

- Medicare covers **100 days** of SNF per episode. Please refer to Medicare General information, Eligibility, and Entitlement Manual chapter 3 sect 10.4.1 for information.
- SNFs are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries when their Medicare covered service(s) are ending 48 hours prior to the termination of services. The NOMNC informs beneficiaries on how to request an expedited determination from their Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) and gives beneficiaries the opportunity to request an expedited determination from a BFCC-QIO. A Detailed Explanation of Non-Coverage (DENC) is given only if a beneficiary requests an expedited determination. The DENC explains the specific reasons for the end of covered services.
- Jefferson Health Plans uses the product's specific definition of medical necessity, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and available InterQual® criteria as documented in the Subacute and SNF modules.

Skilled Nursing Facility - Medicaid

- Prior authorization for post-acute skilled nursing admissions is required.
- There must be an accepting facility prior to submitting the request or else the auth will not be processed.
- The services are reasonable and necessary for the treatment of a patient's illness or injury; i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.
- The documentation must be submitted timely and show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.

Skilled Nursing Facility - Medicaid continued

- Medicaid has a bed hold benefit. The benefit provides a 15-day bed hold per hospital confinement. An authorization is required for payment. If Jefferson Health Plans isn't notified of a need for a bed hold, those days will be denied.
- Medicaid has a 30-day custodial benefit and authorization is required for payment.
- There is no more 30-day disenrollment.
 - If member is applying for LTSS (CHC) proof of application is required. Auth will be reviewed for medical necessity, even beyond 30 days of skilled confinement. Once downgraded to custodial level of care, the 30 days will be given up front. If a CHC start date is not available on day 31, the auth will be put in CHC pended status until a start date is obtained. Once a start date is received, the auth will be updated to pay all remaining days.
- Jefferson Health Plans uses the product's specific definition of medical necessity, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and available InterQual® criteria as guidelines for the review and decision making based on the 2022 InterQual criteria in the Subacute and SNF modules.

Home and Inpatient Hospice



Home Hospice

Medicaid

Does not require prior authorization from a par provider

Medicare

Jefferson Health Plans Medicare members convert to traditional Medicare for all hospice services.

Members may continue all part B coverage unrelated to the hospice diagnosis (dental, vision, etc.)

Inpatient Hospice

- Inpatient Hospice is a benefit for all Medicaid Members.
 - A member qualifies for inpatient hospice if they are actively dying or require treatment that can't be managed in the home.
- Documents required for a pre-certification of a hospice admission are:
 - Signed Hospice Election Form
 - Signed Certificate of Terminal Illness.
 - Plan of care
 - Current assessment of the members condition/symptoms
 - What are the current exacerbating symptoms and interventions?
 - When did they start occurring?
 - Why is member unable to be managed at home?
 - Who is the members support network?

Inpatient Hospice Review Process

- Every inpatient hospice case will be reviewed for medical necessity by Jefferson Health Plans Medical Directors.
- All inpatient hospice requests must be submitted with the required signed documentation before a medical necessity review is completed.
- If approved for inpatient level of care (LOC), 5 days will be approved.
- If the initial request or continued stay request is deemed not medically necessary, the request will be downgraded and be paid at a home hospice level of care.
- Appeal and P2P options will be available.

PA Medicaid Regulations and Codes

- Jefferson Health Plans must be notified when members begin to receive hospice care, and when they end their hospice care.
- Outpatient Hospice providers must educate members about the services which are included in Hospice care, and that the member should not obtain these services from other providers while enrolled in Hospice care. It is best practice to obtain and maintain a signed copy of this education in your records.
- Jefferson Health Plans follows the PA Medicaid regulations/codes in regards to the requirements of hospice care, please refer to the below.
 - Refer to 55 Pa. Code § 1101 (General Provisions), 55 Pa. Code § 1130 (Hospice Services) and §1101 (General Provisions), MA Bulletins, and the State Operations Manual Appendix M-Guidance to Surveyors: Hospice, and the Hospice Services Handbook. Please note that Levels of Care needs must be documented as well and that some services can only be provided when the member nears the end of life. he requirements of hospice care, please refer to the below.

Ambulatory Surgical Center



Ambulatory Surgical Center

- All services performed in an outpatient location that require Prior Authorization can be located at [Prior Authorization](#).
- Please request services utilizing the Jefferson Health Plans Provider Portal.
- Services should be requested at least three weeks prior to scheduled procedure.
- Authorizations for services approved will remain open for **3 months**, except organ transplants request which will remain open for **1 year**.

Complaints, Grievances and Appeals



Complaints, Grievances and Appeals

- When Jefferson Health Plans denies, decreases, or approves 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, healthcare provider or other member's representative (with the appropriate written consent of the member) to request that Jefferson Health Plans reconsider its decision.
 - In some cases, a member can ask DHS to hold a “fair hearing” because they disagree with a Jefferson Health Plans' decision. A member must exhaust Jefferson Health Plans' Complaint or Grievance Process before they request a Fair Hearing.
- For more information, visit
- [Health Partners \(Medicaid\) Member Handbook](#)
 - [Provider Manual Chapter 13: Complaints, Grievances, and Appeals](#)
 - eLearning course, [Complaints, Grievances and Medical Necessity Reviews: Learn The Process](#) or call Provider Services Helpline at 1-888-991-9023.

Cultural and Linguistic Requirements and Services



Cultural and Linguistic Requirements and Services

- Cultural Competency is one of the main ingredients in closing the disparities gap in health care.
- It requires a commitment from doctors and other caregivers to understand and be responsive to the different attitudes, values, verbal cues, and body language that people look for in a doctor's office by virtue of their heritage.



Cultural and Linguistic Requirements for members with Limited English Proficiency (LEP)

- Participating providers are required, by law, to provide translation and interpreter services (including American sign language services) at their practice location, at the providers cost.
 - If you need assistance our helpline can assist providers in locating services for members who need a qualified interpreter present at an appointment or telephonically. Please contact our Provider Services Helpline at 1-888-991-9023.

A Physician's Practical Guide to Culturally Competent Care is sponsored by DHHS Office of Minority Health. This is a free, self-directed training course for physicians and other health care professionals.

- This is a recommended web site that offers CME/CE credit and equips health care professionals with awareness, knowledge, and skills to better treat the increasingly diverse U.S. population they serve.

cccm.thinkculturalhealth.hhs.gov

Fraud, Waste and Abuse (FWA)



Fraud, Waste, and Abuse

Special Investigations Unit (SIU)

- JeffersonHealth Plans prohibits all illegal and/or unethical conduct by members, employees, and providers. Our Special Investigations Unit (SIU) proactively addresses questionable activity and investigates referrals of illegal and unethical conduct. Investigative findings are forwarded to state and/or federal law enforcement agencies for appropriate legal action upon a substantiated finding of fraudulent conduct.

Examples of Illegal and/or Unethical Conduct

- Providers up-coding claims or submitting claims for services not provided
 - Providers providing false statement to obtain credentials (MediCheck)
 - Providers paying members incentives for patronage
 - Pharmacist paying provider kickbacks for referrals
 - Members selling membership cards or allowing others to use their membership ID numbers to obtain services
 - Members selling medications obtained through the program
 - Members obtaining services or equipment not medically necessary for their conditions
 - Employees selling Health Partners Plans' information
 - Employees accepting money or gifts in exchange for manipulating some part of Health Partners Plans' system
-
- For more information, please visit Fraud, Waste and Abuse page on our website: [Fraud, Waste & Abuse Information | Health Partners Plans](#)

FWA False Claims Act

- The False Claims Act is the most important tool U.S. taxpayers have to recover the billions of dollars stolen through fraud by U.S. government contractors, including 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. DOJ has increased False Claims Act (FCA) penalties to \$11,665 - \$23,331 per false claim, effective June 2020.
- If you wish to report fraud or suspicious activity, please call the Special Investigation Unit Hotline at 1-866-477-4848.

FWA False Billing & Procedural Neglect

- False Billing
 - Services already paid for or never rendered
 - Upcoding: Billing to increase revenue instead of billing to reflect actual work performed
 - Unbundling: Billing for each procedure separately instead of using grouping that is to be billed together
 - Forging physician signatures when such signatures are required for obtaining reimbursement
- Procedural Neglect
 - Perform medically unnecessary procedures
 - Falsified diagnoses to justify additional tests or overstated treatments

MA Provider Self-Audit Protocol

The DHS [Medical Assistance Provider Self-Audit Protocol](#) allows providers to disclose any overpayments or improper payments:

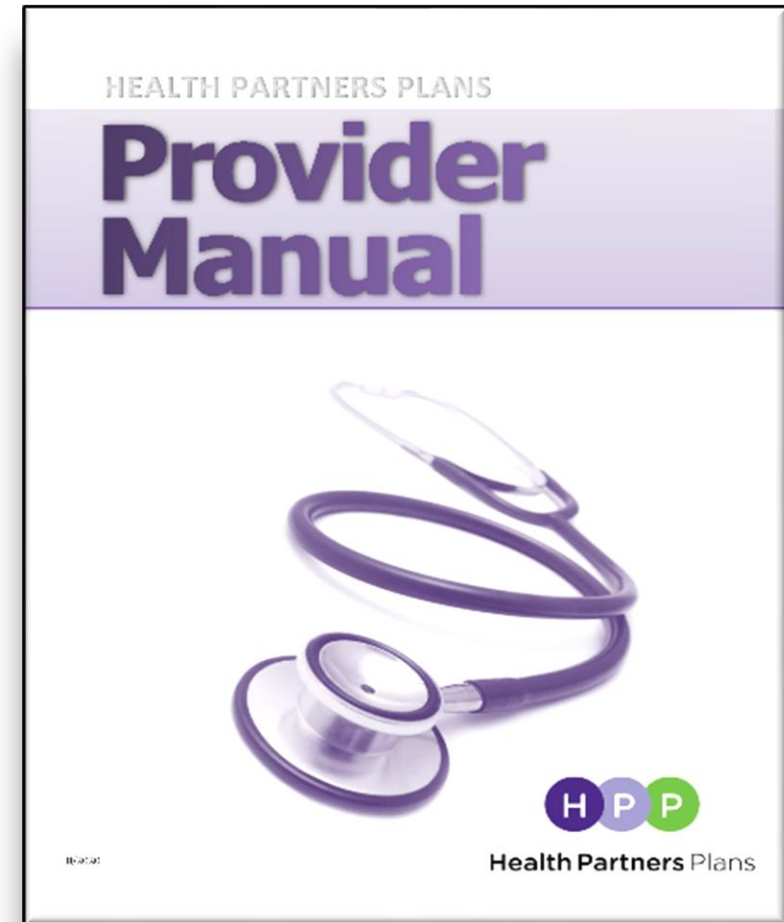
- 100 Percent Claim Review
- Provider-Developed Audit Work Plan for BPI Approval
- Intended for MA providers that participate in both the fee-for-service and managed care environments.
- The protocol provides guidance to providers on the preferred methodology to return inappropriate payments to DHS.
- Providers also have the option for conducting an audit via the DHS Pre-Approved Audit Work Plan with Statistically Valid Random Sample (SRVS)

Provider Screening and Enrollment

- Under the regulations of 42 CFR §455.436, Jefferson Health Plans is required upon enrollment and monthly thereafter to check the exclusions status of our providers on the following “U.S. Department of Health and Human Services-Office of Inspector General’s (HHS-OIG)” data bases:
 - List of Excluded Individuals and Entities (LEIE)
 - Excluded Parties List System (EPLS)
- Additionally, State requirements include Medichex screening.
- In-network providers are also responsible for conducting the same above screen process for their owners, staff, subcontractors/downstreams and report upwards any true matches.
- Screening against all exclusion databases must be done both prior to hire/contracting and monthly thereafter. Providers should maintain documentation of the screenings and results, and should notify Jefferson Health Plans immediately, should anyone be identified on one of these exclusion sites.

Online Tools

- [Welcome Providers](#)
 - [Provider Manual](#)
 - [Training and Education](#)
 - [Provider Portal](#)
 - [Provider Directories](#)
 - [Formularies](#)
 - [Clinical Resources](#)
 - [Plan Information](#)
 - [Provider Newsletters](#)
 - [Quality and Population Health](#)



Provider Portal



Health Partners Plans

[Contact Support](#)



Provider Login

Enter your credentials

Username

[Forgot your username?](#)

Password

[Forgot your password?](#)

[Log in](#)

Need to register?

Register a new user or provider office.

[Register](#)

Provider Portal

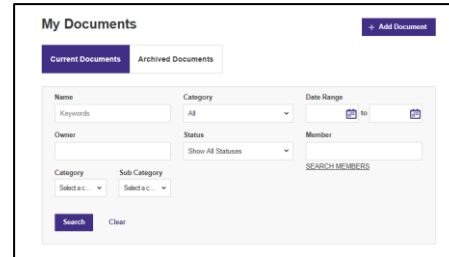
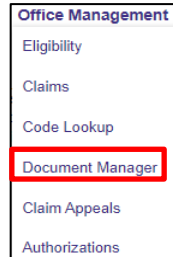
The following transactions and services are available through the provider portal, powered by HealthTrio:

- **Eligibility and Benefits** - It's important to verify a patient's eligibility before rendering services to a member. It's recommended to verify eligibility on the date of service, and each time the patient is seen. Benefit plan information is available on the eligibility screen.
- **Claim Status Inquiry** - Providers can search for claims from the Patient Management and Office Management menus.
- **Claims Appeals (Reconsiderations)**- Providers can submit claim appeals and check their status within the provider portal. There is an option to appeal claim decision at the top left corner of the screen. To begin an appeal, select **Claim Appeals**. This will open the Appeal Details screen.
- **Authorization Requests** - Allows a provider to enter service requests online for electronic submission to the health plan. We offer electronic entry of Admission, Outpatient, Specialist, Homecare, and Transportation service request types.

Provider Portal

- **Document Manager** - Supports the uploading and sharing of many kinds of documents between users. This feature supports advanced search capability, categorization and archival of documents, linkage of documents to claims and authorizations and comments between users.

- Care Gap Report
- QCP Reports
- Stars Report
- HEDIS Site Report
- Member Roster



- **Provider Communications** - Important news about Jefferson Health Plans updates, policy, notifications and educational webinars.
 - If you have a business need for these functions and currently do not have access to provider portal, please click the Register/Access by clicking <https://hppprovider.healthtrioconnect.com/app/index.page>
- **Resources**
 - [Provider Registration Guide](#) (PDF)
 - [Local Admin & User Guide](#) (PDF)
 - [Initial User Login Guide](#) (PDF)
 - [Username and Password Reset Guide](#) (PDF)
 - [HP Connect Frequently Asked Questions](#) (PDF)

Plan Contacts and Resources

Provider Services Helpline
888-991-9023
9:00-5:30 pm

Medical Providers

Prompt 1

Pharmacies

Prompt 2

Join our Provider Network

Prompt 3

Member Services

Prompt 4

Additional Resources

Utilization Management

866-500-4571

Care Coordination

215-845-4797

eviCore Radiology auths, PT/OT/ST and other expanded services

888-693-3211

ECHO Health – electronic funds transfer and remittance advice

888-834-3511

Quality Management

855-218-2314

Skilled Nursing Facilities and Rehabilitation

215-991-4395 (MC) 267-385-3825 (MA)
Fax: 215-991-4125

Health Partners Plans (CHIP) Magellan Behavioral Health

800-424-3702

Health Partners Medicare Magellan Behavioral Health

800-424-3706

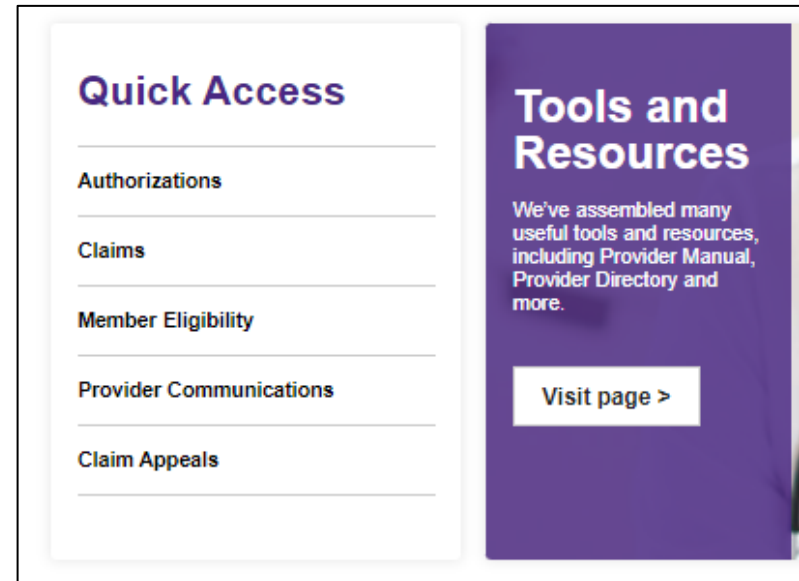
Plan Contacts and Resources

Providers	JeffersonHealthPlans.com/providers
Provider Manual	Healthpartnersplans.com/providermanual
Provider Portal	Healthpartnersplans.com/hp-connect
Training & Education	Healthpartnersplans.com/training
Provider Directories	Healthpartnersplans.com/directory
Formularies	Healthpartnersplans.com/formulary
ECHO Health	https://www.echohealthinc.com
Claims	Healthpartnersplans.com/claims
Contracting	Contracting@jeffersonhealthplans.com

Provider Relations

Provider Relations relies on multiple ways of communications to reach our provider network.

- Webinars
- Fax Blasts
- Provider Portal
- Provider Newsletter
- Training & Education
- Provider Relations Representatives
- Provider Portal Provider Communications
- Provider Communication Education Specialists



Complete Your Attestation

Thank you for your participation in the Jefferson Health Plans provider network and for your commitment to our member's health care needs!

Attestation:

- Please complete the provider education attestation by accessing the following link:
 - <https://www.healthpartnersplans.com/providers/provider-education-attestation?tot=Orientation>

Questions

Please use the Q&A panel for all questions.

For any additional questions that may arise, please email:
providercommunications@jeffersonhealthplans.com

Upcoming webinars: Register at
<https://www.healthpartnersplans.com/providers/training-and-education/webinars>

Appendix

Additional Content

- Provider Portal- slide 17 -19
- Smart Data Solutions - slide 23
- Coordination of Benefits – slide 29
- **Balance Billing – slide 33**
- Special (HMO SNP) Plan Reminders – slide 34
- Prior Authorization Process slides 44-54
- Oxygen Certification Requirements – slide 66
- Home Health Services and Non-Emergent Transportation Facsimile - slide 75
- Skilled Nursing Facility – slide 80
- FWA False Billing & Procedural Neglect – slide 96
- Appendix/ Additional Plan Contacts and Resources – slides 102-106



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