Provider Manual Quick Reference Guide

Jefferson Health Plans

Cultural Competency/Limited English Proficiency (LEP) Requirements – Chapter 2

Call the 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.

Jefferson Health Plans 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, Jefferson Health Plans will assist your office and will invoice your office for the services.

Involuntary Member Transfers – Chapter 3

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.

Jefferson Health Plans

Attn: Member Relations Department

901 Market Street, Suite 500

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.

Utilization Management – Chapter 7

Prior Authorization guidelines - Visit the provider authorization webpage or the prior authorization section of this chapter for more information on services that require authorization.

Access and Availability (A&A) Standards – Chapter 10

Criteria	PCP	Specialist
Routine office visits	Within 10 days	Within 10-15 days, depending on the specialty
Routine physical	Within 3 weeks	n/a
Preventive care	Within 3 weeks	n/a
Urgent care	Within 24 hours	Within 24 hours
Emergency care	Immediately and/or refer to ER	Immediately and/or refer to ER
First newborn visit	Within 2 weeks	n/a

Criteria	OBGYN
Initial prenatal visit	Within 24 hours of identification of high risk by Jefferson Health Plans or maternity care provider
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
Routine GYN	Within 10 days
Routine OB/GYN	Within 5 days of effective date of enrollment
Urgent care	Within 24 hours
Emergency care	Immediately and/or refer to ER

Claims Timely Filing Criteria – Chapter 11

Original Timely Filing*: 180 calendar days from the date of service or discharge date to submit and have accepted a valid initial claim.

Secondary Timely Filing: Third-party resource claims must be submitted within 60 calendar days of the initial determination notification from the primary carrier.

Timely Appeals: Provider appeals must also be submitted within 180 days of the Jefferson Health Plans denial date.

* If a claim does not appear on an Explanation of Payment within 45 calendar days of submission and no rejection notice has been received, the provider must pursue the claim status to ensure it was accepted.

Complaints, Grievances and Appeals Timeframes – Chapter 12

INPATIENT FACILITY PROVIDER APPEALS	COMPLAINTS, GRIEVANCES, & APPEALS (CG&A)
Submit appeal requests to Inpatient Facility Provider Appeals for the following determinations: • **Readmission/Combined Admissions** *Readmission appeal request submissions must contain the medical records from both admissions to be processed • **Authorization Adverse Clinical Determination/Denial Determinations for Inpatient Admissions** Authorization Adverse Clinical Determination: Medical Necessity or Administrative denial rendered by Jefferson Health Plans Medical Director Inpatient Facility Provider Appeals Department Jefferson Health Plans 901 Market Street, Suite 500 Philadelphia, PA 19107 email: appeals@jeffersonhealthplans.com Fax: 267-515-6677	**Submit appeal requests to CG&A for the following determinations:** • **Waiver of Liability (WOL)/Non-Par Provider Payment appeals *_Medicare Only_*** • **Par Provider Pre-service appeals** • **Member Pre-service and Member payment appeals** • **Member complaints or grievances** • **Provider claim appeal (post Claims Reconsideration decision) *_Medicaid only_*** Complaints, Grievances & Appeals Department Jefferson Health Plans 901 Market Street, Suite 500 Philadelphia, PA 19107 Fax: 215-991-4105