



Provider Manual | May 2023

Primary Care | Specialist | Ancillary | Hospital
Long-Term Services and Supports



Keystone First
Community HealthChoices

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Introduction

About Keystone First Community HealthChoices

Who We Are

Keystone First Community HealthChoices (hereinafter known as “the Plan”) is a Pennsylvania Community HealthChoices (CHC) Managed Care Organization (MCO) that will coordinate physical health care and long-term services and supports (LTSS) for older persons, persons with physical disabilities, and Pennsylvanians who are dually eligible for Medicare and Medicaid (Community Well Duals). We are committed to delivering quality care that enables our Participants to live safe and healthy lives with as much independence as possible and to receive services in the community, preserve consumer choice, and allow them to have an active voice in the services they receive.

Our Mission

We Help People:

Get Care Stay Well

Build Healthy Communities

Our Values

Our service is built on these values:

Advocacy

Care of the Poor

Compassion

Competence

Dignity

Diversity

Hospitality

Stewardship

Important Plan Telephone Numbers

Department	Phone	Fax
24 Hour Nurse Line	855-332-0117	
Bright Start Maternity Program (Prenatal)	800-521-6867	
Care Management/ HIV/AIDS Program	855-349-6280	888-247-0373
Personal Care Connector Team (LTSS)	855-349-6280	
ECHO Provider Support Line	800-845-6592	
Clinical Sentinel Hotline/Department of Human Services	800-537-8862	
Concurrent Review	800-521-6622	855-540-7068
Contracting Department	866-546-7972	717-651-1673
Credentialing Department	800-642-3510, option1	215-863-6369
Dental Benefits	855-434-9241	
Department of Aging	717-783-1550	
Department of Human Services Community HealthChoices	800-932-0939	
Department of Human Services Medical Assistance Program Services	800-537-8862	
Discharge Notification	800-521-6622	215-937-7366
DME Prior Authorization	800-521-6622	855-540-7067
EDI Technical Support edi.kfchc@keystonefirstchc.com	800-521-6007	
Enterprise Incident Management https://www.hhsapps.state.pa.us/eim/	866-444-1264	
ER Hospital Admission	800-521-6622	855-540-7065
Home Infusion	800-521-6622	215-937-5322
Keystone First Community HealthChoices Fraud & Abuse Hotline	866-833-9718	
Maternity Data	800-521-6622	215-937-7325
Medical Assistance Transportation Program	County Numbers	
Medical Director Hotline	877-693-8480	
Participant Services Department	855-332-0729 855-235-4976 (TTY)	
NaviNet Customer Service	888-482-8057	
NIA (Outpatient Radiology Services)	800-642-2602	
Office of Long-Term Living (OLTL)	800-932-0939	
Pennsylvania Eligibility Verification System	800-766-5387	
Pennsylvania Tobacco Cessation Information	800-784-8669	
Pharmacy Services/Prior Authorization Department	866-907-7088	855-851-4058
Prior Authorization	800-521-6622	855-540-7066
Provider Claim Services Unit	800-521-6007	
Provider Network Management	800-521-6007	
Provider Services Department	800-521-6007	
Quality Assurance and Performance Improvement Transportation Unit	855-210-6641 855-332-0729 855-235-4976 (TTY)	855-534-6740

Department	Phone	Fax
TTY - Telecommunications for the Hearing Impaired	855-235-4976	
Utilization Management (Main Toll-Free Number)	800-521-6622	866-755-9949
Discharge Notification	800-521-6622	
Vision Benefit Administrator (Davis Vision)	800-773-2847	800-933-9375

Definitions

Abuse	Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the MA Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or agreement obligations and the requirements of state or federal law and regulations for healthcare in a managed care setting, committed by the Community HealthChoices Managed Care Organization (CHC-MCO), a subcontractor, Provider, or Participant, among others.
Activities of Daily Living (ADL)	Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility and eating.
Actuarially Sound Capitation Rate	Actuarially sound Capitation rates are projected to provider reasonable, appropriate and attainable costs that are required under the terms of the contract and for the operation of the Primary Contractor for the time period and the population covered under the terms of the contracts, and such Capitation rates are developed in accordance with the requirement in 42 C.F.R. §438.4(b).
Advanced Healthcare Directive	A healthcare power of attorney, living will or a written combination of a healthcare power of attorney and living will.
Behavioral Health Managed Care Organization (BH-MCO)	An entity, operated by county government or licensed by the Commonwealth as a risk-bearing HMO, which manages the purchase and provision of Behavioral Health Services under an Agreement with the Department.
Beneficiary	A person determined eligible to receive services in the Medical Assistance (MA) Program.
Centers for Medicare and Medicaid Services (CMS)	The federal agency within the Department of Health and Human Services responsible for oversight of MA Programs.
Certified Nurse Midwife	A licensed registered nurse licensed to practice midwifery in the Commonwealth.
Certified Registered Nurse Practitioner (CRNP)	A registered nurse licensed in the Commonwealth who is certified in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in the Commonwealth.
Claim	A bill from a Provider that is assigned a claim reference number. A claim does not include an encounter form for which no payment is made or only a nominal payment is made.
Clean Claim	A claim that can be processed without obtaining additional information from the provider or from a third party. A clean claim includes a claim with errors originating in the MCO's claims system. Claims under investigation for fraud or abuse or under review to determine if they are Medically Necessary are not clean claims.

Client Information System (eCIS)

The Department's database of Beneficiaries, including Participants, containing demographic and eligibility information for all Participants.

Clinical Eligibility Determination Complaint

A determination of an individual's clinical eligibility for LTSS.

A dispute or objection regarding a network Provider or the coverage, operations, or management of the Plan, which has not been resolved by the Plan and has been filed with the Plan or with the Pennsylvania Insurance Department's Bureau of Managed Care (BMC), including but not limited to:

- A denial because the requested service/item is not a covered service; which does not include BLE;
- A failure of the CHC-MCO to meet the required time frames for providing a service/item; or
- A failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames; or
- A denial of payment by the CHC-MCO after a service has been delivered because the service/item was provided, without authorization by the CHC-MCO, by a health care Provider not enrolled in the Pennsylvania MA Program; or
- A denial of payment by the CHC-MCO after a service has been delivered because the service/item provided is not a covered service/item for the Participant.
- A denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

The term does not include a grievance

Concurrent Review

A review conducted by the Plan during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be Medically Necessary or whether a different service or lesser level of service is Medically Necessary.

Confidential Information

Information which the Plan and/or its customers considers to be and treats as private and is not common knowledge to other persons or organizations, including Participant enrollment, claims and medical information, and confidential information pertaining to the business of the Plan or its customers.

County Assistance Office (CAO)

The county offices of the Department that determine eligibility for all benefit programs, including MA, on the local level.

Cultural Humility

The ability of organizations, systems and health care professionals to respect and respond to value, respect and respond to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.

Cultural Competency

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.
Culturally and linguistically appropriate practices	Seek to advance health equity, improve the quality of health care and reduce health care disparities by assessing, respecting and responding to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services. (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).
Denied Claim	An adjudicated claim that does not result in a payment to a Provider.
Department	The Department of Human Services (DHS) of the Commonwealth of Pennsylvania.
Disability Competency	The demonstration that an entity or individual has the capacity to understand the diverse nature of disabilities and the impact that different disabilities can have on a Participant, access to services, and experience of care.
Disease Management	An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.
Dual Eligible	An individual who is eligible to receive service through both Medicare and Medicaid.
Dual Eligible Special Needs Plan (D-SNP)	A Medicare Advantage Plan that primarily or exclusively enrolls individuals who are enrolled in both Medicare and Medicaid.
Electronic Benefits Transfer (EBT) ACCESS Card	An identification card issued by the Department of Human Services (DHS) to each individual eligible for Medical Assistance (MA). The card is used by Providers to verify the individual's MA eligibility and specific covered benefits.
Eligibility Period	A period of time during which a Participant is eligible to receive MA benefits. An Eligibility Period is indicated by the eligibility start and end dates on eCIS. A blank eligibility end date signifies an open-ended eligibility period.
Eligibility Verification System (EVS)	An automated system available to Providers and other specified organizations for automated verification of Participants' MA eligibility, CHC-MCO enrollment, primary care practitioner (PCP) assignment, third party resources, and scope of benefits.
Emergency Medical Condition	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:

	<ul style="list-style-type: none"> • 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
Emergency Participant Issue	A problem of a CHC-MCO Participant, including problems related to whether an individual is a Participant, the resolution of which should occur immediately or before the beginning of the next day in order to prevent a denial or significant delay in care to the Participant that could precipitate an Emergency Medical Condition or need for urgent care.
Emergency Services	Covered inpatient and outpatient services that: <ul style="list-style-type: none"> • Are furnished by a Provider and • Are needed to evaluate or stabilize an Emergency Medical Condition.
Encounter	Any covered service provided to a Participant regardless of whether it has an associated claim.
Enrollment	The process by which a Participant is enrolled in a CHC-MCO.
Enrollment Date	Date that a beneficiary becomes eligible for CHC.
Expanded Services	Any Medically Necessary service, covered under Title XIX of the Social Security Act, 42 U.S.C.A. 1396 et seq., but not included in the State's Medicaid Plan, which is provided to Participants.
Family Planning Services	Diagnosis, treatment, drugs, supplies, and related counseling which are provided to individuals of child-bearing age to enable the individuals to determine freely the number and spacing of their children.
Federally Qualified Health Center (FQHC)	An individual health center site location that is receiving, or meets all of the requirements to receive (FQHC "look alike"), grant funds under Sections 329, 330, 340, or 340A of the Public Health Services (PHS) Act; or that does not currently meet all of the FQHC Community requirements under the PHS Act, but does meet all applicable requirements for Medical Assistance (MA) providers as set forth in Chapter 1101 of the MA regulations (including licensure and certification standards under Pennsylvania Law), and receives a temporary waiver from the Secretary of the U.S. Department of Health and Human Services allowing the health center to act as a FQHC
Formulary	A Department approved list of Medicaid covered drugs and products not included on the Statewide Preferred Drug List (PDL) and determined by the CHC-MCO's Pharmacy and Therapeutics Committee to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness and cost.
Fraud	Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The Fraud can be committed

Grievance	<p>by many entities, including the CHC- MCO, a contractor, a subcontractor, a Provider, or a Participant.</p> <p>Requests to have the Plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A Grievance may be filed regarding the Plan’s decision to: 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level or service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item, but approve an alternative service/item. 5) deny a request for a Benefit Level Exception (BLE). The term does not include a complaint.</p>
Healthcare Acquired Condition (HAC)	<p>A condition occurring in any inpatient hospital setting, identified as a HAC by the US DHHS Secretary under §1886(d)(4)(D)(iv) of the SSA, other than Deep Vein Thrombosis/Pulmonary Embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.</p>
Healthcare Associated Infection	<p>A localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that:</p> <ul style="list-style-type: none"> • Occurs in a patient in a healthcare setting. • Was not present or incubating at the time of admission, unless the infection was related to a previous admission to the same setting. • If occurring in a hospital setting, meets the criteria for a specific infection site as defined by the Centers for Disease Control and Prevention (CDC) in its National Healthcare Safety Network.
Health Information Organization (HIO)	<p>An entity that governs the exchange of health-related information among organizations according to nationally recognized standards.</p>
Health Maintenance Organization (HMO)	<p>A Commonwealth licensed risk-bearing entity which combines delivery and financing of health care, and which provides basic health services to enrolled Participants for fixed, prepaid fees.</p>
Home- and Community-Based Services	<p>A range of services and supports provided to individuals in their homes and communities including assistance with ADLs and Instrumental Activities of Daily Living (IADL), which promote the ability for older adults and adults with disabilities to live independently to the greatest degree and remain in their homes for the longest time as is possible.</p>
Hospice	<p>A coordinated program of home and inpatient care that provides non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six (6) months or less including palliative and supportive care to Participants and their families.</p>
Instrumental Activities of Daily Living (IADL)	<p>Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing housework, and communication.</p>

**interRAI Home Care (HC) –
International Resident
Assessment Instrument
Home Care**

The interRAI HC is a State-mandated assessment tool developed by a network of researchers and practitioners in over 35 countries committed to improving care for persons who are disabled or medically complex. The consortium strives to promote evidence- informed clinical practice and policy decision making through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings.

[\(http://www.interrai.org/organization/\)](http://www.interrai.org/organization/)

<http://www.interrai.org/bibliography.html>

<http://www.interrai.org/instruments/>

<http://www.interrai.org/home-care.html>

Linguistic competency

The demonstration that an entity or individual has the capacity to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency (LEP), those who have low literacy skills or are not literate, and individuals with disabilities that require communication accommodations.

**Living Independence for the
Elderly (LIFE)**

A comprehensive service delivery and financing program model in Pennsylvania (which is known nationally as the Program of All-Inclusive Care for the Elderly) that provides comprehensive healthcare services under dual capitation agreements with Medicare and the MA Program to individuals age 55 and over who are nursing facility clinically eligible (NFCE).

Lock-in

The restriction of a Participant who is involved in fraudulent activities or who is identified as abusing MA services to one or more specific Providers to obtain all of his/her services in an attempt to appropriately manage care.

**Long-Term Services and
Supports (LTSS)**

Services and supports provided to a Participant who has functional limitations or chronic illnesses that have a primary purpose of supporting the ability of the Participant to live or work in the setting of his or her choice, which may include the individual's home or worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Medical Assistance (MA)

The MA Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C.A 1396 et seq., and regulations promulgated there under, and 62 P.S. 101 et seq. and regulations at 55 Pa. Code Chapters 1101 et seq.

**Medical Assistance
Transportation Program
(MATP)**

A non-emergency medical transportation service provided to eligible persons who need to make trips to-from a MA reimbursable service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

**Medically Necessary (also
referred to as Medical
Necessity)**

Compensable under the MA Program and meeting any one of the following standards:

- Will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist a Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age.
- Will provide the opportunity for a Participant receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

Medicare

The federal health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 U.S.C. §§ 1395 et seq., covering almost all American sixty-five (65) years of age and older and certain individuals under sixty-five (65) who have disabilities or chronic kidney disease. An agreement required under the Medicare Improvements for Patients and Providers Act of 2008, Pub. Law 110-275, between a D-SNP and the Department which documents each entity's roles and responsibilities with regard to Dual Eligibles and describes the D-SNP's responsibility to integrate and coordinate Medicare and Medicaid benefits.

Medicare Improvements for Patients and Providers Act (MIPPA)

A thirteen (13) digit number consisting of a combination of the nine (9) digit base Master Provider Index (MPI) Provider Number and a four (4) digit service locator.

Medicaid Management Information System (MMIS) Provider ID Network

All contracted or employed Providers with the Plan who are providing covered services to Participants.

Network Provider

An MA-enrolled Provider that has a written Network Provider Agreement and participates in the CHC-MCO's Network to serve Participants.

Non-Participating Provider

A Provider not enrolled in the Pennsylvania MA Program and/or the Plan.

Nursing Facility

A general, county or hospital-based nursing facility, which is licensed by the Department of Health (DOH), enrolled in the MA Program.

Nursing Facility Clinically Eligible Other Related Conditions

Having clinical needs that require the level of care provided in a Nursing Facility.

A physical disability such as cerebral palsy, epilepsy, spina bifida or similar conditions which occur before the age of twenty-two (22), is likely to continue indefinitely and results in three (3) or more substantial functional limitations in the following areas: self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living.

Out-of-Area Covered Services

Covered Services provided to a Participant under one (1) or more of the following circumstances:

- The Participant has an Emergency Medical Condition that occurs while outside the CHC zone.

- The health of the Participant would be endangered if the Participant returned to the CHC zone for needed services.
- The Participant is attending a college or university in a state other than Pennsylvania or a zone other than his or her zone of residence or who is travelling outside of the CHC zone but remains a resident of the Commonwealth and the CHC zone and requires Covered Services, as identified in his or her Person-Centered Service Plan (PCSP) or otherwise.
- The Provider is located outside the CHC zone, but regularly provides Covered Services to Participants at the request of the CHC-MCO.
- The needed Covered Services are not available in the CHC zone.

Out-of-Network Provider

A Provider that does not have a signed Provider Agreement with the CHC-MCO and does not participate in the CHC-MCO's network but provides services to a CHC-MCO Participant.

Out-of-Plan Services

Services which are non-capitated and are not the responsibility of the Plan as covered services.

Participant

An eligible individual who is enrolled with AmeriHealth Caritas PA CHC.

Person-Centered Service Plan (PCSP)

A written description of Participant-specific healthcare, LTSS, and wellness goals to be achieved, and the amount, duration, frequency and scope of the Covered Services to be provided to a Participant in order to achieve such goals, which is based on the comprehensive assessment of the Participant's healthcare, LTSS and wellness needs and preferences.

**Person-Centered Service Planning
Primary Care Practitioner (PCP)**

The process of developing an individualized PCSP based on an assessment of needs and preferences of the Participant.
A specific physician, physician group or CRNP acting within the scope of his or her practice, who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services; and maintaining continuity of care on behalf of a Participant.

Prior Authorization

A determination made by the Plan to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Participant prior to the Provider's initiation or continuation of the requested services.

PROMISE™ Provider Identification Number (MMIS/PPID Number) Provider

A 13-digit number consisting of a combination of the 9-digit base MPI Provider Number and a 4-digit service location.

An individual or entity that is engaged in the delivery of medical or professional service, or ordering or referring for those services, and is legally authorized to do so by the Commonwealth or State in which it delivers the services, including a licensed hospital or healthcare facility, medical equipment supplier, or person who is licensed, certified or

Provider Agreement

otherwise authorized to provide healthcare services under the laws of the Commonwealth or states in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, CRNP, RN, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, pharmacist, home care agency, durable medical equipment supplier, LTSS Provider and an individual accredited or certified to provide behavioral health services. A Department-approved written agreement between the Plan and a Provider to provide medical or professional services to the Plan Participants to fulfill the requirements of this Agreement.

Provider Appeal or Formal Provider Appeal

A written request from a health care Provider for reversal of a determination by AmeriHealth Caritas PA CHC, with regard to two (2) major types of issues: (1) Disputes not resolved to the network Provider's satisfaction through AmeriHealth Caritas PA CHC's Informal Provider Dispute process and (2) denials for services already rendered by the health care Provider to a Participant including denials that do not clearly state the health care Provider is filing a Participant Complaint or Grievance appeal on behalf of a Participant (even if the materials submitted with the appeal contain a Participant consent).

Examples of Provider appeals include, but are not limited to:

- Determinations of medical necessity through concurrent review, such as denials or downgrades for inpatient services.
- Denials for services provided to Participants without obtaining required prior authorization.
- Claims payment issues not resolved to the network Provider's satisfaction through the Informal Provider Dispute Process.
- Other denials-including retrospective review-for services already rendered by the health care Provider to a Participant.
- Appeals of health care Provider credentialing denials by AmeriHealth Caritas PA CHC and health care Provider terminations are addressed through separate appeal processes.

Provider Dispute or Informal Provider Dispute

A verbal or written expression of dissatisfaction by a network Provider regarding a decision by AmeriHealth Caritas PA CHC that directly impacts the network Provider. Disputes are generally administrative in nature and do not include decisions concerning Medical Necessity. Disputes may focus on issues concerning AmeriHealth Caritas PA CHC services and processes, other health care Providers, Participants, or claims (e.g., frequency of on-site visits, dissatisfaction with detail of Participant information on panel list, Participant non-compliance, timeliness of claims payments, etc.). Examples of disputes include, but are not limited to:

- Service issues with AmeriHealth Caritas PA CHC, including failure by AmeriHealth Caritas PA CHC to return a Provider's calls, frequency of site visits by AmeriHealth Caritas PA CHC's Provider Account Executives and/or lack of Provider network orientation/education by AmeriHealth Caritas PA CHC.
- Issues with AmeriHealth Caritas PA CHC processes, including failure to notify network Providers of policy changes, dissatisfaction with AmeriHealth Caritas PA CHC's Prior Authorization process, dissatisfaction with AmeriHealth Caritas PA CHC's referral process and dissatisfaction with AmeriHealth Caritas PA CHC's Provider Appeal process.
- Contracting issues, including dissatisfaction with AmeriHealth Caritas PA CHC's reimbursement rate, incorrect payments paid to the network Provider and incorrect information regarding the network Provider in AmeriHealth Caritas PA CHC's Provider database.

Provider Preventable Condition

A condition that meets the definition of a HCAC or other Provider-preventable condition as defined in 42 CFR§447.26(b).

Quality Management/ Quality Improvement

An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.

Related Parties

An entity that is an affiliate of the CHC-MCO or subcontracting CHC-MCO and (1) performs some of the CHC-MCO or subcontracting CHC-MCO's management functions under contract or delegation; or (2) furnishes services to Participants under a written agreement; or (3) leases real property or sells materials to the CHC-MCO or subcontracting CHC-MCO at a cost of more than \$2,500.00 during any year of a CHC agreement with the Department.

Restraint

A Restraint can be physical or chemical.

- A physical restraint includes any apparatus, appliance, device or garment applied to or adjacent to a resident's body, which restricts or diminishes the resident's level of independence or freedom.
- A chemical restraint includes psychopharmacologic drugs that are used for discipline or convenience and not required to treat medical symptoms.
- A device used to provide support for functional body position or proper balance or a device used for medical treatment, such as sandbags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet for prevention of injury during seizure activity, are not considered mechanical restraints.

Retrospective Review	A post-service review conducted by the Plan to determine whether services were delivered as authorized and consistent with the Plan’s payment policies and procedures.
Seclusion	The involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.
Service Coordination	Activities to identify, coordinate and assist Participants to gain access to needed covered services and non-covered services such as social, housing, educational and other services and supports.
Service Coordinator	An appropriately qualified professional who is the CHC–MCO’s designated, accountable point of contact for each Participant’s PCSP and Service Coordination.
Services My Way	The Budget Authority model of service, which provides Participants with a range of opportunities for Participant Self-Direction under which Participants have the opportunity to hire and manage staff that perform personal assistance type services, manage a flexible spending plan, and purchase allowable goods and services through their spending plan.
Special Needs Plan	Medicare Advantage Plans that primarily or exclusively enroll Special Needs Individuals.
Statewide Preferred Drug List (Statewide PDL)	A list of drugs and products that are grouped into therapeutic classes. The Department’s Pharmacy and Therapeutics (P&T) Committee recommends therapeutic classes to include on the Statewide PDL, preferred or non-preferred status for the drugs in each class, and corresponding prior authorization guidelines for each class. The committee's recommendations are approved by the secretary of the Department of Human Services (DHS) prior to implementation. The Statewide PDL applies to beneficiaries who receive their pharmacy benefits through the FFS and managed care delivery systems.
Step Therapy	A type of Prior Authorization requirement intended as a cost savings that begins drug therapy with the most cost-effective drug therapy and progresses to other more costly therapies determined to be Medically Necessary.
Subcontract	A contract between the Plan and an individual or entity to perform part or all of the Plan’s responsibilities under the Community HealthChoices Program excluding Provider Agreements.
Third Party Liability (TPL)	The financial responsibility for all or part of a Participant's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than the Plan.
United States	As used in the context of payment for services or items provided outside of the United States, the term “United States” means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. The definition shall be updated when indicated in order to remain consistent with the Social Security Act.

Urgent Medical Condition	Any illness, injury or severe condition which under reasonable standards of medical practice, would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The terms also include situations where a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.
Utilization Management	An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.
Utilization Review Guidelines	Detailed standards, decision algorithms, models, or informational tools that describe the factors used to make Medical Necessity determinations for services, including, but not limited to, level of care, place of service, scope of service, and duration of service.
Value-Added Service	A service that is not a Covered Service that the CHC-MCO offers to encourage Participant Enrollment, encourage healthy lifestyles, or otherwise support CHC program objectives.
Value-Based Payments (VBP) Arrangements	Agreements between the MCO and providers, which specify how providers are paid for services rendered. VBP arrangements link provider payments to the value of services provided and to relevant quality measures that are indicative of health outcomes.
Value-Based Purchasing Models	VBP Models define a way to organize and deliver care and may incorporate one or more VBP Payment Strategies as ways to pay providers.
Value-Based Purchasing Payment Strategies	Refers to the mechanism that MCOs use to pay providers (such as performance-based contracting, shared savings, shared risk, population-based payment). For details on the Plan's Value-Based program(s) visit the provider section at www.amerihealthcaritaschc.com
Vital documents	Documents which contain information that is critical for obtaining or understanding CHC-MCO benefits and services such as Provider directories, Participant handbooks, denial and grievance notices and other documents that are critical to obtaining services.

Section I: Covered Benefits



CHC Participants

Individuals 21 and older who are:

- Dually eligible for Medicare and Medicaid (Community Well Duals);
- Have a physical disability and eligible for HCBS;
- Receiving care in the OBRA waiver AND determined nursing facility clinically eligible; OR
- Receiving care in a nursing home paid for by Medicaid.

Covered Benefits

All Participants are entitled to the medical benefits provided under the Pennsylvania Community HealthChoices Program. Additionally, Participants who qualify through DHS are eligible to receive LTSS benefits under the same program.

Benefit limits and copayments may apply. Please refer to the Participant Copayment Schedule that follows this section. The most current version of the Participant Copayment Schedule can also be found online at <http://www.keystonefirstchc.com/pdf/participants/copays.pdf>.

CHC Covered Physical Health Services	
Category	Category
Inpatient Hospital Services Inpatient Acute Hospital Inpatient Rehab Hospital	Clinic Services Independent Clinic Maternity- Physician, Certified Nurse Midwives, Birth Centers Renal Dialysis Services Ambulatory Surgical Center (ASC) Services
Outpatient Hospital Clinic Services Outpatient Hospital Clinic Outpatient Hospital Short Procedure Unit Federally Qualified Health Center/ Rural Health Clinic	
Other Laboratory and X-ray Service Laboratory Radiology (For example: X-rays, MRIs, CTs)	Prescribed Drugs, Dentures, and Prosthetic Devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist Prescribed Drugs Dentures Prosthetic Devices Eyeglasses
Nursing Facility Services	
Family Planning Clinic Services and Supplies	

<p>Physician Services</p> <p>Primary Care Practitioner</p> <p>Physician Services and Medical and Surgical Services provided by a Dentist</p>	<p>Diagnostic, Screening, Preventative, and Rehabilitative Services</p> <p>Tobacco Cessation</p> <p>Therapy (Physical, Occupational, Speech, Rehabilitative)</p>
<p>Medical care and any other type of remedial care</p> <p>Podiatrist Services</p> <p>Optometrist Services</p> <p>Chiropractor Services</p>	<p>Certified Registered Nurse Practitioner Services</p> <p>Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary</p> <p>Ambulance Transportation</p> <p>Non- Emergency Transport</p> <p>Emergency Room</p>
<p>Home Health Services</p> <p>Home Healthcare Including Nursing, Aide, and Therapy</p> <p>Medical Supplies</p> <p>Durable Medical Equipment</p> <p>Therapy (Physical, Occupational, Speech)</p> <p>Personal Protective Equipment (PPE)</p>	<p>Hospice care</p> <p>Limited Abortions*</p>
<p>CHC LTSS Benefits- Nursing Facility Services</p>	
<ul style="list-style-type: none"> Nursing Facility Services are professionally supervised nursing care and related medical and other health services furnished by a healthcare facility licensed by the Pennsylvania Department of Health as a long-term care nursing facility under Chapter 8 of the Healthcare Facilities Act (35 P.S. §§ 448.801-448.821) and certified as a nursing facility provider in the MA Program (other than a facility owned or operated by the Federal or State government or agency thereof). Nursing facility services include services that are skilled nursing and rehabilitation services under the Medicare Program and health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services, but which are needed and provided on a regular basis in the context of a planned program or healthcare and management. A Participant must be NFCE to receive nursing facility services under the CHC Program. Nursing Facility Services includes at least the items and services specified in 42 C.F.R. § 438.10(f)(11)(i). Nursing facility services are covered as defined in 55 Pa. Code § 1187.51. Exceptional DME for CHC Participants residing in a Nursing Facility. 	
<p>Covered Home and Community- Based Services</p>	
<p>Adult Daily Living</p>	<p>Non-Medical Transportation</p>
<p>Assistive Technology</p>	<p>Nutritional Consultation</p>
<p>Behavior TherapySer</p>	<p>Occupational Therapy</p>

Benefits Counseling	Participant-Directed Community Supports
Career Assessment	Participant-Directed Goods and Services
Cognitive Rehabilitation	Personal Assistance Services
Community Integration	Personal Emergency Response System
Community Transition Services	Pest Eradication
Counseling	Physical Therapy
Employment Skills Development	Residential Habilitation
Financial Management Services	Respite
Home Adaptations	Specialized Medical Equipment and Supplies
Home Delivered Meals	Speech and Language Therapy
Home Health Aide	Structured Day Habilitation
Job Coaching	TeleCare
Job Finding	Vehicle Modifications
Nursing	

*Some services are included on the CHC Covered Physical Health Services list and the CHC LTSS Benefits list. The CHC LTSS Benefits are available only after the Participant's State Plan, Medicare or private insurance limitations have been reached, or the service is not covered under the State Plan, Medicare or private insurance.

Definitions for the LTSS listed above can be found in the 1915(c) Home and Community Based Services Waiver, as may be amended from time to time, found at <https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-Supporting-Documents.aspx>

Note: An Abortion is a Covered Service only when a physician has found, and certified in writing to the Medicaid agency that, on the basis of that physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term (which is in accordance with 42 CFR 441.202).

Please note:

Under the Community HealthChoices Program, behavioral health services are coordinated through, and provided by, the Participant's BH-MCO. These services are not part of the Plan's benefit package but are available to all the Plan's Participants through the BH- MCOs.

For Participants with a life-threatening, degenerative, or disabling disease or condition, or Participants with other Special Needs, a standing referral may be available. For more information on obtaining standing referrals, please contact the Provider Services department at **1-800-521-6007**.

Out-of-Area Covered Services - Covered Services provided to a Participant under one (1) or more of the following circumstances:

- An Emergency Medical Condition that occurs while outside the CHC zone.
- The health of the Participant would be endangered if the Participant returned to the CHC zone for needed services.
- The Participant is attending a college or university in a state other than Pennsylvania or a zone other than his or her zone of residence or who is traveling outside of the CHC zone but

remains a resident of the Commonwealth and the CHC zone and requires Covered Services, as identified in his or her PCSP or otherwise.

- The Provider is located outside the CHC zone, but regularly provides Covered Services to Participants at the request of the CHC-MCO.
- The needed Covered Services are not available in the CHC zone.

Services Not Covered

Some services are not covered by the Pennsylvania Community HealthChoices Program and/or the Plan, including, but not necessarily limited to, the following:

- Services that are not Medically Necessary
- Services rendered by a health care Provider who does not participate with the Plan except for:
 - Medicare-covered services (see note at the end of the section titled Prior Authorization Requirements in Section III);
 - Emergency services,
 - Family planning services, or
 - When otherwise prior authorized by the Plan.
- Cosmetic surgery, such as tummy tucks, nose jobs, face lifts and liposuction
- Experimental treatment and investigational procedures, services and/or drugs
- Acupuncture
- Infertility services
- Paternity testing
- Any service offered and covered through another insurance program, such as worker's compensation, TRICARE or other commercial insurance that has not been prior authorized by the Plan. However, Medicare covered services provided by a Medicare provider do not require prior authorization
- Motorized lifts for vehicles*
- Services provided outside the United States and its territories. The Plan is prohibited from making payments for services provided outside of the United States and its territories
- Private duty (also known as shift care) skilled nursing and/or private duty home health aide services for Participants 21 years of age or older*
- Services not considered a "medical service" under Title XIX of the Social Security Act

*LTSS eligible Participants may be eligible for these services. Please refer to the LTSS section of the manual for details.

When in doubt about whether the Plan will pay for health care services, please contact the Provider Services department at **1-800-521-6007**.

Participant Copayment Schedule

Participants do not have any copays for naloxone. When administered during an overdose, naloxone blocks the effects of opioids on the brain and restores breathing within two to eight minutes.

For opioid treatment resource information and resources including state, local and plan resources, visit <https://www.keystonefirstchc.com/providers/resources/opioid/opioid-treatment.aspx>.

Certain drugs do not have copays, such as:

- High blood pressure drugs.
- Cancer drugs.
- Diabetes drugs.
- Epilepsy drugs.
- Heart disease drugs.
- Mental health drugs (except for anti-anxiety drugs that are controlled substances, such as alprazolam and diazepam).
- Anti-Parkinson’s disease drugs.
- Anti-glaucoma drugs.
- Drugs used only to treat HIV/AIDS.
- Drugs, including immunizations, that Participants can get in a health care Provider’s office.

This is not a complete list of services that do not have copays. Please call Participant Services with questions.

Services	Copay
Ambulance (Non-emergency)	No copay
Ambulatory surgical center	No copay
Birth Center	No copay
Blood and blood products	No copay
Chiropractor	No copay
Dentist	No copay
Durable medical equipment (purchase)	No copay
Durable medical equipment (rent)	No copay
Emergency room service	No copay
Family planning	No copay
FQHC/Rural Health Clinic	No copay
Home health agency services	No copay
Hospice	No copay
Hospital: inpatient (acute)	No copay
Hospital: inpatient (rehab)	No copay
Hospital: outpatient clinic	No copay
Laboratory tests	No copay
Medical supplies	No copay
Nurse midwife (maternity services)	No copay
Obstetrician/gynecologist	No copay
Optometrist	No copay
Oxygen	No copay
Physician/CRNP	No copay
Podiatrist	No copay
Portable X-ray	No copay
Prescription brand name RX	No copay
Prescription generic Rx	No copay
Renal dialysis	No copay
Short procedure unit	No copay
Skilled Nursing facility	No copay
Tobacco cessation	No copay

Section II: Long-Term Services and Supports



Introduction

The information contained in this section of the Provider Manual applies to Providers who are contracted with Keystone First Community HealthChoices (CHC) to provide covered long-term services and support (LTSS) services. Please note that, in general, the responsibilities, expectations and processes outlined in this Provider Manual pertain to all Providers, including LTSS Providers, unless otherwise indicated in this section or specified via subsequent communications. For more information, please contact Provider Services at 1-800-521-6007.

Participants are:

Individuals 21 and older who are:

- Dually eligible for Medicare and Medicaid (Community Well Duals);
- Have a physical disability and eligible for HCBS.
- Receiving care in the OBRA waiver AND determined nursing facility clinically eligible; OR
- Receiving care in a nursing home paid for by Medicaid.

Individuals are not eligible if they are:

- Receiving LTSS in the OBRA waiver and are NOT nursing facility clinically eligible;
- An Act 150 program participant, who is not dually eligible for Medicare and Medicaid;
- A person with an intellectual or developmental disability who is receiving services through the Department of Human Services' Office of Developmental Programs; OR
- A resident in a state-operated nursing facility, including the state veterans' homes

Covered Services:

Keystone First CHC covers the same physical health benefits that are currently available through the Medicaid Adult Benefit Package. Individuals eligible for LTSS will have all services currently available in the Office of Long-Term Living (OLTL) waivers. The following additional services will also be available:

- Pest eradication
- Benefits counseling
- Enhanced employment services

Waiver & LTSS Continuity of Care

Keystone First CHC shall not reduce or terminate LTSS services in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Keystone First CHC shall ensure Participants receiving LTSS will be permitted to see all current Providers on their approved service plan, when they initially enroll with Keystone First CHC, even on a non-network basis, until an updated service plan is completed, either agreed upon by the Participant or resolved through the appeals or fair hearing process and implemented.

Keystone First CHC shall honor existing exceptions to policy granted by the DHS for the scope and duration designated. Keystone First CHC shall extend the authorization of LTSS from a non-contracted Provider as necessary to ensure continuity of care pending the Provider's contracting with Keystone First CHC, or the Participant's transition to a contract Provider. Keystone First CHC shall facilitate a seamless transition to new services and/or Providers, as applicable, in the plan of care developed by Keystone First CHC without any disruption in services.

Provider

If a Participant enrolls with Keystone First CHC and is already established with a Provider who is not a part of the network, Keystone First CHC shall make every effort to arrange for the Participant to continue with the same Provider if the Participant so desires. In this case, the Provider would be requested to meet the same qualifications as other Providers in the network. If a LTSS Provider chooses not to become part of the Keystone First CHC LTSS network the Participant will be transitioned to an in-network Provider of their choice at the end of the Continuity of Care period.

Please refer to the Continuity of Care section of the manual for complete details.

Participant Referral to the LTSS Program

At Keystone First CHC, the Care and Service Coordination teams are thoroughly trained by a Master Trainer on how to conduct and complete the Comprehensive Needs Assessment interRAI (description below). The Keystone First CHC team's eLTSS platform features a built-in InterRAI assessment making it easy for the Service Coordinator to complete the assessment during face-to-face meetings with Participants, on or offline using an iPad or laptop.

The Pennsylvania Department of Human Services (DHS) has designated the interRAI HC as the tool that Keystone First CHC will use to determine the level of care and assessed supports needed for individuals wishing to access community supports. The intention of the multi-purpose evaluation is to provide uniformity and streamline the documents completed to determine the appropriate level of care and outline the assessed needs of the individual. The tool is also used to evaluate whether or not the needs are being met and the Provider's ability to perform the tasks as assigned.

The comprehensive needs assessment is done according to the following schedule:

- Initial assessment to be completed within 5 days of enrollment
- Within 14 days of a change in condition (trigger event)
- Within 12 months of the last comprehensive assessment

Service Coordinators will conduct an assessment, as described, using tools and processes previously noted for Participants who have been identified as potentially meeting the nursing facility clinically eligible (NFCE) level of care. Keystone First CHC shall refer individuals who are

identified as potentially eligible for LTSS to DHS or its designee for level of care determination, if applicable. Participants must apply for the waiver and be granted a waiver payment slot before any LOC reviews will be done by DHS.

Credentialing LTSS Providers

The Plan credentials and recredentials Providers in accordance with the National Committee for Quality Assurance (NCQA) credentialing standards and ensures that all Providers, and facilities Providers who deliver LTSS meet licensing, certification and qualifications required by: Centers for Medicaid and Medicare Services; the Pennsylvania Home and Community Based Services (HCBS) Waiver Program; Pennsylvania Department of Human Services (DHS); Pennsylvania Department on Aging; and the Pennsylvania Department of Public Health.

Keystone First CHC practitioners/facilities covered by this policy will be re-credentialed at least every 36 months.

LTSS Providers are required to accept the contractual terms and conditions, reimbursement terms and meet the state and the health plan's credentialing and quality standards. Keystone First CHC will maintain a network that includes LTSS Providers whose physical locations and services accommodate individuals with physical, behavioral and intellectual/developmental disabilities.

Credentialing staff abide by policies and procedures for the collection, use, transmission, storage, access to and disclosure of Confidential Information in order to protect the privacy and confidentiality rights of the Plan's Participants, Practitioners, Keystone First CHC and Providers to ensure the appropriate and legitimate use of the information.

This applies but is not limited to the following practitioner/Keystone First CHC LTSS Provider types.

LTSS Provider Types - Medical

- Habilitative
- Rehabilitative
- Home Care Social Services
- Health Care Facility
- Assisted Living Community
- Medical Equipment Supplier/Contractor
- Transportation
- And other residential settings

LTSS Providers will either be credentialed directly by Keystone First CHC, or indirectly by delegated vendors who uphold DHS credentialing criteria.

Keystone First CHC Credentialing

All LTSS providers are required to meet the following state minimum requirements:

- Current, unrestricted state license, if entity is licensed.
- Current, active certifications, where applicable
- Current, active, unrestricted Medicaid ID number. *
- If eligible, individual National Provider Identification (NPI) number and group NPI number. **
- Current certificate of liability insurance.
- Explanation of any “Yes” answer(s) from General Questions section
- Acceptable outcomes for recent inspections or monitoring from licensing agencies as applicable

*This means all Providers must enroll and meet applicable Medical Assistance Provider requirements of DHS and receive a MMIS Provider ID/Pennsylvania Promise ID (MMIS/PPID). The enrollment requirements for facilities, physicians and practitioners include registering every service location with DHS and having a different service location extension for each location.

** DHS provider type 59 providers are not required to bill with an NPI number. Type 59 providers must bill their Plan Provider (Legacy) ID number in box 33b.

Additionally, the Keystone First CHC credentialing process will include a review of the following for each provider:

- Medicaid sanction status through the U.S. Office of the Inspector General’s (OIG’s) List of Excluded Individuals through Provider Trust, Entities Database and the General Services Administration
- Background checks as required by DHS

Delegated Vendor Credentialing

- In instances where a Provider is part of a delegated vendor credentialing LTSS network, Keystone First CHC will rely on the credentialing methodology adopted by that organization. All LTSS Providers must meet at least the minimum requirements listed above.

Self-Directed LTSS Providers

- Self-directed LTSS Providers who are not employed by a Provider agency or licensed/accredited by an agency/board that conducts background checks will also be subject to:
 - Criminal background checks
 - Dependent adult abuse background checks
 - Licensing, certification and qualifications as set forth above.

LTSS Provider Credentialing Rights

Right to Review Information Submitted

LTSS Providers have the right to review information submitted to support the credentialing application process with the exception of peer references and National Practitioner Data Bank (NPDB) reports. Currently Keystone First CHC does not require peer references for LTSS Providers. In addition, non-licensed Providers have the right to be notified if information received by the Credentialing department is substantially different than was reported by the Provider. The Credentialing department will notify the Provider of the information that varies substantially from what was submitted. The notification may be sent via email, fax, or phone. The Credentialing department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the practitioner.

Right to Correct Erroneous Information

LTSS Providers have the right to correct erroneous information submitted in support of their credentialing application. Corrections must be submitted in writing to the credentialing staff within ten (10) business days of notification to the Provider. Corrections or information received will be reviewed and documented in the practitioner's file. The practitioner can submit the correction either by email, fax, or phone to the Credentialing department. Corrections received by phone will be documented in the Credentialing database by the Credentialing department.

Right to be Informed of Application Status

LTSS Providers may request information about the status of the application they submitted at any time during the process. Such requests must be made to the Credentialing department, who will provide information about the status of the application, including whether or not it was received, whether or not it was complete upon receipt, and/or whether or not it is scheduled to be presented to the Credentialing Committee or Medical Director for review, etc.

Requests can be made either by email, fax, or phone. The Credentialing department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the practitioner.

Individual Provider Application

The application process for individual LTSS Providers requires the submission of a completed application. The application must include the following:

1. LTSS Credentialing Application
2. Current, unrestricted State License (if applicable)
3. Current State Certification/accreditation (if applicable)
4. State bond (if applicable)
5. CV/Resume (if applicable)
6. Current Insurance liability policy (showing expiration and limits of liability)
7. Explanation of affirmative answers on the application

To obtain a LTSS application, please visit the Keystone First CHC website at <https://www.keystonefirstchc.com/providers/credentialing/index.aspx> or contact your account executive.

Credentialing Committee/Medical Director Decision

Keystone First CHC does not make credentialing/recredentialing decisions based on the applicants' race, ethnic/national identity, gender, age, sexual orientation, the types of procedures in which the practitioner specializes or the patients for which the practitioner provides care. In developing its network, Keystone First CHC strives to meet the cultural and special needs of Participants.

Applicants are notified of their initial credentialing approval within 60 calendar days of the Credentialing Committee's recommendation. Should the Credentialing Committee elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (with the exception of NPDB reports and peer references).

Recredentialing

Recredentialing involves periodic review and reverification of credentials of network Providers. The Credentialing database houses all LTSS Provider information, and a report is run to ensure each Provider organization, facility and individual LTSS Provider is re-credentialed as scheduled. As part of this process, Keystone First CHC periodically reviews Provider information from the National Practitioner's Data Bank (NPDB) as well as the Office of Inspector General list of individuals who have been excluded from participation in Medicare and Medical Assistance Programs. Providers are required to disclose, at the time of discovery, any criminal convictions of staff Participants related to the delivery of health care or services under the Medicare, Medicaid, or Title XX Social Service programs. Such information must also be reported at the time of application for or renewal of network participation (Credentialing and Recredentialing). Providers are also obligated to provide such information to Keystone First CHC at any time upon request.

The recredentialing process occurs at least every three years. The re-credentialing process includes an up-to-date re-examination of all the materials and a review of the following:

- Participant complaints and grievances
- Results of quality indicators monitoring and evaluating activities
- Reverification of licensure standing
- Reverification of Certifications
- Sanction history

Address Changes

As a reminder, Providers are contractually bound to report changes that affect referrals, such as the relocation of an office site and to ensure that all service locations are registered and enrolled with

DHS and have an active MMIS/PPID for each location. The LTSS Provider Change Form can be found in the Provider Center on our website at: <https://www.keystonefirstchc.com/providers/manual-forms/index.aspx>.

LTSS Providers are also responsible to notify their Account Executive in writing within 60 days of the following changes:

- Change of ownership
- Change to the name of the entity (including DBA)
- Change to the Tax ID Number or Employer Identification Number
- Change to the Group Medicaid ID Number (PPID/MPI)
- Change in the status of the business filing with the Pennsylvania Department of State
- Change in service location address (change must first be approved as PA DHS active type 59 with CHC)

Access to LTSS Care

Keystone First CHC and LTSS Providers must meet standard guidelines as outlined in this publication to help ensure that Plan Participants have timely access to LTSS care.

The Plan endorses and promotes comprehensive and consistent access standards for Participants to assure Participant accessibility to health care services. Keystone First CHC has established mechanisms for measuring compliance with existing standards and identifying opportunities for the implementation of interventions for improving accessibility to health care services for Participants.

LTSS Providers are required to have appointment scheduling and wait times for Participants that comply with the access standards defined in the Appointment Availability section of the manual.

LTSS Providers are required to attend an annual Provider education training session conducted by the Plan.

Entities, agencies, and facilities that provide LTSS are required to have policies in place for paid LTSS providers to have access for assistance to necessary supports and resources to enable them to appropriately and safely complete assigned tasks, including immediate telephone and emergency assistance to address threats to the LTSS provider.

Coordination of Care

Keystone First CHC must facilitate and coordinate Participants' access to all necessary covered services and Medicare, Behavioral Health, and other services. Seamless and continuous coordination and data sharing across a continuum of services for the Participant will be provided with a focus on improving healthcare outcomes and independent living. These activities will be provided as part of Person-Centered Service Planning and the PCSP implementation process for Participants who have a PCSP. This is accomplished through Service Coordinators.

Service Coordinator Role

Service Coordinators identify, coordinate and assist Participants gain access to needed LTSS services and State Plan services, as well as non-Medicaid funded medical, social, housing, educational, and other services and supports.

The Service Coordinators role is personal and face-to-face contact to help Participants navigate the system and coordinate their care. They are a single point of contact for Participants with a primary function of providing information, facilitating access, locating, coordinating and monitoring needed services and supports for LTSS Participants. Service Coordinators are responsible to inform Participants about:

- Available LTSS benefits
- Required needs assessments
- Participant-centered service planning process *
- Service alternatives
- Service delivery options including opportunities for Participant self-direction
- Roles, rights including DHS Fair Hearing rights, risks and responsibilities, and to assist with fair hearing requests when needed and requested

*Person-centered planning and self-direction are key foundations for LTSS.

Service Coordinators also:

- Protect a Participant’s health, welfare and safety on on-going basis
- Collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the PCSP.
- Conduct reevaluation of level of care annually or more frequently as needed in accordance with DHS requirements.
- Assist the Participant and his or her PCPT in identifying and choosing willing and qualified Providers.
- Coordinate efforts and prompt the Participant to complete activities necessary to maintain LTSS eligibility.
- Explore coverage of services to address Participant identified needs through other sources, including services provided under the State Plan, Medicare or private insurance and other community resources.
- Actively coordinate with other individuals and entities essential in the physical and behavioral care delivery for the Participant to provide for seamless coordination between physical, behavioral and support services.

Contacting Service Coordinators

- Each Participant will have their Service Coordinator’s contact information, including direct phone number and e-mail address. Additionally, a Participant may call Participant Services at 1-855-332-0729 for assistance.
- Providers receive the Participant’s Service Coordinator contact information for their Keystone First CHC patients through the PCSP or they may call Provider Services at 1-800-521-6007 for assistance.

Participant Self-Directed Services

Participants who are eligible have the opportunity to self-direct Personal Assistance Services and Respite through one of two models.

- Participants may elect to receive personal assistance services through a Participant-Directed Employer Authority model, in which the Participant employs his or her own personal assistance provider, who can be a family Participant, a friend, a neighbor or any other qualified personal assistance worker; or
- Participants may elect the Budget Authority model called Services My Way, in which the PCSP is converted to a budget and the Participant develops a spending plan to purchase needed goods and services. Participants in this model may elect to receive personal assistance through an agency and/or to employ their own personal assistance Providers.

Person-Centered Planning Team (PCPT) is a team of individuals identified by the Participant to participate in the Person-Centered Service Planning process. Team Participants understand the goals that are important to the Participant and support those goals.

The PCPT will convene:

- During the initial assessment as part of Person-Centered Service Planning
- Before a potential change in condition
- After a trigger event*
- Annually
- Upon request by the Participant or their Representative

*A trigger event is defined as:

- A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge.
- A change in functional status.
- A change in caregiver or informal support status if the change impacts one or more areas of health or functional status.
- A change in home setting or environment if the change impacts one or more areas of health or functional status.
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status functioning.
- As requested by the Participant or designee, caregiver, Provider, or the PCPT or PCPT Participant, or DHS.

In addition to the trigger events listed above, if the CHC-MCO identifies that a Participant has not been receiving services to assist with activities of daily living as indicated on the service plan for a period of five (5) days or more, and the suspension of services was pre-planned, the CHC-MCO must communicate with the Participant to determine the reason for the service suspension within 24 hours of identifying the issue. If, after communicating, the CHC-MCO determined that the

Participant's health status or needs have changed, then the CHC-MCO must conduct a comprehensive needs reassessment within fourteen (14) days of identifying the issue.

Provider's Role in Service Planning

Providers play an integral role in Service Planning and should notify the Service Coordinator* when there is a change in condition, hospital admission, change in caregiver status and assist in identifying the subtle changes that could prevent an admission to the hospital or nursing facility. Providers are vital PCPT Participants with valuable input to ensure that the Participant successfully meets their goals.

Keystone First CHC's approach is to assist Participants with identifying members of a Person-Centered Planning Team, which is comprised of individuals who are important to the Participant because they can offer support, guidance, information, and assistance during the development of Person-Centered Service Plans. PCPs, Service Providers, advocates, Care Managers, clergy and caregivers are just a few examples of potential Participants of the Person-Centered Planning Team.

* Providers receive the Participant's Service Coordinator contact information for their Keystone First CHC patients through the PCSP or they may call Provider Services at 1-800-521-6007 for assistance.

LTSS Services Requiring Prior Authorization

All LTSS services require prior authorization. The Service Coordinator is responsible for authorizing a Participant's LTSS services. Please call Provider Services at 1-800-521-6007 with any questions.

Billing for LTSS Providers

Please refer to the billing section of the manual for complete details.

LTSS Provider Standards

Keystone First CHC LTSS Providers are held to the same standards as all other Providers. All LTSS Providers should review all sections of the manual to ensure that they are compliant with quality standards, cultural responsiveness requirements and more. The LTSS section of the Keystone First CHC manual covers items that are specific to the LTSS Provider but does not preclude them from the standards and requirements through the Keystone First CHC Provider Manual.

LTSS Covered Services

Adult Daily Living

Adult Daily Living services are designed to assist Participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are generally furnished for four (4) or more hours per day on a regularly scheduled basis for one (1) or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the

Participant. Adult Daily Living includes two (2) components: Basic Adult Daily Living services and Enhanced Adult Daily Living services.

Basic Adult Daily Living services are comprehensive services provided to meet the needs noted above in a licensed center. Per licensing regulations under 6 Pa. Code, Chapter 11, Subchapter A, and § 11.123 Core Services (Older Adult Daily Living Center (OADLC) Regulations § 11.123(2)), the required core services for these settings include personal assistance, nursing in accordance with regulation, social and therapeutic services, nutrition and therapeutic diets and emergency care for Participants. Basic Adult Daily Living services can be provided as either a full day or a half day. The individual's service plan initiates and directs the services he/she receives while at the center.

In addition to providing Basic Adult Daily Living services, Enhanced Adult Daily Living services must include the following additional service elements:

- **Nursing Services:** In addition to the requirements found in the OADLC Regulations § 11.123(2), a Registered Nurse (RN) must be available on-site one (1) hour weekly for each enrolled waiver participant. At a minimum, each waiver participant must be observed every other week by the RN with the appropriate notations recorded in the Participant's service plan, with the corresponding follow-ups being made with the Participant, family, or physician.
- **Staff to Participant Ratio** of one to five (1:5).
- **Operating Hours:** open a minimum of eleven (11) hours daily during the normal work week. A normal work week is defined as Monday through Friday.
- The guidelines for the required specialized services for the OADLC provider to include physical therapy, occupational therapy, speech therapy, and medical services can be found in Subchapter B, § 11.402.
- Enhanced Adult Daily Living services can be provided as either a full day or a half day.
- For Adult Daily Living Providers that are certified as Enhanced, all Participants attending that center are considered to be receiving Enhanced services.

As necessary, Adult Daily Living may include assistance in completing activities of daily living and instrumental activities of daily living. This service also includes assistance with medication administration and the performance of health-related tasks to the extent State law permits.

This service must be provided in accordance with 42 C.F.R. § 441.301(c)(4) and (5), which outlines allowable settings for home and community-based waiver services. Services can be provided as either a full day or half day. Providers may bill for one (1) day when Basic or Enhanced Adult Daily Living services are provided for four (4) or more hours in a day. Providers must bill for a half day when Basic or Enhanced services are provided for fewer than four (4) hours in a day.

Assistive Technology

Assistive Technology consists of devices and services which are intended to ensure the health, welfare, independence, and safety of the Participant and to increase, maintain, or improve a

Participant's functioning in communication, self-help, self-direction, life-supports, or adaptive capabilities.

An Assistive Technology device is an item, piece of equipment or product system whether acquired commercially, modified or customized that is needed by the Participant, as specified in the Participant's PCSP and determined necessary in accordance with the Participant's assessment. Assistive Technology is intended to ensure the health, welfare, independence or safety of the Participant and to increase, maintain or improve a Participant's functioning in communication, self-help, self-direction, life-supports or adaptive capabilities.

Assistive Technology services include supports to a Participant in the selection, acquisition or use of an Assistive Technology device. Training to utilize adaptations, modifications, and devices is included in the purchase, as applicable. Independent evaluations conducted by a certified professional, not otherwise covered under the State Plan or other waiver services, may be reimbursed as a part of this service.

Assistive Technology devices must be recommended by an independent evaluation or physician's prescription. They will only be approved by the CHC-MCO when there is sufficient documentation in the independent evaluation or physician's prescription that specifies the item is used to ensure the health, welfare, independence or safety of the Participant and serves as a less costly alternative than other suitable devices and alternative methods.

Depending on the type of technology, and in accordance with their professional scopes of practice and expertise, the independent evaluation may be conducted by a licensed occupational therapist; a speech, hearing, or language therapist; a physical therapist; a certified assistive technology professional; or other certified professional meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Independent evaluations conducted by a certified professional as defined in the provider qualifications for this service, not otherwise covered under the State Plan or other waiver services, may be reimbursed as a part of this service.

Assistive Technology is limited to:

- Purchasing, leasing, or otherwise providing for the acquisition of Assistive Technology devices for Participants.
- Selecting, designing, fitting, connecting, customizing, adapting, applying, maintaining, installing, programming, repairing, or replacing Assistive Technology devices. Repairs are covered when it is more cost-effective than purchasing a new device and the device or repairs are not covered under a warranty.
- Electronic systems that enable a Participant with functional limitations and identified needs to control various appliances, lights, telephone, doors, and security systems in his or her room, home, or other surroundings.

- Training or technical assistance for the Participant, or where appropriate, the Participant's family members, paid caregiver and informal supports on the use of Assistive Technology.
- An independent evaluation of the Assistive Technology needs of a Participant. This includes a functional evaluation of the Assistive Technology needs and appropriate services for the Participant in his or her customary environment.
- Extended warranties.
- Ancillary supplies, software, mobile apps, hubs, and equipment necessary for the proper functioning of Assistive Technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices that assist Participants with a communication prompting need identified through the independent evaluation or physician's prescription described below; and
- Generators to power life-sustaining equipment are covered for Participants residing in private homes when the following has been documented: The generator purchased is the most cost-effective to ensure the health and safety of the Participant; AND the Participant's health and safety is dependent upon electricity as documented by a physician.

All items purchased through Assistive Technology shall meet the applicable standards of manufacture, design, and installation.

If the Participant receives Speech, Occupational or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Assistive Technology, the Assistive Technology must be consistent with the Participant's behavior support plan or Speech, Occupational or Physical Therapy service.

Assistive Technology services may only be funded through the waiver when the services are not covered by the State Plan or a responsible third-party, such as Medicare or private insurance. Service Coordinators must assure that coverage of services provided under the State Plan or a responsible third-party continues until the State Plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the Participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

This service excludes those items that are not of direct medical or remedial benefit to the participant or are primarily for a recreational or diversionary nature. Items designed for general use shall only be covered to the extent necessary to meet the Participant's needs as identified through the independent evaluation or physician's prescription described below and be for the primary use of the Participant.

Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

This service does not include TeleCare services. Data plans are excluded from coverage.

Benefits Counseling

Benefits counseling is a service designed to inform, and answer questions from, a Participant about competitive integrated employment and how and whether it will result in increased economic self-sufficiency and/or net financial benefit through the use of various work incentives. This service provides an accurate, individualized assessment. The service provides information to the individual regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, housing subsidies, food stamps, etc. The service also will provide information and education to the Participant regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Benefits counseling provides work incentives counseling and planning services to persons actively considering or seeking competitive integrated employment or career advancement.

Benefits Counseling may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the

Participant. Initial Benefits Counseling may only be provided if it is documented in the service plan that Benefits Counseling services provided by a Certified Work Incentives Counselor through a Pennsylvania-based federal Work Incentives Planning and Assistance (WIPA) program were sought, and it was determined that such services were not available either because of ineligibility or because of wait lists that would result in services not being available within thirty (30) calendar days.

Career Assessment

Career Assessment is an individualized employment assessment used to assist in the identification of potential career options based upon the interests and strengths of the Participant. Services support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant.

Career Assessment is an individualized employment assessment that includes:

- Conducting a review of the Participant's work and volunteer history, interests and skills, which may include information gathering or interviewing.
- Conducting situational assessments to assess the Participant's interest and aptitude in a particular type of job.
- Identifying types of jobs in the community that match the Participant's interests, strengths and skills.
- Developing a Career Assessment Report that specifies recommendations regarding the Participant's needs, interests, strengths, and characteristics of potential work environments. The Career Assessment Report must also specify training or skills development necessary to achieve the Participant's employment or career goals, which could be addressed by other waiver services in the Participant's service plan.

This service includes Discovery for individuals who, due to the impact of their disability, their skills, preferences, and potential contributions cannot be best captured through traditional, standardized means, such as functional task assessments, situational assessments, and/or traditional normative assessments which compare the individual to others or arbitrary standards of performance and/or behavior. Discovery involves a comprehensive analysis of the person in relation to following:

- Strongest interests toward one or more specific aspects of the labor market;
- Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment;
- Conditions necessary for successful employment or self-employment.

Discovery includes the following activities: observation of person in familiar places and activities, interviews with family, friends and others who know the person well, observation of the person in an unfamiliar place and activity, and identification of the person's strong interests and existing strengths and skills that are transferable to individualized integrated employment or self-employment. Discovery also involves identification of conditions for success based on experience shared by the person and others who know the person well, and observation of the person during the Discovery process. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized integrated employment or self-employment.

The service also includes transportation as an integral component, such as transportation to a situational assessment during the delivery of Career Assessment.

Career Assessment services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the Participant. This means that Career Assessment services may only be provided when documentation has been obtained that one of the following has occurred:

1. Office of Vocational Rehabilitation (OVR) of the Commonwealth of Pennsylvania has closed a case for the Participant or has stopped providing services to the Participant;
2. The Participant was determined ineligible for OVR services; or
3. For anyone eligible for IDEA services, it has been verified that the services are not available in a complete and approved Individualized Education Program (IEP) developed pursuant to IDEA.

Documentation in accordance with Department requirements must be maintained in the file by the Supports Coordinator and updated with each reauthorization to satisfy the State assurance that the service is not otherwise available to the Participant under other federal programs.

Career Assessment does not include supports to continue paid or volunteer work once it is obtained. Career Assessment services may only occur once per service plan year and payment will be made only for a completed assessment.

Community Integration

Community Integration (CI) is a short-term, goal-based support service designed to assist Participants in acquiring, retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community. Community integration can include cueing and on-site modeling of behavior to assist the Participant in developing maximum independent functioning in community living activities.

CI is goal-based and situational to assist individuals in achieving maximum function during life-changing events such as a transition from a Nursing Facility, moving to a new community or from a parent's home, or a change in condition that requires new skill sets. Services and training must focus on specific skills and be related to the expected outcomes outlined in the Participant's service plan. Services must be provided at a one to one (1:1) ratio.

CI goals must be reviewed and/or updated at least quarterly by the Service Coordinator in conjunction with the Participant to assure that expected outcomes are met and the service plan is modified accordingly. The length of service should not exceed thirteen (13) weeks on new plans. If the Participant has not reached the goal at the end of 13 (thirteen) weeks, then documentation of the justification for continued training on the desired outcome must be incorporated into the PCSP at the time of the quarterly review. If the Participant has not reached his or her CI goals by the end of twenty-six (26) weeks, the goals need to change, or it is concluded that the individual will not independently complete the goal and the Service Coordinator must assess for a more appropriate service to meet the Participant's need. Each distinct goal may not remain on the PCSP for more than twenty-six (26) weeks. No more than thirty-two (32) units per week for one (1) CI goal will be approved in the PCSP. If the Participant has multiple CI goals, no more than forty-eight (48) units per week will be approved in the PCSP.

CI cannot be billed simultaneously with Residential Habilitation, Structured Day Habilitation or Personal Assistance Services.

The Plan retains the discretion to 1) authorize CI for individuals who have not experienced a "life-changing event"; and 2) authorize more than 48 units (12 hours) of CI in one week for up to 21 hours per week and for periods longer than 26 weeks.

Community Transition Services

Community Transition Services are one-time expenses for transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Community Transition Services may be used to pay the necessary expenses for a Participant to establish his or her basic living arrangement and to move into that arrangement. The following are allowable expenses that may be incurred:

- Essential furnishings and initial supplies such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items.

- Moving Expenses.
- Security deposits that are required to obtain or retain a lease on an apartment or home.
- Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating)
- Services necessary for the Participant's health and safety such as one-time cleaning and allergen control.

Community Transition Services are furnished only to the extent that: they are reasonable and necessary, as determined through the Person-Centered Service Plan (PCSP) development process; clearly identified in the service plan and the Participant is unable to meet such expense; or when the service cannot be obtained from other resources.

Expenditures may not include ongoing payment for rent or mortgage expenses. Community Transition Services do not include food, regular utility charges and/or household appliances or items that are intended for purely for diversion/recreational purposes.

Community Transition Services does not include pest eradication. Individuals receiving Community Transition Services who require pest eradication may obtain it through the Pest Eradication Service.

Community Transition Services are limited to the purchase of the specific items to facilitate transition and not the supports or activities provided by the Service

Coordinator/Transition Coordinator to obtain the items. The Plan pays individual vendors, such as landlords, utility companies, service agencies, furniture stores, and other retail establishments for the covered, identified items.

Community Transition Services include only those non-recurring set-up expenses incurred during the 180 consecutive days prior to discharge from a nursing facility or hospital or another provider-operated living arrangement to an apartment or home in a private residence where the person is directly responsible for his or her own living expenses.

Community Transition Services are limited to an aggregate of \$4,000 per Participant, per lifetime, as tracked and pre-authorized by the Plan.

This service is separate and distinct and does not cover those services that may otherwise be available under Assistive Technology, Home Adaptations, Pest Eradication, Specialized Medical Equipment and Supplies, and Vehicle Modifications.

Employment Skills Development

Employment Skills Development services provide learning and work experiences, including volunteer work, where the Participant can develop strengths and skills that contribute to employability in paid employment in integrated community settings. Services are aimed at furthering habilitation goals that will lead to greater opportunities for competitive and integrated

employment and career advancement at or above minimum wage. Employment Skills Development services are necessary, as specified in the PCSP, to support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant.

Employment Skills Development services are designed to:

- Be individually tailored to directly address the Participant's employment goals as identified in the needs assessment and included in the service plan. If the Participant has received a Career Assessment that has determined that the Participant is in need of acquiring particular skills in order to enhance his or her employability, those identified skills development areas must be addressed within the Participant's service plan and by the Employment Skills Development service.
- Enable each Participant to attain the highest level of work in the most integrated setting and with the job matched to the Participant's career goals, interests, strengths, priorities, abilities and capabilities, while following applicable Federal and State wage guidelines.
- Support acquisition of skills needed to obtain competitive, integrated employment in the community.
- Develop and teach general, translatable skills, including, but not limited to, the ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; basic workplace requirements, like adherence to time and attendance expectations; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety; and training to enable the effective use of transportation resources.
- Provide and support the acquisition of skills necessary to enable the Participant to obtain competitive, integrated work where the compensation for the Participant is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by Participants without disabilities, which is considered to be the optimal outcome of Employment Skills Development services.

Support may be provided to Participants for unpaid volunteer placement and training experiences, which may be provided in community-based settings. Skills development as a part of placement and training may occur as a one-to-one training experience or in a group setting in accordance with Department requirements.

Employment Skills Development includes transportation as an integral component of the service (e.g., transportation to a volunteer or training activity). Employment Skills Development may be provided in facilities licensed under Pa. Code Chapter 2390, but only after the Participant has been referred to OVR and the following is documented: the Participant was either determined ineligible by OVR or his or her OVR case is closed, and the provision of Employment Skills Development services has already been attempted in a competitive integrated employment setting or an unlicensed community-based setting outside the Participant's home. Participants receiving Employment Skills Development services must have measureable employment-related goals in their service plan.

Services must be delivered in a manner that supports the Participant's communication needs, including, but not limited to, age-appropriate communication, translation services for Participants that are of limited-English proficiency or who have other communication needs requiring translation, and assistance with the Provider's understanding and use of communication devices used by the Participant.

If the Participant receives Behavior Therapy services, this service includes implementation of the behavior support plan and, if necessary, the crisis support plan. The service includes collecting and recording the data necessary to support the review of the service plan, the behavior support plan and the crisis support plan, as appropriate.

The Employment Skills Development service Provider must maintain documentation in accordance with Department requirements. The documentation must be available to the Service Coordinator for monitoring at all times on an ongoing basis. The Service Coordinator will monitor on a quarterly basis to see if the training objectives are being met.

Handicapped employment, as defined in 55 Pa. Code Chapter 2390, may not be funded through the waiver. Waiver funding is not available for the provision of Employment Skills Development (e.g., sheltered work performed in a facility) where Participants are supervised in producing goods or performing services under contract to third parties.

Exceptional Durable Medical Equipment

Exceptional DME is defined as DME that has an acquisition cost of Five Thousand Dollars (\$5,000.00) or more and is either Specially Adapted DME or other DME that is designated as exceptional DME by the Department annually by notice in the Pennsylvania Bulletin. Exceptional DME can either be purchased or rented.

"Specially Adapted DME" is DME that is uniquely constructed or substantially adapted or modified in accordance with the written orders of a physician for the particular use of one (1) resident, making its contemporaneous use by another resident unsuitable.

The list of exceptional DME that has been designated by the Department is as follows:

1. Air fluidized beds. The pressure relief provided by this therapy uses a high rate of airflow to fluidize fine particulate material (e.g., beads or sand) to produce a support medium that has characteristics similar to liquid. The bed may have a Gore-Tex cover.
2. Powered air flotation bed (low air loss therapy). A semi-electric or total electric bed with a fully integrated powered pressure-reducing mattress which is characterized by all of the following:
 - a. An air pump or blower with a series of interconnected woven fabric air pillows which provides sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress allowing some air to escape through the support surface to the resident. The bed may have a Gore-Tex cover.

- b. Inflated cell height of the air cells through which air is being circulated is five (5) inches or greater.
 - c. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses) and air pressure provide adequate patient lift, reducing pressure and preventing bottoming out.
 - d. A surface designed to reduce friction and shear.
 - e. May be placed directly on a hospital bed frame.
 - f. Automatically readjusts inflation pressures with change in position of bed (e.g., head elevation and the like).
3. Augmentative communication devices. Used by residents who are unable to use natural oral speech as a primary means of communication. The specific device requested must be appropriate for use by the resident and the resident must demonstrate the abilities or potential abilities to use the device selected. Portable devices need to supplement, aid or serve as an alternative to natural speech for residents with severe expressive communication disorders. Nonportable devices may be covered only if required for visual enhancement or physical access needs that cannot be accommodated by a portable device.
4. Ventilators (and related supplies).
 - a. Used by residents twenty-one (21) years of age and older who require full ventilator support for a minimum of eight (8) hours per day to sustain life.

Financial Management Services

Financial Management Services (FMS) include fiscal-related services to Participants choosing to exercise employer and/or budget authority. FMS reduce the employer-related burden for Participants while making sure Medicaid and Commonwealth funds used to pay for services and supports as outlined in the Participant's PCSP are managed and disbursed appropriately as authorized. The FMS Provider must operate as either a qualified Vendor Fiscal/Employer Agent (F/EA) or as a qualified Government Fiscal/Employer Agent (F/EA). The F/EA must:

- Have an FMS policies and procedures manual that includes the policies, procedures and internal controls that describe the proper operation of the F/EA and that are in accordance with federal, state, and local tax, labor, workers compensation and program rules and regulations.
- Enroll Participants in FMS and apply for and receive approval from the IRS to act as an agent on behalf of the Participant.
- Provide orientation and skills training to Participants on required documentation for all directly hired support workers, including the completion of Federal and State forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers' compensation.
- Conduct criminal background checks and, when applicable, child abuse clearances, on potential employees.
- Distribute, collect and process support worker timesheets as verified and approved by the Participant.

- Prepare and issue support workers' payroll checks, as approved in the Participant's PCSP.
- Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and Pennsylvania Department of Revenue rules and regulations.
- Broker workers' compensation for all support workers through an appropriate agency.
- Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws.
- Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually.
- Assist in implementing the state's quality management strategy related to FMS.
- Establish an accessible customer service system for the Participant and the Service Coordinator.
- Assist Participants in verifying support workers citizenship or alien status.
- Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only).
- Provide written financial reports to the Participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the Participant, Service Coordinator, and OLTL.
- Obtain a NPI for all direct care employees using taxonomy code "Attendant Care Provider" and including home address for the direct care worker's "Business Mailing Address."
- Process voluntary payroll deductions for any worker who requests it. Any requested voluntary deductions will be conducted in accordance with the Wage Payments and Collection Law (42 P.S. S. 260.3).
- Ensure that all direct care workers have completed a required pre-service orientation prior to being authorized to provide services. This pre-service orientation must, at a minimum, include operational procedures and paperwork, roles and responsibilities in independent living system, worker rights and responsibilities, and transparency, fraud and abuse. Pre-service orientation must be provided by a not-for-profit organization independent from the FMS, service coordination entities, or home care agencies. The FMS must contract for the provision of pre-service orientation with a not-for-profit organization that has experience and a track record in supporting Direct Care Workers' training, has experience providing pre-service orientation in the Participant direct model of service delivery, and has statewide capacity to implement consistent, timely pre- service orientation.

FMS is reimbursed on a per-member per-month basis with a onetime start-up fee for all new Participants that enroll for FMS. The one-time start-up fee applies to new Participants and will only be paid once in a lifetime per Participant. The initial start-up fee covers the lengthy process of enrolling Participants as a common law employee. The one-time start-up fee and the ongoing per-member per-month service fee may not be billed simultaneously.

Home Adaptations

Home Adaptations are physical adaptations to the primary private residence of the Participant, as specified in the Participant's PCSP and determined necessary in accordance with the Participant's assessment, to ensure the health, welfare and safety of the Participant and enable the Participant to

function with greater independence in the home. This includes primary egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home. Home Adaptations consist of installation, repair, maintenance, permits, necessary inspections, and extended warranties for the adaptations. Adaptations to a household are limited to the following:

- Ramps from street, sidewalk or house.
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the health, welfare and safety of the Participant.
- Vertical lifts, only when vertical lifts and installation are not covered under the MA State Plan.
- Track lift systems. A track lift system involves the installation of a “track” in the ceiling for moving a Participant with a disability from one location to another. (Note: Portable lift systems are not considered home adaptations and are covered by the MA State Plan or the Specialized Medical Equipment and Supplies service in this waiver.)
- Handrails and grab-bars in and around the home.
- Accessible alerting systems for smoke/fire/carbon monoxide for Participants with sensory impairments. Service Coordinators must first seek these types of alert systems from local municipalities and/or fire departments.
- Outside railing to safely access the home.
- Widened doorways, landings and hallways.
- Swing-clear and expandable offset door hinges.
- Flush entries and leveled thresholds.
- Slip resistant flooring.
- Kitchen counter, sink and other cabinet modifications (including brackets for appliances). These types of adaptations will be considered only when the Participant will be preparing their own meals, or the adaptation reduces the Participant’s dependence upon another person.
- Bathroom adaptations for bathing, showering, toileting and personal care needs.
- Stair gliders and stair lifts only when stair gliders, stair lifts and installation are not covered under the MA State Plan. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely.
- Raised electrical switches and sockets.
- Other adaptations, subject to CHC-MCO approval, to address specific assessed needs as identified in the service plan.

All adaptations to the home shall be provided in accordance with applicable State or local building codes. In addition, the contractor is responsible for ensuring that the dwelling is structurally sound and can accommodate the proposed modification prior to commencing any modifications.

Home Adaptations shall meet standards of manufacture, design and installation. Home Adaptations must be an item of modification that the family would not be expected to provide to a family member without a disability or specialized needs.

Wheelchair lifts, stair glides, ceiling lifts, and metal accessibility ramps are covered by the State Plan, along with installation of the equipment or appliance. Other home adaptations in this service specification are not covered in the State Plan. Home Adaptations may only be funded through the waiver when the services are not covered by a responsible third-party, such as Medicare or private insurance, and when all other payors and community resources have been exhausted. Service Coordinators must assure that coverage of services provided under a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with OLTL requirements must be maintained in the Participant's file by the Service Coordinator and updated with each authorization.

This service does not include, but requires, an independent evaluation. Depending on the type of adaptation, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist or a physical therapist meeting all applicable Department standards, including regulations, policies, and procedures relating to Provider qualifications. Such assessments may be covered through another waiver service, as appropriate.

Depending on the complexity of the home adaptation, the independent evaluation by an occupational therapist or a physical therapist may be supplemented with an assessment by individuals holding the following certifications: Certified Environmental Access Consultant (CEAC), Certified Living in Place Professional (CLIPP) or Executive Certificate in Home Modifications. Assessors with these certifications must have at least two years of experience assessing home adaptations for older adults or individuals with disabilities.

Home Adaptations included in the service plan and begun while the person was institutionalized are not considered complete and may not be billed until the date the Participant leaves the institution and enters the waiver.

Home adaptations must be obtained in the least expensive, most cost-effective manner. Adaptations will not be approved if the home is in foreclosure, delinquent tax status, is not structurally sound, or the adaptation presents a safety concern based on applicable state and local building codes. Rent-to-purchase vertical lifts and stair glides may be rented provided the rental cost does not exceed the purchase price. When long-term use by the Participant is expected or when rental is anticipated to exceed the cost of purchase, the equipment will be purchased for the Participant, or a permanent home adaptation will be considered.

Building a new room that adds to the total square footage of the home is excluded except when necessary for the addition of an accessible bathroom when the cost of adding the bathroom is less than retrofitting an existing bathroom. Specialized Medical Equipment and Supplies is excluded.

Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the Participant; this includes items that are not up to code.

Service Coordinators are responsible for helping Participants explore all other sources, such as homeowner's insurance, landlord/property owner's insurance, and community resources, when Participants need assistance covering general maintenance and upkeep to the home.

Materials and equipment must be based on the Participant's need as documented in the PCSP.

Adaptations at rental properties must meet the following:

- There is a reasonable expectation that the Participant will continue to live in the home.
- Written permission is secured from the property owner for the adaptation, including that there is no expectation that waiver funds will be used to return the home to its original state.
- The landlord will not increase the rent because of the adaptation.

Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service. This service may not be provided to Participants receiving Residential Habilitation or residing in Assisted Living Residences, Domiciliary Care Homes, or other provider owned and operated settings.

Home Delivered Meals

The Home Delivered Meals service provides meals that meet at least one-third (1/3) of the Dietary Reference Intakes to people in their private homes. Home Delivered Meals provides meals to Participants who cannot prepare or obtain nutritionally adequate meals for themselves or for whom the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. Home Delivered Meals must be specified in the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the

Participant. Participants may receive more than one (1) meal per day, but they cannot receive meals that constitute a "full nutritional regimen" (three (3) meals per day).

All meals must be consistent with a prescribed menu approved by a dietician and, in accordance with the menu:

- May consist of hot, cold, frozen, dried, canned, fresh or supplemental foods.
- Can either be a hot, cold, frozen or shelf-stable meal.

Home Delivered Meals are provided only during those times when neither the Participant nor anyone else in the household is able or available to provide them, and where no other relative, caregiver, community/volunteer agency or third-party payor is able to provide, or be responsible for, their provision. Meals provided as part of this service shall not constitute a full nutritional

regimen (three (3) meals per day). Transportation for the delivery of meals is included in the service cost and will not be reimbursed separately.

Home Health Services

Home Health Services consist of the following components: Home Health Aide Services, Nursing Services, Physical Therapy, Occupational Therapy and Speech and Language Therapy.

1. Home Health Aide Services

Home Health Aide services are direct services prescribed by a physician to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. The physician's order must be obtained every sixty (60) days for continuation of service. Home Health Aide services are provided by a home health aide who is supervised by a registered nurse. The registered nurse supervisor must reassess the Participant's situation in accordance with 55 Pa. Code § 1249.54. Home Health Aide activities include personal care, performing simple measurements and tests to monitor a Participant's medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist.

Home Healthcare Aide services cannot be provided simultaneously with Personal Assistance Services, Adult Daily Living Services, or Respite Services.

2. Nursing Services

Nursing services are direct services prescribed by a physician that are needed by the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Nursing services are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. The physician's order must be obtained every sixty (60) days for continuation of service. Nursing services are individual, and can be continuous, intermittent, or short-term based on individual's assessed need.

3. Physical Therapy

Physical Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. Physical Therapy can be provided by a licensed physical therapist or physical therapist assistant as prescribed by a physician, and in accordance with the Physical Therapy Practice Act (63 P.S. §§ 1301 et seq.). Services must be provided at a 1:1 ratio.

4. Occupational Therapy

Occupational Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order must be obtained every sixty (60) days for continuation of service. Occupational Therapy services can be provided by a licensed occupational therapist or an occupational therapist assistant in accordance with the Occupational Therapy Practice Act (63 P.S. §§ 1501 et seq.). Services must be provided at a 1:1 ratio.

5. Speech and Language Therapy

Speech and Language Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant.

Training caretakers and development of a home program for caretakers to implement the recommendations of the therapist are included in the provision of Speech and Language Therapy services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. Speech and Language Therapy services are provided by a licensed American Speech Language Hearing Associate or a certified speech-language pathologist in accordance with applicable State standards, including the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech language system. Speech and Language Therapy services also include the examination for, and adapting and use of, augmentative and alternative communication strategies. Services must be provided at a 1:1 ratio.

Job Coaching

Job Coaching services are individualized services providing supports to Participants who need ongoing support to learn a new job and maintain a job in a competitive employment arrangement in an integrated work setting in a position that meets job and career goals. Participants in a competitive employment arrangement receiving Job Coaching services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Job Coaching can also be used to support Participants who are self-employed. Job Coaching services are necessary, as specified in the service plan, to support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant. Job Coaching provides two (2) components in accordance with an assessment: Intensive Job Coaching and Extended Follow-along.

Intensive Job Coaching includes on-the-job training and skills development; assisting the Participant with development of natural supports in the workplace; and coordinating with employers or employees, coworkers and customers, as necessary. Intensive Job Coaching includes assisting the Participant in meeting employment expectations, performing business functions, addressing issues as they arise, and also includes travel training and diversity training to the specific business where the Participant is employed. Intensive Job Coaching provides support to assist Participants in stabilizing in an integrated situation (including self-employment) and may include activities on behalf of the Participant when the Participant is not present to assist in maintaining job placement. Participants receiving Intensive Job Coaching require on-the-job support for more than twenty percent (20%) of their work week at the outset of the service, phasing down to twenty percent (20%) per week during the Intensive Job Coaching period (at which time, Extended Follow-along will be provided if ongoing support is needed).

Job Coaching supports within this range should be determined based on the Participant's needs.

Intensive Job Coaching for the same employment site and/or position may only be authorized for up to six (6) months and may be reauthorized for additional six (6) month periods, upon review with the service planning team. Intensive Job Coaching may only be reauthorized twice, for a total of eighteen (18) consecutive months of Intensive Job Coaching support for the same employment site and/or position. Intensive Job Coaching is recommended for new employment placements or may be reauthorized for the same location after a period of Extended Follow-along, due to change in circumstances (e.g., new work responsibilities, personal life changes, etc.).

Extended Follow-along is ongoing support available for an indefinite period as needed by the Participant to maintain his or her paid employment position once he/she has been stabilized in his or her position (receiving less than twenty percent (20%) onsite support for at least four (4) weeks). Extended Follow-along support may include reminders of effective workplace practices and reinforcement of skills gained during the period of Intensive Job Coaching. Once transitioned to Extended Follow-along, Providers are required to make at least two (2) visits per month, up to a maximum of two hundred-forty (240) hours per service plan year. This allows an average of twenty (20) hours per month to manage difficulties which may occur in the workplace, and the limit may be used for the Participant over an annual basis, as needed. If circumstances require more than that amount per service plan year, the service must be billed as Intensive Job Coaching.

Job Coaching services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the Participant. This means that Job Coaching may only be provided when documentation has been obtained that one of the following has occurred:

- OVR has closed a case for the Participant or has stopped providing services to the Participant;
- The Participant was determined ineligible for OVR services; or

- For anyone eligible for IDEA services, it has been verified that the services are not available in a complete and approved Individualized Education Program (IEP) developed pursuant to IDEA.

Job Coaching does not include facility-based or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

Job Coaching does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business.

Job Finding

Job Finding is an individualized service that assists Participants in obtaining competitive, integrated employment paid at or above the minimum wage. Job Finding identifies and/or develops potential jobs and assists the Participant in securing a job that fits the Participant's skills and preferences and employer's needs. If the Participant has received a Career Assessment, the results of that assessment must be addressed within the PCSP and by the Job Finding service.

Job Finding may include customized job development. Customized job development is based on individualizing the employment relationship between employees and employers in a way that matches the needs of the employer with the assessed strengths, skills, needs, and interests of the Participant, either through task reassignment, job carving, or job sharing.

Job Finding, which may include prospective employer relationship building, is time limited. Job Finding requires authorization up to ninety (90) days, with re-authorization every (90) days, for up to one (1) year. At each ninety (90) day interval, the PCSP team will meet to clarify employment goals and expectations and review the job finding strategy. The service also includes transportation as an integral component of the service, such as to a job interview, during the delivery of Job Finding.

Job Finding does not include activities covered through Job Coaching once employment is obtained. Job Finding does not include skills training to qualify for a job.

Job Finding services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the Participant. This means that job finding may only be provided when documentation has been obtained that one of the following has occurred:

- OVR has closed a case for the Participant or has stopped providing services to the Participant;
- The Participant was determined ineligible for OVR services; or
- For anyone eligible for IDEA services, it has been verified that the services are not available in a complete and approved Individualized Education Program (IEP) developed pursuant to IDEA.

Non-Medical Transportation

Non-Medical Transportation services enable Participants to gain access to LTSS services as specified in the PCSP. This service is offered in addition to medical transportation services required under 42 C.F.R. § 440.170(a) (if applicable) and shall not replace them. Non-Medical Transportation services include mileage reimbursement for drivers and others to transport a Participant and/or the purchase of tickets or tokens to secure transportation for a Participant.

Non-Medical Transportation must be billed per one-way trip or billed per item (e.g., a monthly bus pass). Transportation services must be tied to a specific objective identified on the PCSP.

Non-medical Transportation services may only be authorized on the PCSP after an individualized determination that the method is the most cost-effective manner to provide needed transportation services to the Participant and that all other non-Medicaid sources of transportation which can provide this service without charge (such as family, neighbors, friends, community agencies) have been exhausted.

Non-Medical Transportation does not cover reimbursement to the Participant or another individual when driving the Participant's vehicle. Non-Medical Transportation does not pay for vehicle purchases, rentals, modifications or repairs. Non-Medical Transportation is not available for the following activities: Adult Daily Living services with transportation or, Employment Skills Development, Career Assessment or Job Finding. An individual cannot provide both Personal Assistance Services and Non-Medical Transportation simultaneously.

Nursing Facility Services

Professionally supervised nursing care and related medical and other health services furnished by a healthcare facility licensed by the Pennsylvania Department of Health as a long-term care nursing facility under Chapter 8 of the Healthcare Facilities Act (35 P.S. §§ 448.801-448.821) and certified as a nursing facility Provider in the MA Program (other than a facility owned or operated by the Federal or State government or agency thereof). Nursing facility services include services that are skilled nursing and rehabilitation services under the Medicare Program and health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services, but which are needed and provided on a regular basis in the context of a planned program or healthcare and management. A Participant must be NFCE to receive nursing facility services under the CHC Program.

Nursing Facility Services includes at least the items and services specified in 42 C.F.R. § 438.1(c)(8)(i). Nursing facility services are covered as defined in 55 Pa. Code § 1187.51.

Nursing Facility Audits

Please remember that as a CHC-MCO, Keystone First CHC is required to perform Nursing Facility audits.

All Nursing Facilities are expected to provide requested information to the organization(s) retained by Keystone First CHC to perform Nursing Facility audits.

Participant-Directed Community Supports

This service is only available through the Services My Way (budget authority) Participant- directed model.

Participant-Directed Community Supports are specified by the PCSP, as necessary, to promote independence and to ensure the health, welfare and safety of the Participant. The Participant is the common law employer of the individual worker(s) providing services; workers are recruited, selected, hired, trained, managed, and where necessary fired by the Participant.

Participant-Directed Community Supports are aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability. These services include assisting the Participant with the following:

- Basic living skills, such as eating, drinking, toileting, personal hygiene, dressing, transferring and other activities of daily living.
- Health maintenance activities, such as bowel and bladder routines, assistance with medication, ostomy care, catheter care, wound care and range of motion activities.
- Improving and maintaining mobility and physical functioning.
- Maintaining health and personal safety.
- Preparation of meals and snacks.
- Accessing and using transportation (If providing transportation, the support services worker must have a valid driver's license and liability coverage as verified by the Fiscal/Employer Agent (F/EA).
- Participating in community experiences and activities.

Supports will be available to assist the Participant in performing employer-related duties and responsibilities through the Fiscal/Employer Agent (F/EA) and Service Coordinator.

This service may include assistance with the following activities when incidental to Participant-Directed Community Supports and necessary to complete activities of daily living:

- Accompanying the Participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted above to enable the completion of those tasks, and to enable the Participant to work and to otherwise engage in activities in the community.
- Homemaker tasks that are incidental to the delivery of Participant-Directed Community Supports to assure the health, welfare and safety of the Participant such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not comprise the majority of the service.

Participant-Directed Community Supports are provided only for the Participant and not for other household members when neither the Participant nor anyone else in the household, relative or informal caregiver is available, willing and able to perform such activities for the Participant and where no other community/volunteer agency or third-party payer is capable or responsible for their provision.

Individual Support Workers who live in the same residence as the Participant cannot be compensated for carrying out household chores such as shopping, laundry and cleaning unless the activity is being completed solely to benefit the Participant.

Participant-Directed Community Supports may not be provided at the same time as Home Health Aide Services, Respite, Personal Assistance Services and Participant-Directed Goods and Services, Residential Habilitation, Adult Daily Living and Structured Day Habilitation.

An individual cannot provide both Participant-Directed Community Supports and Non-Medical Transportation simultaneously.

Participant-Directed Goods and Services

Participant-Directed Goods and Services are services, equipment or supplies limited to Participants that are utilizing Budget Authority for Participant-directed service. Participant-Directed Goods and Services are purchased from the Participant's Individual Spending Plan.

These items must address an identified need in the Participant's traditional service plan (including improving and maintaining the individual's opportunities for full participation in the community) and meet one or more of the following requirements:

- Decrease the need for other Medicaid services.
- Promote or maintain inclusion in the community.
- Promote the independence of the Participant or decrease dependency on formal support services.
- Increase the individual's health and safety in the home environment.
- Develop or maintain personal, social, physical or work-related skills.
- Fulfill a medical, social or functional need as identified in the Participant's PCSP; and,
- The Participant does not have the funds to purchase the item or service, or the item or service is not available through another source.

Participant-Directed goods and services are purchased from the Participant's Individual Spending Plan.

Participant-Direct Goods and Services does not include personal items, groceries, rent or mortgage payments, entertainment activities, or utility payments and/or any other services not related to the disability. The Service Coordinator or Plan is responsible to ensure that provision of Participant-Directed Goods and Services does not overlap with other service provision.

Personal Assistance Services

Personal Assistance Services (PAS) primarily provide hands-on assistance, including cueing and supervision as described below, to Participants that are necessary, as specified in the service plan, to enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant.

This service will be provided to meet the Participant's needs, as determined by an assessment, in accordance with Department requirements and as outlined in the Participant's service plan.

PAS is aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability. These services include:

- Care to assist with activities of daily living (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the Participant to perform a task, and providing supervision to assist a Participant who cannot be safely left alone.
- Health maintenance activities provided for the Participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's service plan and permitted under applicable State requirements.
- Routine support services, such as meal planning, keeping of medical appointments and other health regimens needed to support the Participant.
- Assistance and implementation of prescribed therapies.
- Overnight PAS provides intermittent or ongoing awake, overnight assistance to a Participant in their home for up to eight hours. This assistance may include the following types of activities as examples, but it is not an exhaustive list: physical assistance or supervision with toileting, transferring, turning/repositioning, assisting/monitoring intake of liquids, mobility issues that may result in fall risks, and verbal prompt/reminders to take medication. The Participant's PCSP must document an assessed need for PAS and any activity beyond what can be provided through the Personal Emergency Response System (PERS) or TeleCare Services. Overnight PAS requires awake staff.

PAS may include assistance with the following activities when incidental to PAS and necessary to complete activities of daily living:

- Accompanying the Participant into the community for purposes related to PAS, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted above to enable the completion of those tasks, and to enable the Participant to work and to otherwise engage in activities in the community.
- Homemaker tasks that are incidental to the delivery of PAS to assure the health, welfare and safety of the Participant such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not comprise the majority of the service.

This service is not covered in the State Plan for adults. PAS may only be funded through the CHC waiver when the services are not covered by a responsible third-party, such as Medicare or private

insurance. Service Coordinators must assure that coverage of services provided under the State Plan or a responsible third-party continues until the plan limitations have been reached or a determination of non-coverage has been established prior to this service's inclusion in the service plan. Documentation in accordance with Department requirements must be maintained in the Participant's file by the Service Coordinator and updated with each reauthorization, as applicable.

PAS workers may accompany Participants into the community when the need is documented in the Participant's PCSP. Costs incurred by the PAS worker while accompanying the Participant into the community, such as admission fees, are not reimbursable under the waiver as PAS.

In addition, PAS workers may provide transportation to Participants as long as the transportation is associated with the provision of PAS, necessary for the Participant to work or engage in the community and documented in the Participant's PCSP.

PAS cannot be used to solely transport a Participant as this would be considered Non-Medical Transportation services which are available in the CHC waiver. In order to bill for PAS, the Participant must have a need for PAS while in community locations for which transportation is necessary and is documented in the Participant's PCSP. PAS workers may provide and bill for Non-Medical Transportation services, however it may not be billed simultaneously with PAS. The PAS worker providing the non-medical transportation services must meet the State's provider qualifications for transportation services and be enrolled in Medical Assistance as a transportation provider or enrolled with the applicable CHC-MCO's non-medical transportation broker.

PAS Services are provided only for the Participant and not for other household members, and only when neither the Participant nor anyone else in the household, relative or informal caregiver is available, willing and able to perform such activities for the Participant, and where no other community/volunteer agency, or third-party payer is capable or responsible for their provision.

PAS workers who live in the same residence as the Participant cannot be compensated for carrying out household chores such as shopping, laundry and cleaning unless the activity is being completed solely to benefit the Participant.

PAS cannot be provided simultaneously with Home Health Aide, Residential Habilitation, Respite, or Participant-Directed Goods and Services. An individual cannot provide both PAS and Non-Medical Transportation simultaneously.

IMPORTANT:

All home and community-based services (HCBS) Providers who provide and bill for personal care services (PCS) and respite services (in unlicensed settings only), are required to use the Electronic Visit Verification (EVV) System. Keystone First Community HealthChoices utilizes the EVV data to confirm that there is a corresponding EVV transaction to support the claims payment. If you submit a claim without the EVV transaction, the claim will be denied.

- In addition to the denial of claims, failure to submit EVV records for verified visits without manual edits may subject you to the imposition of a Corrective Action Plan (CAP). In order to achieve and maintain compliance with this requirement, please make certain that you and your staff are familiar with the following:
- Matching EVV data is required for claim lines billed with codes W1793 (PCS) and T1005 (respite) for dates of service.
- Providers should monitor their EVV compliance on a weekly basis and educate staff on EVV requirements.
- The implementation of EVV must not negatively impact the provision of services. Providing these services should continue as it did before the implementation of these EVV requirements. EVV does not change the method and location for service delivery.

Personal Emergency Response System (PERS)

A Personal Emergency Response System (PERS) is an electronic device that transmits a signal to a central monitoring center to summon assistance in the event of an emergency. The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring center with backup systems which is staffed at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each Participant.

A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a Participant to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a Participant who is unable to request help or to activate a system independently. A portable locator system can be obtained as PERS only if the Participant is unable to access assistance in an emergency situation due to the Participant's age or disability. The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the Participant.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each Participant as applicable.

PERS services are limited to those individuals who: live alone; are alone for significant parts of the day as determined in consideration of their health status, disability, risk factors, support needs and other circumstances; live with an individual who may be limited in his or her ability to access a telephone quickly when a Participant has an emergency; or would otherwise require extensive in-person routine monitoring and assistance.

Installation, including equipment testing, repairs, and monthly monitoring and maintenance fees, including monthly equipment rental, are included covered in this service.

A unit of service is a one-time installation fee or a monthly monitoring fee. Maintenance and repair of PERS rental equipment is the responsibility of the provider. In addition, provider staff are responsible for training Participants regarding the use of the system.

PERS equipment shall include a variety of remote or other specialty activation devices from which the individual can choose in accordance with their specific needs. All PERS equipment shall have an internal battery that provides at least twenty-four hours of power without recharging and sends notification to the emergency response center when the battery's level is low. Equipment includes, but is not limited to:

- Wearable waterproof activation devices; and
- Devices that offer:
 - Voice-to-voice communication capability,
 - Visual indication of an alarm that may be appropriate if the consumer is hearing impaired, or
 - Audible indication of an alarm that may be appropriate if the consumer is visually impaired.

PERS does not include the following:

- Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the PERS equipment.
- Stand-alone smoke or carbon monoxide detectors.
- Remote Telecare monitoring services, i.e., Health Status Measuring and Monitoring and Activity and Sensor Monitoring.
- Monthly telephone charges associated with the Participant's phone service.

When previously approved equipment has been damaged as a result of misuse, abuse or negligence, the Plan will make the determination around the cost-effectiveness of repairing and/or replacing damaged equipment or providing the Participant with additional supports.

The cost of training Participants is included in the charges for installation or the monthly monitoring fee, depending upon how the PLAN and/or provider structures their fee schedule. The maximum units per calendar year shall be one initial installation fee and 12 months of monthly monitoring service. The provider may not charge any additional costs over and above the installation and monthly monitoring fees.

The frequency and duration of this service is based upon the Participant's needs as identified and documented in the Participant's service plan.

Pest Eradication

Pest eradication services will be available to make a Participant's home fit for the Participant to live there. Pest Eradication Services are intended to aid in maintaining an environment free of insects,

rodents and other potential disease carriers to enhance safety, sanitation and cleanliness of the Participant's residence. The service may be considered for inclusion in the PCSP for a Participant transitioning to the community. It can also be made available on an ongoing basis if necessary as determined by the Service Coordinator (SC) and documented in the PCSP. That documentation needs to include the amount, duration and scope of services as determined by the SC. The service cannot be made available as a preference of the Participant to remove something on a property that has no impact on the Participant living there.

Residential Habilitation

Residential Habilitation Services are delivered in Provider owned, rented/leased or operated settings. They can be provided in Licensed and unlicensed settings.

Licensed Settings are settings in which four or more individuals reside and are licensed as Personal Care Homes (reference 55 Pa. Code Chapter 2600) or Assisted Living Residences (reference 55 Pa. Code Chapter 2800). Unlicensed settings are Provider owned, rented/leased or operated settings with no more than three (3) residents.

Residential Habilitation services are provided for up to twenty-four (24) hours per day. Residential Habilitation includes supports that assist Participants with acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. These services are individually tailored supports that can include activities in environments designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice. Supports include cueing, on-site modeling of behavior, and/or assistance in developing or maintaining maximum independent functioning in community living activities, including domestic and leisure activities. Residential Habilitation also includes community integration, personal assistance services and night-time assistance.

This includes any necessary assistance in performing activities of daily living (i.e., bathing, dressing, eating, mobility, and toileting) and instrumental activities of daily living (i.e., cooking, housework, and shopping).

Transportation is provided as a component of the Residential Habilitation service and is therefore reflected in the rate for Residential Habilitation. Providers of (unlicensed and licensed) Residential Habilitation are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their PCSPs. This includes transportation to and from day habilitation and employment services.

Licensed settings may not exceed a licensed capacity of more than eight (8) unrelated individuals. Both licensed and unlicensed settings must be community-based as well as maintain a home-like environment. A home-like environment provides full access to typical facilities found in a home such as a kitchen and dining area, provides for privacy, allows visitors at times convenient to the individual, and offers easy access to resources and activities in the community. Residences are expected to be located in residential neighborhoods in the community. Participants have access to community activities, employment, schools or day programs.

This service must be provided in accordance with 42 C.F.R. § 441.301(c)(4) and (5), which outlines allowable setting for home and community-based services. Settings cannot be located on the grounds of a Nursing Facility, Intermediate Care Facility (ICF), Institute for Mental Disease or Hospital. Instead, they must be located in residential neighborhoods in the community. Individual considerations may be available for those individuals who require continual assistance as identified on their needs assessment to ensure their medical or behavioral stability. By the nature of their behaviors, such individuals are not able to participate in activities or are unable to access the community without direct staff support. Residential Enhanced Staffing is treated as an add-on to the Residential Habilitation service and is only available when Participants require additional behavioral supports.

Residential Enhanced Staffing may be provided at the following levels:

- Level 1: staff-to-individual ratio of one to one (1:1).
- Level 2: staff-to-individual ratio of two to one (2:1) or greater.

Respite

Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care.

Federal and State financial participation through the waivers is limited to 1) Services provided for individuals in their own home, or the home of relative, friend, or other family, or 2) Services provided in a Medicaid certified Nursing Facility. Room and board costs associated with Respite Services that are provided in a facility approved (licensed or accredited) by the State that is not a private residence are reimbursable. Respite Services furnished in a Participant's home are provided in quarter (1/4 or .25) hour units. Respite Services may also be provided in a long-term care facility on a per diem basis. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or resides in the home.

The State will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) as of January 1, 2021, in accordance with the Good Faith Exemption granted by the Centers for Medicare and Medicaid Services and home health services by December 31, 2023, in accordance with section 12006 of the 21st Century CURES Act.

Specialized Medical Equipment and Supplies

Specialized Medical Equipment and Supplies are services or items that provide direct medical or remedial benefit to the Participant and are directly related to a Participant's disability. These services or items are necessary to ensure health, welfare and safety of the Participant and enable the Participant to function in the home, community, or nursing facility with greater independence. This service is intended to enable Participants to increase, maintain, or improve their ability to perform activities of daily living. Specialized Medical Equipment and Supplies are specified in the Participant's PCSP and determined necessary in accordance with the Participant's assessment.

Specialized Medical Equipment and Supplies includes:

- Devices, controls or appliances, specified in the service plan, that enable Participants to increase, maintain or improve their ability to perform activities of daily living
- Equipment repair and maintenance, unless covered by the manufacturer warranty
- Items that exceed the limits set for Medicaid State plan covered services
- Rental Equipment. In certain circumstances, needs for equipment or supplies may be time limited. The Service Coordinator must initially verify that the rental costs cannot be covered by the State Plan. If the State Plan does not cover the rental for the particular piece of equipment needed, then the cost of the rental can be funded through the LTSS Specialized Medical Equipment and Supplies benefit.
- Personal Protective Equipment (PPE) such as gloves, gowns and masks for Participant and informal support/unpaid caregiver use, as long as the PPE is used to deliver care to the Participant, can be obtained under Specialized Medical Equipment and Supplies. PPE may be added to a Participant's PCSP without the need for a physician's prescription. This does not supplant the Occupational Safety and Health Administration (OSHA) requirements under 29 CFR §1910.132 for agencies to provide PPE to their workers.

Non-Covered Items:

- All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream)
- Items covered under third party payer liability
- Items that do not provide direct medical or remedial benefit to the Participant and/or are not directly related to a Participant's disability
- Food, food supplements, food substitutes (including formulas), and thickening agents;
- Eyeglasses, frames, and lenses;
- Dentures
- Any item labeled as experimental
- Recreational or exercise equipment and adaptive devices for such

All items shall meet applicable standards of manufacture, design and installation.

If the Participant receives Speech, Occupational, or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Specialized Medical Equipment and Supplies, the Specialized Medical Equipment and Supplies must be consistent with the Participant's behavior support plan or Speech, Occupational or Physical Therapy service.

This service does not include, but requires, an independent evaluation and a physician's prescription. The independent evaluation may be conducted by a licensed occupational therapist; a speech language pathologist; or a physical therapist meeting all applicable Department standards, including regulations, policies, and procedures relating to Provider qualifications. Such assessments may be covered through one of the following services offered through the waiver: Physical Therapy, Occupational Therapy, or Speech Therapy, or the State Plan as appropriate.

Hearing Aids require, but this service does not cover, an evaluation conducted by a physician certified by the American Board of Otolaryngology. Hearing aids must be purchased from and fitted by a licensed audiologist, licensed physician, or registered hearing aid fitter in association with a registered hearing aid dealer.

Hearing aid purchases are limited to once every three years.

Hearing Aids for Participants residing in a Nursing Facility

Hearing aids are a covered benefit for all Keystone First CHC Participants residing in a Nursing Facility. Prior authorization is required.

- Hearing aids along with all affiliated charges, including replacement due to loss by the Participant, are eligible to be taken as an OME (Other Medical Expenses) when the Participant is in a Nursing facility.
- Hearing aids lost by the Nursing Facility are not eligible for reimbursement.
- Hearing aids must be provided by qualified state MA enrolled providers.
- Charges must be billed directly to Keystone First CHC for reimbursement.
- This benefit does not have a maximum limit but is based on Medical Necessity.

Specialized Medical Equipment and Supplies exclude Assistive Technology.

Structured Day Habilitation

Structured Day Habilitation Services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Structured Day Habilitation Services provide waiver Participants comprehensive day programming to acquire more independent functioning and improved cognition, communication, and life skills. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice, as well as provide the supports necessary for mood and behavioral stability with therapeutic goals according to the written plan of care for the individual.

Services include skills training, sensory/motor development, and education/elimination of maladaptive behavior. Services are directed at preparing the Participant for community reintegration, such as teaching concepts such as compliance, attending to task, task completion, problem solving, safety, communication skills, and money management, and shall be coordinated with all services in the service plan. Services include assistance with activities of daily living, including whatever assistance is necessary for the purpose of maintaining personal hygiene.

Services must be separate from the Participant's private residence or other residential living arrangement. Providers may, however, provide Structured Day Habilitation Services in the community, a Participant's private residence or other residential living arrangement if the room used is used for the sole purpose of these services. The Provider must operate the Structured Day Habilitation Services for a minimum of four (4) hours per day up to a maximum of eight (8) hours per day on a regularly scheduled basis for one (1) or more days per week or as specified in the

Participant's service plan. Structured Day Habilitation Services are distinguished from Adult Daily Living Services by the therapeutic nature of the program. Structured Day habilitation services include the direct services provided by direct care staff and any supervision of the licensed care staff. The direct services must be personal care or directed toward the acquisition of skills. Supervision of Participants is not Medicaid reimbursable.

CHC-MCOs must consider enhanced staffing levels for those individuals that require continual assistance, as identified on their needs assessment, to ensure their medical or behavioral stability. These individuals, by the nature of their behaviors, are not able to participate in activities or are unable to access the community without direct staff support. Enhanced Structured Day Habilitation Services is an add-on to the Structured Day Habilitation Services and is only available when Participants require additional behavioral supports.

Enhanced Structured Day Habilitation Staffing may be provided at the following levels:

- Level 1: staff-to-individual ratio of one to one (1:1).
- Level 2: staff-to-individual ratio of two to one (2:1) or greater.

Telecare

TeleCare integrates social and healthcare services supported by innovative technologies to sustain and promote independence and quality of life and to reduce the need for nursing home placement. By utilizing in-home technology, more options are available to assist and support individuals so that they can remain in their own homes and reduce the need for re-hospitalization. TeleCare services are specified by the service plan, as necessary, to enable the Participant to promote independence and to ensure the health, welfare and safety of the Participant and are provided pursuant to consumer choice. TeleCare includes: 1) Health Status Measuring and Monitoring TeleCare Service, 2) Activity and Sensor Monitoring TeleCare Service, and 3) Medication Dispensing and Monitoring TeleCare Services.

Health Status Measuring and Monitoring TeleCare Services: uses wireless technology or a phone line, including electronic communication between the Participant and healthcare Provider focused on collecting health related data, i.e., vital signs information such as pulse/ox and blood pressure that assists the healthcare Provider in assessing the Participant's condition and providing education and consultation; must be ordered by a primary physician, physician assistant, or nurse practitioner; includes installation, daily rental, daily monitoring and training of the Participant, his or her representative and/or employees who have direct Participant contact; monitoring service activities must be provided by trained and qualified home health staff in accordance with required Provider qualifications; and have a system in place for notification of emergency events to designated individuals or entities.

Activity and Sensor Monitoring TeleCare Service: employs sensor-based technology on a twenty-four (24) hour-per-day, seven (7) day-per-week basis by remotely monitoring and passively tracking Participants' daily routines and may report on the following: wake up times, overnight bathroom usage, bathroom falls, medication usage, meal preparation and room temperature; includes installation, monthly rental, monthly monitoring, and training of employees who have

direct Participant contact; and ensures there is a system in place for notification of emergency events to designated individuals.

Medication Dispensing and Monitoring TeleCare Service: assists Participants by dispensing and monitoring medication compliance; and utilizes a remote monitoring system personally pre-programmed for each Participant to dispense, monitor compliance and provide notification to the Provider or family caregiver of missed doses or non-compliance with medication therapy.

Therapeutic and Counseling Services

Therapeutic and counseling services are services that assist individuals in improving functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in his or her community. Therapeutic and counseling services are provided by professionals and/or paraprofessionals in cognitive rehabilitation therapy, counseling, nutritional counseling and behavior management. The service may include assessing the individual, developing a home treatment/support plan, training family Participants/staff and providing technical assistance to carry out the plan and monitoring of the Participant in the implementation of the plan. This service may be delivered in the Participant's home or in the community as described in the service plan.

- Cognitive Rehabilitation Therapy (CRT) services are a systematic, goal-oriented approach designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions.

Through CRT, the Participant utilizes methods that aim to help make the most of existing cognitive functioning through various methods, including guided practice on tasks that reflect particular cognitive functions, development of skills to help identify distorted beliefs and thought patterns, and strategies for taking in new information, such as the use of memory aids and other assistive devices. The goal for the Participant receiving CRT is to achieve an awareness of their cognitive limitations, strengths, and needs and acquire the awareness and skills in the use of functional compensations necessary to increase the quality of life and enhance their ability to live successfully in the community. CRT services do not pay for equipment. Depending on the Participant's need, equipment may be provided under another waiver service, such as Assistive Technology.

This service may include consultation, ongoing counseling, coaching and cueing, training family members/staff, providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Services are provided by a licensed occupational therapist, licensed psychologist, licensed social worker, licensed professional counselor, licensed speech and language therapist, or a home health agency that employs them. Individuals with a bachelor's or master's degree in an allied rehabilitation field as defined by the Society for Cognitive Rehabilitation who are not licensed or certified may practice under the supervision of a practitioner who is licensed as listed above.

An individual seeking CRT services is required to have a treatment plan developed by the provider. The plan must include the Participant's goals, frequency and duration of service and must be submitted to the Plan. The Participant's goals must be reviewed by the provider and progress submitted to the Plan quarterly.

Services must be provided at a 1:1 ratio.

- Counseling Services are services that assist individuals to improve functioning and independence and are necessary to improve the individual's inclusion in their community. The service may include assessing the individual, developing a home support plan, providing ongoing counseling, training family members/staff, providing technical assistance to carry out the plan, and monitoring of the individual in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Counseling services are non-medical counseling services provided to Participants in order to resolve individual or social conflicts and family issues such as assisting the individual to develop and maintain positive support networks, how to improve personal relationships, or how to improve communication with family members. While counseling services may include family Participants, the therapy must be on behalf of the Participant and documented in his or her service plan. Counseling for unpaid caregivers must be aimed at assisting the unpaid caregiver in understanding and meeting the needs of the Participant and be documented in his/her service plan. Services are provided by a licensed psychologist, licensed social worker, licensed professional counselor, or a home health agency that employs them.

Counseling Services do not include group counseling serving multiple Participants.

- Nutritional Consultation services are services that assist individuals to improve functioning and independence and are necessary to improve the individual's inclusion in their community. Services are provided by professionals and/or paraprofessionals in nutritional counseling. The service may include initial assessment and reassessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the Participant, caregiver and any providers in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Nutritional Consultation assists the Participant and/or their paid and unpaid caregivers in developing a diet and planning meals that meet the Participant's nutritional needs, while avoiding any problem foods that have been identified by a physician. Services include counseling performed by a Registered Dietitian or a Certified Nutrition Specialist. The purpose of Nutritional Consultation services is to improve the ability of Participants, paid and/or unpaid caregivers and Providers to carry out nutritional interventions. Nutritional counseling services are limited to ninety (90) minutes (six (6) units) of nutritional consultations per month. Plans may exceed the ninety (90) minute limit at their discretion and own cost. Home health agencies that employ licensed and registered dietitians may provide nutritional counseling.

This service requires a recommendation by a physician.

- Behavior Therapy services are services that assist individuals to improve functioning and independence and are necessary to improve the individual's inclusion in their community. Services include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan; and the provision of training to individuals, family Participants and direct service Providers. Services include consultation, monitoring the implementation of the behavioral support plan and revising the plan as necessary. This service may be delivered in the individual's home or in the community as described in the service plan.

Behavior Therapy services are provided by professionals and/or paraprofessionals in behavior management, including a licensed psychologist, licensed social worker, licensed behavior specialist, licensed professional counselor, or a home health agency that employs them. Individuals with a master's degree in social work, psychology, education, counseling, or a related human services field who are not licensed or certified may practice under the supervision of a practitioner who is licensed.

Services must be provided at a 1:1 ratio.

Vehicle Modifications

Vehicle modifications are modifications or alterations to an automobile or van that is the Participant's means of transportation in order to accommodate the special needs of the Participant. Vehicle modifications are modifications needed by the Participant, as specified in the service plan and determined necessary in accordance with the Participant's assessment, to ensure the health, welfare and safety of the Participant and enable the Participant to integrate more fully into the community. The vehicle that is modified may be owned by the Participant, a family member who provides primary support to the Participant and is not a paid provider agency of services.

The following are specifically excluded:

- Modifications or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the Participant, and

- Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications.

The waiver cannot be used to purchase vehicles for Participants, their families or legal guardians; however, this service can be used to fund the portion of a new or used vehicle purchase that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation is required to be provided by a vehicle modifications contractor.

Vehicle modifications funded through the waiver are limited to the following: vehicular lifts, portable ramps when the sole purpose of the ramp is for the Participant to access the vehicle, interior alterations to seats, head and leg rests and belts, and customized devices necessary for the Participant to be transported safely in the community, including driver control devices, modifications needed to accommodate a Participant's special sensitivity to sound, light or other environmental conditions, raising the roof or lowering the floor to accommodate wheelchairs. The vehicle cannot exceed five (5) calendar years old, and must have less than 50,000 miles for vehicle modification requests over \$5,000.00. All vehicle modifications shall meet applicable standards of manufacture, design and installation. A vehicle is required to have passed all applicable State standards.

This service does not include, but requires, an independent evaluation. Vehicle Modifications must be obtained in the least expensive, most cost-effective manner. Participants receiving Vehicle Modifications cannot be authorized for Residential Habilitation services during the same time period.

Depending on the type of modification, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by a licensed occupational therapist, physical therapist, or Mobility Specialist meeting all applicable Department standards, including regulations, policies, and procedures relating to provider qualifications. Such assessments may be covered through another waiver service or the State Plan, as appropriate.

Provider Reporting Requirements for Missed Visits

The Community HealthChoices (CHC) Agreement, Section V.A.2, V.J, VIII.D. Exhibit A, and Exhibit W(1), requires all CHC Managed Care Organizations (MCOs) and its providers to report, on a monthly basis, all CHC Participants who utilize home health skilled care, home health aide services and/or Personal Assistance Services (PAS) and have a missed service during the reporting month.

- This report identifies all services that were not delivered for selected reason codes for Participants who utilize home health skilled care, home health aide services and/or PAS.
- Data is gathered on all CHC Participants who utilize home health skilled care, home health aide services and/or PAS services for selected reason codes.

- Reporting missed shifts (also known as missed visits) is one way to identify potential gaps in care to help ensure Participant health and safety and that care needs were able to be met.

Providers are required to report all missed services for Participants who utilize **home health skilled care, home health aide services and/or Personal Assistance Services (PAS)** according to the reporting instructions outlined below.

- All missed visits must be reported timely and accurately by Providers.
 - Entered in HHAeXchange (HHA) within 24-48 hours of the shift being missed.
 - Missed visits should NOT be reported if there is no active service authorization for the date(s) of the missed visit(s).

What is a missed visit?

- A shift of home health skilled care, home health aide services and/or PAS services that is authorized and scheduled but not rendered.
- Service Codes that must be reported:
 - Personal Assistance Services (W1793)
 - Home Health Aide (T2025)
 - Skilled Nursing – RN (T1002 SE)
 - Skilled Nursing – LPN (T1003 SE)
- The following must be clearly noted as part of the comments in the missed shift report:
 - Planned hospitalization(s)
 - Nursing facility stay(s)
 - Rehabilitation stay(s)
 - Shifts that are covered by a different direct care worker (DCW)

Missed Shift Reason Codes and Definition

- **AR** - Participant refused/declined a visit. This can also be used for doctor appointments, when family is visiting, or when Participant does not need/want coverage.
- **HU** - Unplanned hospitalizations only (pre-scheduled procedures and doctor appointments do not fall under this category).
- **UN** - Agency unable to staff. If ANOTHER agency is handling the visit instead, then the visit is NOT missed and should be removed from reporting in HHAeXchange.

COVID-19 Specific Reason Codes

Note: If the missed visit does not have to do with COVID-19 specifically, do not use the codes below.

- **IS** - Participant does not want caregivers in the home other than informal supports due to COVID-19.
- **SI** - Participant is self-isolating due to COVID-19 and does not want any services during this time.

- **FA** - Participant is in the hospital or nursing facility due to a COVID-19 diagnosis.
- **TX** - Worker was switched to cover another case due to COVID-19.
 - **CV** - Any other COVID-19 related issue not covered above. Should only be used in RARE circumstances.

Missed Shift Details

Comments Section

Additional details are required, regardless of the reason for the missed visit and for all missed visits. Provider comments must succinctly describe the circumstances of the missed visit.

- Reason visit was missed.
- Back-up plan that was put into place.
- How care needs were met.
- Who met the Participant's care needs.
- Identify actions taken to resolve issue(s) and whether the issue(s) has been resolved
- For skilled nursing services, the following must be addressed:
 - How was the Participant's health and safety ensured when missing several days of skilled nursing services?
 - Provide clarification if family members(s), backup plan person, and/or informal supports are able, willing, and trained to provide nursing services when the RN/LPN (s) is unable to provide such services.

Health and Safety Risk

When completing health and safety risk information in the missed shift report:

- Answer Yes only if the missed shift caused the health and safety issue.
- Answer No for all others.

Examples:

- Participant is hospitalized due to a stroke:
 - Health and safety would be NO because the lack of direct care worker (DCW) did not cause the stroke (which is a medical event).
- Participant falls in the shower and breaks hip after trying to get in alone since DCW did not come:
 - Health and safety would be YES because if the DCW had been there it is likely Participant would not have fallen or tried to get in shower alone.
- Include the Enterprise Incident Management (EIM) # that was created for the timeframe when the missed shift occurred regardless of whether health and safety is answered Yes or No.
 - Confirm you have entered the correct EIM # for the correct timeframe.
 - DO NOT enter made up or incorrect EIM #s.
 - Ensure the discovery date (date you became aware) and the incident date (date the health and safety issue occurred) are correct.

Reporting Missed Shifts in HHA

If Caregiver does not provide service for scheduled visit or Participant cancels visit, Provider can flag that as Missed Visit under the Visit Info Tab of the visit.

Once flagged as a Missed Visit, Provider will be required to enter supporting information for documentation by the MCO and the state. Fields required include:

- EIM (Yes/No)
- EIM Number (free text)
- Health and Safety (Y/N)
- MAID
- Reason for Missed visit (select from dropdown)
- Action Taken (select from dropdown)
- Any additional notes (free text)

Section III: Referral & Authorization Requirements



Referral Requirements

When a PCP determines the need for medical services or treatment, which will be provided outside the office, he/she must approve and/or arrange referrals to a participating Specialist, hospital or other outpatient facility. Although specialty services will not require a referral form, The Plan expects that primary care and specialty care physicians will continue to follow and engage in a coordination of care process, in accordance with applicable laws, that includes communication and sharing of information regarding findings and proposed treatments.

The primary care physician may write a prescription, call, send a letter or fax a request to the specialist. The referral to the specialist must be documented in the Participant's medical record. The referring practitioner should communicate all appropriate clinical information directly to the specialist without involving the Participant. Out-of-Network Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) health care Provider may refer a Participant who is an Indian to a Keystone First CHC network Provider as defined in 42 CFR § 438.14(a).

Services Requiring a Referral

- Initial visits to a Specialist*/hospital or other outpatient facility

Services Not Requiring a Referral (Participant Self-Referral)

- Prenatal OB visits
- Routine OB/GYN visits
- Routine Family Planning Services. Participants may go to any doctor or clinic of their choice to obtain Family Planning Services
- Routine Eye Exams **
- Routine Dental Services
- Tobacco Cessation Counseling
- Emergency Services including emergency transportation
- Behavioral Health, Drug and Alcohol treatment (a list of Behavioral Health Providers is located in Section of the Manual)
- Initial Chiropractic Visit/Evaluation
- The following Diagnostic Tests performed on an outpatient basis with a prescription- Routine Mammograms, Chest X-rays, Ultrasounds, Non-Stress Tests, Pulmonary Function Tests (Please refer to the Prior Authorization list in this section of the Manual for a list of radiological procedures that require Prior Authorization)
- Pre-Admission Testing and Stat Lab Services
- Diagnostic Tests and Procedures performed in a Short Procedure Unit, Ambulatory Surgery Center or Operating Room****
- Routine lab work with a prescription

* For Participants with a life-threatening, degenerative or disabling disease or condition, or Participants with other Special Needs, a standing referral may be available. For more information

on obtaining standing referrals, please contact the Provider Services department at 1-800-521-6007.

** Some Specialty Eye Care Services may require a referral. See "Ophthalmology Services" in this Section in the Manual.

*** See "Dental Services" in this section of the Manual.

**** A referral is not necessary but Prior Authorization is required for the following:

- Steroid injections or blocks administered for pain management
- Gastroplasty
- Ligation and Stripping of Veins
- All non-emergent plastic or cosmetic procedures, other than those immediately following traumatic injury, including but not limited to, the following:
 - Blepharoplasty
 - Reduction Mammoplasty
 - Rhinoplasty

Referral Process

When a PCP determines the need for medical services or treatment, which occurs outside the PCP office, he/she must approve and/or arrange referrals to a participating Specialist, hospital or other outpatient facility.

Keystone First CHC is required to comply with requirements outlined by the Affordable Care Act (ACA)§42 CFR 455 and the Pennsylvania Department of Human Services (DHS) require that all providers, including those who order, refer or prescribe items or services for Keystone First Participants, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02) outlining all requirements can be accessed on the Keystone First CHC Provider website at <https://www.keystonefirstchc.com/providers/communications/dhs-bulletins-and-news.aspx>.

Keystone First CHC will use the NPI of the ordering, referring or prescribing Provider included on the rendering Provider's claim to validate the Provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering Provider will be denied if it is submitted without the ordering/prescribing/referring Provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA Provider.

Resources – DHS offers a Medical Assistance Enrolled Provider Lookup Function

The DHS lookup function allows enrolled Providers to verify that their colleagues who are ordering, prescribing or referring services are enrolled in the Pennsylvania MA program. Access the lookup function at the following link: <https://tinyurl.com/DHSPromise>.

The PCP should follow the steps outlined below prior to advising the Participant to access services outside of the office.

The PCP's office should:

- Verify Participant eligibility
- Determine if the needed service requires a referral or Prior Authorization from the Plan (See "Services Requiring Referrals and Prior Authorization" in this section of the Manual)
- Select a participating Specialist/ hospital or other outpatient facility appropriate for the Participant's medical needs from the specialist directory, as appropriate. There is also an online network Provider Directory with search capability at <https://www.keystonefirstchc.com/participants/eng/find-provider/index.aspx>. (If an appropriate network Provider is not listed in the network Provider directory please call Provider Services 1-800-521-6007 for assistance. See "Out-of-Plan Referrals" in this Section for additional information.)

How to refer a Participant to a participating Plan specialist:

The primary care physician may write a prescription, call, send a letter or fax a request to the specialist. The referral to the specialist must be documented in the Participant's medical record. The referring practitioner should communicate all appropriate clinical information directly to the specialist without involving the Participant. Provide the following information:

- Participant name and ID number.
- Reason for referral.
- Duration of care to be provided.
- All relevant medical information.
- Referring practitioner's name and the Plan's ID number.

The Specialist office should:

- Contact the PCP if the Participant presents at the office and there has been no communication or indication of the reason for the visit from the PCP.
- Provide the services indicated by the PCP.
- Communicate, in accordance with applicable laws, findings, test results and treatment plan to the Participant's PCP. The PCP and specialist should jointly determine how care should proceed, including when the Participant should return to the PCP's care.
- Contact the PCP if the Participant needs to be referred to another specialist for consultation, treatment, etc.

Claim payment is no longer tied to the presence of a referral; however, when submitting a claim for payment, the referring practitioner's information must be included in the appropriate boxes of the CMS-1500 form as required by CMS.

Approval of Additional Procedures

Additional Procedures Performed in the Specialist Office or Outpatient Hospital/Facility Setting

When a Specialist determines that additional diagnostic or treatment procedures are required during an office visit, the Specialist must first determine if the procedures require further Prior Authorization. See "**Prior Authorization Requirements**" in this section of the Manual.

If the procedure/treatment does require Prior Authorization, call the Utilization Management department **1-800-521-6622** for Prior Authorization. It is not necessary that the Specialist or

Participant re-contact the PCP office; however, the Specialist's office should inform the PCP of all diagnostic procedures, diagnostic tests and follow-up care prescribed for the Participant.

Additional Procedures Requiring Inpatient or SPU Admission

When the Specialist determines that additional medical or surgical procedures require an inpatient or SPU admission, the Specialist must first determine if the procedures require further Prior Authorization. See "Prior Authorization Requirements" in this section of the Manual. When a procedure does require Prior Authorization, the Specialist should contact the Plan's Utilization Management department at 1-800-521-6622 to obtain Prior Authorization. The admission will be reviewed for medical necessity and a case reference number will be assigned. Pre-approval for medical/surgical admissions may be requested directly by the attending specialist. It is not necessary that the Primary Care Practitioner (PCP) be contacted first, however, the Plan requires Specialists to maintain contact with the referring PCP regarding the Participant's status. Specialists should provide timely communication back to the Participant's PCP regarding consultations, diagnostic procedures, test results, treatment plan and required follow up care.

Follow-Up Specialty Office Visits

Although specialty services will not require a referral form, the Plan expects that primary care and specialty care physicians will continue to follow and engage in a coordination of care process, in accordance with applicable laws, that includes communication and sharing of information regarding findings and proposed treatments.

The Specialist office should:

- Contact the PCP if the Participant presents at the office and there has been no communication or indication of the reason for the visit from the PCP.
- Provide the services indicated by the PCP.
- Communicate, in accordance with applicable laws, findings, test results and treatment plan to the Participant's PCP. The PCP and specialist should jointly determine how care should proceed, including when the Participant should return to the PCP's care.
- Contact the PCP if the Participant needs to be referred to another specialist for consultation, treatment, etc.
- Claim payment is no longer tied to the presence of a referral; however, when submitting a claim for payment, the referring practitioner's information must be included in the appropriate boxes of the CMS-1500 form as required by CMS.

When the Specialist requires that the Participant be referred to another Specialist, either for evaluation and management or a diagnostic or treatment procedure, this visit must be approved by the Participant's PCP. Either the Specialist's office or the Participant should advise the PCP office of

the need for the follow up services. The PCP office should then follow the referral process. See "**Referral Process**" in this section of the Manual.

Out-of-Plan Referrals

Occasionally, a Participant's needs cannot be provided through the Plan's Network. When the need for "out-of-plan" services arises, the network Provider should contact the Utilization Management department. The Utilization Management department will make arrangements for the Participant to receive the necessary medical services with a Specialist of the Plan's choice in collaboration with the recommendations of the PCP. Every effort will be made to locate a Specialist within easy access to the Participant.

The Plan's Utilization Management department Telephone Number is **1-800-521-6622**.

If a Non-Participating Provider is approved, that Provider must obtain a Non-Participating Provider number in order to be reimbursed for services provided. The form for obtaining a Non-Participating Provider number can be obtained by calling Provider Services at **1-800-521-6007**.

To comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of Providers (Code of Federal Regulations: 42CFR, §455.410), all Providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made. This applies to non-participating out-of-state Providers as well.

Enroll by visiting: <https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx>.

Standing Referrals

For Participants with a life-threatening, degenerative or disabling disease or condition, or Participants with other Special Needs, a standing referral may be available. For more information on obtaining standing referrals, please contact the Provider Services department at **1-800-521-6007**.

For Participants with a life-threatening, degenerative, disabling disease or condition, or Participants with other Special Needs, a standing referral to a specialist may be available. In order to obtain a standing referral to a specialist for an on-going medical condition, the Participant and the Participant's PCP should discuss the need for a standing referral. The PCP can write a prescription, call, send a letter or fax a request to the specialist. The referral to the specialist must be documented in the Participant's medical record. The referring practitioner should communicate all appropriate clinical information directly to the specialist without involving the Participant.

When a PCP determines the need for medical services or treatment that will be provided outside the PCP office, he/she must approve and/or arrange referrals to a participating

Specialist. Although specialty services do not require a referral form, the Plan expects that primary care and specialty care physicians will continue to follow and engage in the coordination of care process in accordance with applicable laws, that includes communication and sharing of information regarding findings and proposed treatments.

If a Participant needs assistance with the standing referral process, they may call Participant Services at **1-855-332-0729**. Participants can also discuss this option with their Service Coordinator, if applicable. Providers may call Provider Services at **1-800-521-6007**.

Referrals/Second Opinions

Second opinions, or consultations, may be requested by a Participant, the PCP, or the Plan itself. The Plan provides for a second opinion from a qualified Provider within the Network, at no cost to the Participant. If a qualified Provider is not available within the Network, the Plan will assist the Participant in obtaining a second opinion from a qualified Provider outside the Network, at no cost to the Participant, unless co-payments apply. These services require a referral from the PCP. For more information, see the "**Referral Process**" in this section of this Manual for direction.

With respect to second opinion consultations, the following is highly recommended by the Plan:

- The selected consulting network Provider should be in a practice other than that of the attending network Provider
- The selected consulting network Provider should possess a different tax identification number than the attending network Provider
- The selected consulting network Provider should possess a similar medical degree or medical specialty in order to provide an unbiased, but informed medical opinion on the condition for which the consultation is being requested.

Prior Authorization Requirements

The most up-to-date listing of services requiring Prior Authorization can be found in the Provider Center at <https://www.keystonefirstchc.com/providers/resources/prior-auth.aspx> or in posted updates.

Services Requiring Prior Authorization

The following is a list of services requiring prior authorization review for medical necessity and place of service.

All LTSS services require prior authorization. Refer to the LTSS section of the manual for a complete list of these services.

- All elective (scheduled) inpatient hospital admissions, medical and surgical including rehabilitation
- All elective transplant evaluations and procedures
- Elective/non-emergent Air Ambulance Transportation
- All elective transfers for inpatient and/or outpatient services between acute care facilities
- Skilled nursing facility admission of nursing facility ineligible (NFI) Participants for alternate levels of care in a facility, either free-standing or part of a hospital, that accepts patients in need of skilled level rehabilitation and/or medical care that is of lesser intensity than that received in a hospital, not to include long term care placements. Providers must notify the plan within 48 hours of admission
- Select gastroenterology services
- Bariatric surgery

- Pain management services performed in a short procedure unit (SPU) or ambulatory surgery unit (either hospital-based or free-standing) and pain management services not on the Medical Assistance fee schedule performed in a physician's office require prior authorization.
- Cosmetic procedures regardless of treatment setting to include, but not limited to the following: reduction mammoplasty, gastroplasty, ligation and stripping of veins and rhinoplasty
- Outpatient Therapy Services (physical, occupational, speech)
 - Prior authorization is not required for an evaluation and up to 24 visits per discipline within a calendar year
 - Prior authorization is required for services exceeding 24 visits per discipline within a calendar year
- Cardiac and Pulmonary Rehabilitation
- Chiropractic services after the 24th visit
- Home Health Services
 - Prior authorization is not required for up to 18 home visits per modality per calendar year including: skilled nursing visits by a RN or LPN; Home Health Aide visits; Physical Therapy; Occupational Therapy and Speech Therapy; Home Respiratory Therapy; Mechanical Ventilation Care; Stoma Care and Maintenance, including Colostomy and Cystectomy and services of Clinical Social Workers in home health or hospice settings.
 - The duration of services may not exceed a 60-day period. The Participant must be re- evaluated every 60 days
 - Private Duty Nursing services
 - Injectables
 - Home Sleep Study
- DME
 - Home Accessibility DME (refer to the DME section of the manual for complete details)
 - Purchase of all items in excess of \$750
 - The rental or purchase of ALL wheelchairs (motorized and manual) and all wheelchair items (components) regardless of cost per item.
 - DME monthly rental items regardless of the per month cost/charge
 - Select wheelchair components
- Enterals
 - Prior authorization is required
- Diapers/Pull-ups:
 - Any request in excess of 300 per month for diapers or pull-ups or a combination of both.
 - Requests for brand specific diapers.
- Any service(s) performed by non-participating or non-contracted practitioners or Providers, unless the service is an emergency service
- All services that may be considered experimental and/or investigational

- Neurological Psychological Testing
- Genetic Laboratory Testing
- All miscellaneous/unlisted or not otherwise specified codes
- Any service/product not listed on the Medical Assistance Fee Schedule or services or equipment in excess of limitations set forth by the Department of Human Services fee schedule, benefit limits and regulation. (Regardless of cost, i.e., above or below the \$750 DME threshold)
- Radiology - The following services, when performed as an outpatient service, requires prior authorization by the Plan's radiology benefits vendor. Refer to the Radiology Services section for prior authorization details.
 - Positron Emission Tomography (PET)
 - Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiography (MRA)
 - Nuclear Cardiology /MPI
 - Computed Axial Tomography (CT/CTA/CCTA)
 - Emergency room, Observation Care and inpatient imaging procedures do not require Prior Authorization.
- Select prescription medications. For information on which prescription drugs require authorization, the Plan's Formulary can be found in the Provider Center at <https://www.keystonefirstchc.com/providers/pharmacy/index.aspx>.
- Select dental services. For information on which dental services require authorization, please refer to the Dental Services Section.
- Elective termination of pregnancy – Refer to the Termination of Pregnancy section for complete details.

Prior Authorization Lookup tool. This user-friendly resource allows users to enter a Current Procedural Terminology (CPT) or a Healthcare Common Procedure Coding System (HCPCS) code to verify authorization requirements in real time before delivery of service.

The Prior Authorization Lookup tool was designed to help reduce the administrative burden of calling Provider Services to determine whether prior authorization is required. The tool is easy to use and offers general information for outpatient services performed by a participating provider. To access the Prior Authorization Lookup tool, visit:

<https://www.keystonefirstchc.com/providers/resources/prior-authorization-lookup.aspx>.

Confirming authorization requirements is as simple as entering a CPT code or a HCPCS code and clicking "submit". The results of this tool are not a guarantee of coverage or authorization. All results are subject to change in accordance with plan policies and procedures.

Prior authorization is not a guarantee of payment for the service authorized. The Plan reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between the time authorization was issued and the time the service was provided

Reimbursement for all rendering Providers for an approved authorization is determined by satisfying the mandatory requirement to have a valid Pennsylvania Medicaid Provider ID. Claims

submitted by rendering Providers will be denied if the ordering, referring or prescribing provider is not enrolled in the Pennsylvania Medical Assistance program.

To check enrollment status of the practitioner ordering, referring or prescribing the service you are providing is enrolled in Medical Assistance visit the DHS Provider look-up portal at:

<https://tinyurl.com/DHSPromise>.

Participants with Medicare coverage may go to Medicare health care Providers of choice for Medicare covered services, whether or not the Medicare health care Provider has complied with the Plan's Prior Authorization requirements. The Plan's policies and procedures must be followed for Non-Covered Medicare services.

Policies and Procedures

Medically Necessary (also referred to as Medical Necessity)

Compensable under the MA Program and meeting any one of the following standards:

- Will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist a Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age.
- Will provide the opportunity for a Participant receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

Determination of medical necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective, or exception basis*, must be documented in writing.

The determination is based on medical information provided by the Participant, the Participant's family/caretaker and the PCP, as well as any other practitioners, programs, and/or agencies that have evaluated the Participant. All such determinations must be made by qualified and trained practitioners.

For information on Dental Program (Benefit) Exception, Please refer to the Dental Provider Supplement of this manual.

***Program (Benefit) Exception:** Providers, Participants and/or Providers on behalf of a Participant may request coverage for items or services that are included in the Participant's benefit package but are not currently listed on the Medical Assistance Program Fee Schedule.

Requests for these exceptions must be submitted to the Utilization Management department at **1-800-521-6622** and will follow the standard prior authorization process.

All requests that are considered an exception to Program will be forwarded to a Physician Reviewer to review for Medical Necessity.

Alerts

Benefit Limits and Copayments

There may be benefit limits or copayments associated with the services mentioned in this section. Please refer to the Participant Copayment Schedule located in this Manual or in the Provider Center at <https://www.keystonefirstchc.com/pdf/participants/copays.pdf>.

Authorization and Eligibility

Due to possible interruptions of a Participant's State Medical Assistance coverage, it is strongly recommended that Providers call for verification of a Participant's continued eligibility on the 1st 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 call the Plan's Utilization Management department to obtain Prior Authorization for continuation of service.

DHS Medical Assistance Program Services

The DHS Medical Assistance Program Services ensures requests for Medically Necessary care and services to the Plan and the appropriate BH-MCO are responded to in a timely manner. This service helps all Medical Assistance consumers who are enrolled in the Community HealthChoices Program.

Calls are answered by nurses who work for DHS. If a health care Provider or Participant requests medical care or services, and Keystone First CHC or the BH-MCO have not responded in time to meet the health care Provider or Participant's needs, call the Service. A health care Provider or Participant can call if Keystone First CHC or the BH-MCO has denied Medically Necessary care or services or will not accept a request to file a Grievance, or if they are having trouble getting shift home health services that have been authorized by Keystone First CHC.

The Service operates Monday through Friday between 9:00 a.m. and 5:00 p.m. To reach the Service call **1-800-537-8862**. The Service cannot provide or approve urgent or emergency medical care.

Ambulance

The Plan is responsible to coordinate and reimburse for **Medically Necessary** transportation by ambulance for physical, psychiatric or behavioral health services.

The Plan will assist Participants in accessing non-ambulance transportation services for physical health appointments through the Medical Assistance Transportation Program (MATP); however, the Plan is not financially responsible for payment for these services. Participants should be advised

to contact the BH-MCO in their county of residence for assistance in accessing non- ambulance transportation for behavioral health appointments.

County	MATP Service Phone Number
Bucks	215-794-5554 or 888-795-0740
Chester	484-696-3854 or 877-873-8415
Delaware	610-490-3960
Montgomery	215-542-7433
Philadelphia	877-835-7412

For the most up-to-date information about MATP or to contact your local MATP Provider, see link here: <http://matp.pa.gov/>.

Participants experiencing a medical emergency are instructed to immediately contact their local emergency rescue service - 911

The Plan has contracted with specific Ambulance Providers throughout the service area and will reimburse for Medically Necessary ambulance transportation services. For ambulance transportation to be considered Medically Necessary, one or more of the following conditions must exist:

- The Participant is incapacitated as the result of injury or illness and transportation by van, taxicab, public transportation or private vehicle is either physically impossible or would endanger the health of the Participant
- There is reason to suspect serious internal or head injury
- The Participant requires physical restraints
- The Participant requires oxygen or other life support treatment en route
- Because of the medical history of the Participant and present condition, there is reason to believe that oxygen or life support treatment is required en route
- The Participant is being transported to the nearest appropriate medical facility
- The Participant is being transported to or from an appropriate medical facility in connection with services that are covered under the MA Program
- The Participant requires transportation from a hospital to a non-hospital drug and alcohol detoxification facility or rehabilitation facility and the hospital has determined that the required services are not Medically Necessary in an inpatient facility

Behavioral Health Services

Behavioral Health Services, including all mental health, drug and alcohol services are coordinated through and provided by:

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE-By County		
County	Behavioral Health Plan	Phone Number
Bucks County	Magellan Behavioral Health	1-877-769-9784
Chester County	Community Care Behavioral Health	1-866-622-4228

Delaware County	Community Care Behavioral Health	1-833-577-2682
Montgomery County	Magellan Behavioral Health	1-877-769-9782
Philadelphia County	Community Behavioral Health	1-888-545-2600

Participants may self-refer for behavioral health services. However, PCPs and other physical healthcare Providers often need to recommend that a Participant access behavioral health services. The health care Provider or his/her staff can obtain assistance for Participants needing behavioral health services by calling the toll-free numbers noted above.

Cooperation between network Providers and the BH-MCOs is essential to assure Participants receive appropriate and effective care. Network Providers are required to:

- Adhere to state and Federal confidentiality guidelines for Participant medical records, including obtaining any required written Participant consents to disclose confidential mental health and drug and alcohol records.
- Refer Participants to the appropriate BH-MCO, once a mental health or drug and alcohol problem is suspected or diagnosed
- To the extent permitted by law, participate in the appropriate sharing of necessary clinical information with the behavioral health Provider including, if requested, all prescriptions the Participant is taking.
- Be available to the behavioral health Provider on a timely basis for consultation
- Participate in the coordination of care when appropriate
- Make referrals for social, vocational, educational and human services 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 Participant may receive appropriate support and services necessary to effectively treat the problem

The BH-MCO provides access to diagnostic, assessment, referral and treatment services including but not limited to:

- Inpatient and outpatient psychiatric services
- Inpatient and outpatient drug and alcohol services (detoxification and rehabilitation)

Participants do not have any copays for naloxone. When administered during an overdose, naloxone blocks the effects of opioids on the brain and restores breathing within two to eight minutes.

For Opioid Treatment resource information and resources, including state, local and plan resources, visit <http://www.keystonefirstchc.com/providers/resources/opioid/opioid-treatment.aspx>. Health care Providers may call the Plan's Participant Services department at **1- 855-332-0729** whenever they need help referring a Participant for behavioral health services.

Dental Services

Participants do not need a referral from their PCP and can choose to receive dental care from any Provider who is part of the dental network. Participant inquiries regarding covered dental services should be directed to the Plan's Participant Services department at **1-855-332-0729**.

All Participants have dental benefits. Providers with inquiries regarding covered dental services should call the Plan's Dental Provider Services at **1-877-408-0878**. Provider Services staff are available Monday-Friday 8:00 a.m. – 6:00 p.m.

Please refer to the Dental Provider Supplement of this manual for complete and detailed Dental procedures and policies.

Participant Dental Benefits

Dental services that are covered for participants include the following, when Medically Necessary:

- Cleanings
- X-rays
- Fillings
- Crowns and adjunctive services*
- Extractions
- Dentures *
- Surgical procedures*
- Anesthesia*
- Emergencies
- Periodontal*
- Endodontics (including Root Canals) *

*Prior Authorization is required and medical necessity must be demonstrated.

The Plan's dental benefits for Participants include:

- 1 dental exam and 1 cleaning per Provider or group every 180 days
- Re-cementing of crowns
- Pulpotomies to provide symptomatic relief of dental pain
- Dentures: one removable prosthesis per Participant, per arch, regardless of type (full/partial), per lifetime
 - If the Participant received a partial or full upper denture since April 27, 2015, paid for by the Plan, other MCO's, or the state's fee-for-service plan, he/she may be able to get another partial or full upper denture.

For any questions on eligibility or dental benefits, please contact the Plan's Provider Services department at **1-800-521-6007**.

Durable Medical Equipment

Please refer to the LTSS section of the manual for Exceptional DME benefit coverage.

Covered Services

The Plan Participants are eligible to receive Medically Necessary durable medical equipment (DME) needed for home use.

DME/Exceptional DME

DME/Exceptional DME Monthly Rentals:

- All DME monthly rental items regardless of the per month cost/charge
- The rental of ALL wheelchairs (motorized and manual) and all wheelchair items (components)

All DME monthly rental items regardless of the per month cost/charge or Participant age must be Prior Authorized. In addition, certain conditions apply to the following supplies:

Enteral Nutritional Supplements:

- Prior Authorization is required.

Diapers/pull-up diapers:

- Prior authorization is required for diaper/pull-up diapers if:
 - Participant needs more than 300 generic diapers and/or pull-up diapers per month.
 - Brand-specific diapers.

Home Accessibility DME

Home Accessibility Durable Medical Equipment (DME) is equipment and appliances that are used to serve a medical purpose and are generally not useful to a person without a disability, illness or injury. These items can withstand repeated use and can be reusable or removable.

Covered items include:

- Wheelchair lifts
- Stair glides
- Ceiling lifts
- Metal accessibility ramps
- Other items used by a member with a mobility impairment to enter and exit the home
- Are used to support activities of daily activities
- Are removable and reusable

Also covered are:

- Installation costs
- Medically necessary repairs to the equipment

- Parts or supplies recommended by the manufacturer
- Labor to attach or mount the item
- Required permits
- Installing an electrical outlet or connection to an existing electrical source
- Pouring a concrete slab or foundation
- External supports such as bracing a wall
- Removing/replacing an existing railing or banister as needed to accommodate the equipment

PCPs, Specialists and Hospital Discharge Planners are directed to contact the Plan's Utilization Management department at **1-800-521-6622**. Because Participants may lose eligibility or switch plans, DME Providers are directed to contact Participant Services for verification of the Participant's continued Medical Assistance eligibility and continued enrollment with the Plan when equipment is authorized for more than a one-month period of time. Failure to do so could result in Claim denials.

Occasionally, Participants require equipment or supplies that are not traditionally included in the MA Program. The Plan will reimburse participating DME network Providers based on their documented invoice cost or the manufacturer's suggested retail price for DME and medical supplies not covered by the MA Program but covered under Title XIX of the Social Security Act, provided that the equipment or service is Medically Necessary, and the network Provider has received prior authorization from the Plan. In order to receive Prior Authorization, the requesting network Provider can fax a letter of medical necessity to the Plan at **1-866-855-9841**. The letter of medical necessity must contain the following information:

- Participant's name
- Participant's ID number
- The item being requested
- Expected duration of use
- A specific diagnosis and medical reason that necessitates use of the requested item.

Each request is reviewed by the Plan's Physician Advisor. Occasionally, additional information is required, and the network Provider will be notified by the Plan of the need for such information. If you have questions regarding any DME item or supply, please contact the DME Unit at **1-800-521-6622** or the Provider Services department at **1-800-521-6007**.

Elective Admissions and Elective Short Procedures

In order for the Plan to monitor quality of care and utilization of services, all Providers are required to obtain Prior Authorization from the Utilization Management department **1-800-521-6622** for all non-emergency elective medical/surgical inpatient hospital admissions, as well as certain specific procedures performed in a SPU. See "Prior Authorization Requirements" earlier in this Section.

- In order to qualify for payment, Prior Authorization is mandatory for designated procedures done in a SPU and elective inpatient cases.
- The Plan will accept the hospital or the attending network Provider's request for Prior Authorization of elective inpatient hospital and/or designated SPU admissions, however, neither party should assume the other has obtained Prior Authorization.
- To prior authorize an elective inpatient or designated SPU procedure, practitioners are requested to contact the Utilization Management department at **1-800-521-6622**.
- The Prior Authorization request will be approved when medical necessity is determined.
- Procedures scheduled for the following calendar month can be reviewed for medical necessity; however, the Plan cannot verify the Participant's eligibility for the date of service. The network Provider is required to verify eligibility prior to delivering care. Contact the Provider Services department at **1-800-521-6007** or check eligibility online at www.navinet.net.
- SPU procedures, which have been prior authorized for a particular date, may require rescheduling. The SPU authorizations are automatically assigned a fourteen (14) day window (the scheduled procedure date plus thirteen 13 days during which a SPU procedure can be rescheduled without notifying the Plan). Should the rescheduled date cross a calendar month, the network Provider is responsible for verifying that the Participant is still eligible with the Plan before delivering care.

Denied Prior Authorization requests may be appealed to the Medical Director or his/her designee. See "Provider Dispute/Appeal Procedures; Participant Complaints, Grievances and Fair Hearings" in Section VIII of this Manual for information on how to file an appeal.

Note: Behavioral health admissions must be coordinated with the appropriate BH-MCO. Behavioral Health Services are provided by the appropriate BH-MCO. Please refer to the Referral & Authorization Section of the Manual for additional information on behavioral health services.

Emergency Admissions, Surgical Procedures and Observation Stays

Participants often present to the ER with medical conditions of such severity, that further or continued treatment, services, and medical management is necessary. In such cases, the ER staff should provide stabilization and/or treatment services, assess the Participant's response to treatment and determine the need for continued care. To obtain payment for services delivered to Participants requiring admission to the inpatient setting, the hospital is required to notify the Plan of the admission within 24 hours and provide clinical information to establish medical necessity within 48 hours. The Plan performs Concurrent Review of inpatient hospitalizations to assess the Medical Necessity of an inpatient stay based on the Participant's clinical information, to evaluate appropriate utilization of inpatient services, and promote delivery of quality care on a timely basis. An appropriate level of care, for an admission from the ER, may be any one of the following:

- ER Medical Care
- Emergency Surgical Procedure Unit (SPU) Service
- Emergent Observations Stay Services - Maternity & Other Medical/Surgical Conditions
- Emergency Inpatient Admission

- Emergency Medical Services

ER Medical Care

ER Medical Care is defined as an admission to the emergency department for an emergency medical condition where short-term medical care and monitoring are necessary.

Important Note: The Plan is prohibited from making payment for items or services to any financial institution or entity located outside of the United States and its territories.

All Providers, particularly emergency, critical care and urgent care Providers, must be alert for the signs of suspected abuse and neglect, and as mandatory reporters under the Adult Protective Services Law know their legal responsibility to report such suspicions.

Mandatory Abuse and Neglect Reporting

- All Providers are mandatory reporters of abuse and neglect, including:
- Assisted Living Facility
- Domiciliary Care Home
- Home Health Care Agency
- Intermediate Care Facility for Individuals with Intellectual Disabilities or with Other Related Conditions
- Nursing Facility
- Older Adult Daily Living Center
- Personal Care Home
- Residential Treatment Facility
- **An organization or group of people that uses public funds and is paid, in part, to provide care and support to adults in a licensed or unlicensed setting**

A report can be made on behalf of the adult whether they live in their home or in a care facility such as a nursing facility, group home, hospital, etc. Reporters may remain anonymous and have legal protection from retaliation, discrimination, and civil and criminal prosecution. The statewide Protective Services hotline is available 24 hours a day.

Adult Protective Services (APS)

For individuals 18 years of age or older but under 60 years of age

Contact Protective Services Hotline at **1-800-490-8505**

Older Adult Protective Services Act (OAPSA)

For individuals 60 years of age and older

Contact Protective Services Hotline at **1-800-490-8505**

In 2010, the APS Law, Act 70 of 2010, was enacted to provide protective services to adults between 18 and 59 years of age who have a physical or mental impairment that substantially limits one or more major life activities. The APS Law establishes a program of protective services in order to detect, prevent, reduce and eliminate abuse, neglect, exploitation and abandonment of adults in need.

The Older Adults Protective Services Act (OAPSA), which was amended by Act 13 of 1997, mandates reporting requirements on suspected abuse. Any employee or administrator of a facility who suspects abuse is mandated to report the abuse. All reports of abuse should be reported to the local Area Agency on Aging and licensing agencies. If the suspected abuse is sexual abuse, serious physical injury, serious bodily injury, or suspicious death as defined under OAPSA, the law requires additional reporting to the Department of Aging and local law enforcement.

DEFINITIONS OF ABUSE REQUIRING ADDITIONAL REPORTING:

- Sexual Abuse—intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest. Sexual Harassment requires reporting to the AAA only.
- Serious Physical Injury—an injury that causes a person severe pain or significantly impairs a person's physical functioning, either temporarily or permanently.
- Serious Bodily Injury—an injury which creates a substantial risk of death, or which causes serious permanent disfigurement or protracted loss or impairment of the function of a body Participant or organ.
- Suspicious Death—a death that would arouse suspicion or is questionable.

Facilities (Defined by OAPSA)

- Adult Daily Living Centers
- Personal Care Homes
- Assisted Living Residences
- Birth Centers
- Community Homes for Individuals with Mental Retardation
- Community Residential Rehabilitation Services
- Department of Human Services (DHS) Nursing Facilities
- DHS-licensed and DHS operated residential facilities for adults
- Domiciliary Care Homes
- Family Living Homes
- *Home Care Registry
- **Home Health Care Organization or Agency
- Hospices
- Intermediate Care Facilities for the Mentally Retarded (private and state)
- Long Term Care Nursing Facilities
- Long Term Structured Residences
- Personal Care Homes

- State Mental Hospitals

*A Home Care Registry or "Registry" is further defined to include those agencies licensed by the Department of Health any organization or business entity that supplies, arranges, or refers independent contractors to provide activities of daily living or instrumental activities of daily living or specialized care in the consumer's place of residence or other independent living environment for which the registry receives a fee, consideration or compensation of any kind.

**Home Health Care Agency is further defined to include those agencies licensed by the Department of Health and any public or private organization which provides care to a care- dependent individual in their place of residence.

Statewide Elder Abuse Hotline: 1-800-490-8505

Any person who believes that an older adult is being abused, neglected, exploited or abandoned may call the elder abuse hotline. The hotline is open 24 hours a day.

Emergency Medical Services

Emergency Room Policy

"An Emergency Medical Condition" is 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

Prior Authorization/Notification for ER Services/Payment:

The Plan does not require Prior Authorization or prior notification of services rendered in the ER. ER staff should immediately screen all Participants presenting to the ER and provide appropriate stabilization and/or treatment services. Reimbursement for Emergency Services will be made at the contracted rate. The Plan reserves the right to request the emergency room medical record to verify the Emergency Services provided.

PCP Contact Prior to ER Visit

A Participant should present to the ER after contacting his/her PCP. Participants are encouraged to contact their PCP to obtain medical advice or treatment options about conditions that may/may not require ER treatment. Prior Authorization or prior notification of services rendered in the ER is not required.

Authorization of Inpatient Admission Following ER Medical Care

If a Participant is admitted as an inpatient following ER Medical Care, a separate phone call is required to the Utilization Management department at **1-800-521-6622** for authorization or electronically through NaviNet Provider Portal, Medical Authorizations o within 24 hours of admission. See the Provider Services section of the manual for details on how to access Medical Authorizations through NaviNet. The facility staff should be prepared to provide information to support the need for continued inpatient medical care beyond the initial stabilization period within 48 hours of admission. The information should include treatment received in the ER; the response to treatment; result of post-treatment diagnostic tests; and the treatment plan. All ER charges are to be included on the inpatient billing form. Reimbursement for authorized admissions will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER Services. The inpatient case reference number should be noted on the bill.

Post-Stabilization Services

The Plan will cover Post-Stabilization Services.

The Plan will cover Post-Stabilization Services without authorization, and regardless of whether the Participant obtains the services with a participating or non-participating Provider if any of the following situations exists:

- The Post-Stabilization Services were administered to maintain the Participant's stabilized condition within one (1) hour of the Provider's request to the Plan for pre- approval of Post-Stabilization Services.
- The Post-Stabilization Services were not pre-approved by the Plan because the Plan did not respond to the Provider's request for pre-approval of the Post-Stabilization Services within one (1) hour of the request.
- The Post-Stabilization Services were not pre-approved by the plan because the Provider could not reach the plan to request pre-approval.
- The Plan and the treating physician could not reach an agreement concerning the Participant's care and a Plan physician is not available for consultation. In this situation, the Plan must give the treating physician the opportunity to consult with a Plan physician, and the treating physician may continue with the care of the Participant until a plan physician is reached or one of the criteria applicable to termination of a Plan financial responsibility described below is met.

Financial responsibility for Post-Stabilization Services that the Plan has not pre-approved ends when:

- A network physician with privileges at the treating hospital assumes responsibility for the Participant's care;
- A network physician assumes responsibility for the Participant's care through transfer;
- The CHC-MCO and the treating physician reach an agreement concerning the Participant's care; or

- The Participant is discharged.

Emergency SPU Services

When trauma, injury or the progression of a disease is such that a Participant requires:

- Immediate surgery, and
- Monitoring post-surgery usually lasting less than twenty-four (24) hours, with
- Rapid discharge home, and
- Which cannot be performed in the ER

The ER staff should provide Medically Necessary services to stabilize the Participant and then initiate transfer to the SPU.

Authorization of Emergency SPU Services

Prior Authorization of an Emergency SPU service is not required. However, the hospital is responsible for notifying the Plan's Utilization Management department within forty-eight (48) hours or by the next business day following the date of service (whichever is later) for all Emergency SPU Services. Notification can be given either by phone or fax, utilizing the Hospital Notification of Emergency Admissions Form (See the Appendix of the Manual for the form).

Authorization of Inpatient Admission Following Emergency SPU Services

If a Participant is admitted as an inpatient following Emergency SPU Services, notification is required to the Utilization Management department at **1-800-521-6622** for authorization, or electronically through Medical Authorizations on the NaviNet Provider Portal. See the Provider Services section of the manual for details on how to access Medical Authorizations through NaviNet within 24 hours. The facility clinical staff should be prepared to provide additional information to support the need for continued medical care beyond 24 hours such as: procedure performed, any complications of surgery, and immediate post-operative period vital signs, pain control, wound care etc. All ER and SPU charges are to be included on the inpatient billing form. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER and/or SPU services. The inpatient case reference number should be noted on the bill.

Emergent Observation Stay Services

The Plan considers Observation Care to be an outpatient service. Observation Care is often initiated as the result of a visit to an ER when continued monitoring or treatment is required.

Observation Care can be broken down into two categories:

- Maternity Observation, and
- Medical Observation (usually managed in the outpatient treatment setting)

Maternity/Obstetrical Observation Stay

A Maternity Observation Stay is defined as a stay for the monitoring and treatment of patients with medical conditions related to pregnancy not requiring admission, including but not limited to:

- Symptoms of premature labor
- Abdominal pain
- Abdominal trauma
- Vaginal bleeding
- Diminished or absent fetal movement
- Premature rupture of membranes (PROM)
- Pregnancy induced hypertension/Preeclampsia
- Hyperemesis
- Gestational Diabetes

Participants presenting to the ER with medical conditions related to pregnancy should be referred, whether the medical condition related to the pregnancy is an emergency or non-emergency, to the Labor and Delivery Unit (L & D Unit) for evaluation and observation. **Authorization is not required for Maternity/Obstetrical Observation at participating facilities. These services should be billed with Revenue Codes 720 – 729.**

ER Medical Care rendered to a pregnant Participant that is unrelated to the pregnancy should be billed as an ER visit, regardless of the setting where the treatment was rendered, i.e., ER, Labor & Delivery Unit or Observation. Refer to "Claims Filing Instructions" referenced in the appendix of the Manual for Claim submission procedures. The Plan claims filing instructions can be found at <https://www.keystonefirstchc.com/providers/claims-billing/index.aspx>

Authorization of Inpatient Admission Following OB Observation

If a Participant is admitted after being observed, notification is required to the Utilization Management department at **1-800-521-6622** for authorization, or electronically through Medical Authorizations on the NaviNet Provider Portal. See the Provider Services section of the manual for details on how to access Medical Authorizations through NaviNet within 24 hours. If the hospital does not have an L&D Unit, the hospital ER staff will include in their medical screening a determination of the appropriateness of treating the Participant at the hospital versus the need to transfer to another facility that has an L&D Unit, as well as Level II (Level III preferred) nursery capability. For Participants who are medically stable for transfer and who are not imminent for delivery, transfers are to be made to the nearest Plan-participating hospital. Hospitals where Participants are transferred should have an L&D Unit, Perinatology availability, as well as Level II (Level III preferred) nursery capability. In situations where the presenting hospital does not have an L&D Unit and transfer needs to occur after normal business hours or on a weekend, the hospital staff should facilitate the transfer and notify The Plan's Patient Care Management department via a phone call or fax the first business day following the transfer.

A case reference number will be issued for the inpatient stay, which conforms to the protocols of this policy and Participant eligibility. All ER and Observation Care charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER and/or Observation Stay Services. The inpatient case reference number should be noted on all Claims related to the inpatient stay.

Lack of timely notification may result in a Denial of Services. For information on appeal rights, please see "Provider Dispute/Appeal Procedures; Participant Complaints, Grievances and Fair Hearings" in Section VIII of the Manual.

Medical Observation Stay

A Medical Observation Stay is defined by clinical status of the patient not length of hospital time that determines observation stay. Observation level of care may be considered for patients with medical conditions including, but not limited to:

- Head Trauma
- Chest Pain
- Post trauma/accidents
- Sickle Cell disease
- Asthma
- Abdominal Pain
- Seizure
- Anemia
- Syncope
- Pneumonia

Participants presenting to the ER with Emergency Medical Conditions should receive a medical screening examination to determine the extent of treatment required to stabilize the condition. The ER staff must determine if the Participant's condition has stabilized enough to warrant a discharge or whether it is medically appropriate to transfer to an "observation" or other "holding" area of the hospital, as opposed to remaining in the ER setting. **Authorization is not required for a Medical Observation Stay.**

Authorization of Inpatient Admission Following Medical Observation

If a Participant is admitted as an inpatient following a Medical Observation Stay, notification is required to the Utilization Management department at 1-800-521-6622 for authorization or electronically through Medical Authorizations on the NaviNet Provider Portal within 24 hours. See the Provider Services section of the manual for details on how to access Medical Authorizations through NaviNet. The Hospital ER or Observation unit staff should include in their medical screening a determination of the appropriateness of treating the Participant as an inpatient versus retention in the Observation Care setting of the facility. If the Participant is admitted as an inpatient, all ER and Observation charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no

separate payment for the ER and/or Observation Stay Services. The inpatient care case reference number should be noted on all Claims related to the inpatient stay.

Emergency Inpatient Admissions

Emergency Admissions from the ER, SPU or Observation Area

If a Participant is admitted after being treated in an Observation, SPU or ER setting of the hospital, the hospital is responsible for notifying the Plan's Utilization Management department within 24 hours or by the next business day (whichever is later) following the date of service (admission). Notification can be given either by phone 1-800-521-6622 or fax 1-855-332-0991 utilizing the Hospital Notification of Emergency Admissions form. The form can be found in the Provider Forms section on <https://www.keystonefirstchc.com/providers/manual-forms/index.aspx> or electronically through Medical Authorizations on the NaviNet Provider Portal. See the Provider Services section of the manual for details on how to access Medical Authorizations through NaviNet. The Observation, SPU or ER charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the Observation, SPU or ER services. The inpatient case reference number should be noted on the bill.

Lack of timely notification may result in a Denial of Services. For information on appeal rights, please see "Provider Dispute/Appeal Procedures; Participant Complaints, Grievances and Fair Hearings" in Section VIII of the Manual.

Utilization Management Inpatient Stay Monitoring

The Utilization Management (UM) department is mandated by the department of Human Services to monitor the progress of a Participant's inpatient hospital stay. This is accomplished by the UM department through the review of appropriate Participant clinical information from the Hospital. Hospitals are required to provide the Plan, within two (2) business days from the date of a Participant's admission (unless a shorter timeframe is specifically stated elsewhere in this Provider Manual), all appropriate clinical information that details the Participant's admission information, progress to date, and any pertinent data.

As a condition of participation in the Plan's Network, Providers must agree to the UM department's monitoring of the appropriateness of a continued inpatient stay beyond approved days, according to established criteria, under the direction of the Plan's Medical Director. As part of the concurrent review process and in order for the UM department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the Plan must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

Emergency Services Provided by Non-Participating Providers

The Plan will reimburse health care Providers who are not enrolled with the Plan when they provide Emergency Services for a Plan Participant. * However, to comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of Providers (Code of Federal Regulations: 42CFR, §455.410), all Providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made. This applies to non- participating out-of-state Providers as well.

Enroll by visiting: <https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx>

Keystone First CHC will use the NPI of the ordering, referring or prescribing Provider included on the rendering Provider's claim to validate the Provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering Provider will be denied if it is submitted without the ordering/prescribing/referring Provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA Provider.

The health care Provider must obtain a Non-Participating Plan Provider number in order to be reimbursed for services provided. The form for obtaining a Non-Participating Provider number can be obtained by calling Provider Services at **1-800-521-6007**.

Non-Participating Providers can find the complete Non-Participating Emergency Services Payment Guidelines in the Appendix of the on-line Provider Manual in the Provider Center of www.keystonefirstchc.com.

Please note that applying for and receiving a non-participating Provider number after the provision of Emergency Services is for reimbursement purposes only. It does not create a participating Provider relationship with the Plan and does not replace Provider enrollment and credentialing activities with the Plan (or any other health care plan) for new and existing network Providers.

*Important Note: The Plan is prohibited from making payment for items or services to any financial institution or entity located outside of the United States and its territories.

Family Planning

Participants are covered for Family Planning Services without a referral or Prior Authorization from the Plan. Participants may self-refer for routine Family Planning Services and may go to any physician or clinic including physicians and clinics not in the Plan's Network. Participants that have questions or need help locating a Family Planning Services Provider can be referred to Participant Services at **1-855-332-0729**.

The Plan Participants are entitled to receive family planning services without a referral or co- pay, including:

- Medical history and physical examination (including pelvic and breast)
- Diagnostic and laboratory tests
- Drugs and biologicals
- Medical supplies and devices
- Counseling
- Continuing medical supervision
- Continuing care and genetic counseling

Infertility diagnosis and treatment services, including sterilization reversals and related office (medical or clinical) drugs, laboratory, radiological and diagnostic and surgical procedures are not covered.

Sterilization

Sterilization is defined as any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing.

A Participant seeking sterilization must voluntarily give informed consent on the Department of Human Services' Sterilization Consent Form (MA 31 form). The informed consent must meet the following conditions:

- The Participant to be sterilized is at least 21 years old and mentally competent. A mentally incompetent individual is a person who has been declared mentally incompetent by a Federal, State or local court of competent jurisdiction unless that person has been declared competent for purposes which include the ability to consent to sterilization.
- The Participant knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure
- The Participant was counseled on alternative temporary birth control methods
- The Participant was informed that sterilization is permanent in most cases, but that there is not a 100% guarantee that the procedure will make him/her sterile
- The Participant giving informed consent was permitted to have a witness chosen by that Participant present when informed consent was given
- The Participant was informed that their consent can be withdrawn at any time and there will be no loss of health services or benefits
- The elements of informed consent, as set forth on the consent form, were explained orally to the Participant
- The Participant was offered language interpretation services in the Participant's preferred language, if necessary, or other interpretation services if the Participant is blind, deaf or otherwise disabled
- The Participant must give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of emergency abdominal surgery) but not more than 180 calendar days before the date of the sterilization. In the case of premature delivery, informed consent must have been given at least 30 days before the expected date of delivery. A new consent form is required if 180 days have passed before the sterilization procedure is provided.

DHS's Sterilization Consent Form must accompany all claims for reimbursement for sterilization services. The form must be completed correctly in accordance with the instructions. The claim and consent forms will be retained by the Plan.

Submit claims to:

Keystone First Community Health Choices
Family Planning
P.O. Box 7146
London, KY 40742

Home Health Care

The Plan encourages 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 avoid unnecessary admissions of Participants who could effectively be treated at home
- To allow Participants to receive care when they are homebound, meaning their condition or illness restricts their ability to leave their residence without assistance or makes leaving their residence medically contraindicated.

Home health care should be utilized for the following types of services:

- Skilled Nursing
- Infusion Services
- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Medical Social Worker
- Home Dietician Therapy

The Plan's Special Care/Care Management department will coordinate Medically Necessary home care needs with the PCP, attending specialist, hospital home care departments and other Providers of home care services. Contact the Plan's Utilization Management department at 1- 800-521-6622. For Home Infusion care, please call 1-800-561-6622.

Due to possible interruptions of the Participant's State Medical Assistance coverage, it is strongly recommended that Providers call for verification of the Participant's continued eligibility the 1st of each month. If the need for service extends beyond the initial authorized period, the Provider must call The Plan's Utilization Management department to obtain authorization for continuation of service.

Hospice Care

If a Participant requires hospice care, the PCP should contact the Plan's Utilization Management department. The Plan will coordinate the necessary arrangements between the PCP and the hospice Provider in order to ensure receipt of Medically Necessary care. The Plan's **Utilization Management department Telephone Number is 1-800-521-6622.**

Hospital Transfer Policy

When a Participant presents to the ER of a hospital **not participating** with the Plan **and the Participant requires admission to a hospital**, the Plan may require that the Participant be stabilized and transferred to a Plan-participating hospital for **admission**. When the medical condition of the Participant requires admission for stabilization, the Participant may be admitted, stabilized, and then transferred within twenty-four (24) hours of stabilization to the closest Plan-participating facility.

Elective inter-facility transfers must be prior authorized by the Plan's Utilization Management department at 1-800-521-6622.

These steps must be followed by the health care Provider:

- Complete the authorization process
- Approve the transfer
- Determine prospective length of stay
- Provide clinical information about the patient

Either the sending or receiving facility may initiate the Prior Authorization; however, the original admitting facility will be able to provide the most accurate clinical information. Although not mandated, if a transfer request is made by a Plan-participating facility, the receiving facility may request the transferring facility obtain the Prior Authorization before the case will be accepted. When the original admitting facility has obtained the Prior Authorization, the receiving facility should contact the Plan to confirm the authorization, obtain the case reference number and provide the name of the attending health care Provider.

In emergency cases, notification of the transfer admission is required within forty-eight (48) hours or by the next business day (whichever is later) by the receiving hospital. Lack of timely notification may result in a denial of service.

Within 24 hours of notification of inpatient stay, the hospital must provide a comprehensive clinical review, initial assessment and plans for discharge.

Hysterectomies

A hysterectomy is defined as a surgical procedure in which all or part of the uterus is removed.

The Patient Acknowledgement for Hysterectomy (MA 30) must be attached to the claim when a Provider is submitting a claim form for a beneficiary who received a hysterectomy. The informed consent must meet the following conditions:

Medical necessity criteria must be met in order to perform a hysterectomy and all elective (scheduled) inpatient hospital admissions medical and surgical, including rehabilitation, require prior authorization.

DHS's Sterilization Consent Form must accompany all claims for reimbursement for hysterectomy services. The form must be completed correctly in accordance with the instructions. The claim and consent forms will be retained by the Plan.

Submit claims to:

Keystone First Community HealthChoices
P.O. Box 7146
London, KY 40742

Medical Supplies

Certain medical supplies are available with a valid prescription through the Plan's medical benefit and are provided through participating pharmacies and durable medical equipment (DME) suppliers. Such as:

- Vaporizers (one per 365 days)
- Humidifiers (one per 365 days)
- Diapers/Pull-Up Diapers (incontinence supplies) request in excess of 300 per month for diapers or pull-ups or a combination of both require Prior Authorization.
- Diabetic supplies
 - Insulin, disposable insulin syringes and needles
 - Disposable blood and urine testing agents
 - Blood Glucose Monitor (one per 365 days).
 - Please refer to the Pennsylvania Department of Human Services Statewide Preferred Drug List (PDL) for the current preferred products and quantity limits.
 - Lancets, control solution and strips.
 - Some continuous glucose monitors (CGMs) and supplies.
 - Glucose tablets, alcohol swabs (150 per 34 days).
- Blood pressure monitors less than \$80 are covered by the Plan with a prescription through the pharmacy benefit. Coverage is currently limited to one (1) unit per 365 days. Requests that exceed these limits should be referred to the prior authorization department for medical necessity review.
- Spacers are covered under the Plan's pharmacy benefit. Quantity limits are two per 365 days. Requests that exceed these limits should be referred to the prior authorization department for medical necessity review.

- Peak flow meters (one per 365 days). Requests that exceed these limits should be referred to the prior authorization department for medical necessity review.
- For current price and quantity limits, or to request school supply or replacement of a lost device, contact Pharmacy Services at **1-866-907-7088**.

Nursing Facility

Covered Services

If a Participant needs to be referred to a Nursing Facility, the PCP or representative from the transferring hospital should contact the Plan's Utilization Management department. The Plan will coordinate necessary arrangements between the PCP, the referring facility, the Nursing Facility, and the Options Assessment Program in order to provide the needed care.

The Options Assessment Program was implemented by DHS to identify individuals who are reviewed by the Options Assessment Unit and considered eligible for long-term care using two criteria: (1) must be over 18 years of age and (2) meet the criteria for nursing home level of care. Once the Options Assessment is completed Participants may qualify for long-term care if they have multiple needs, which may include severe mental health conditions; severe developmental delays/Mental Retardation conditions; paraplegia/quadruplegia; elderly. The Plan is not responsible for providing or paying for the Options Assessment. Network Providers are responsible for contacting the Area Agency on Aging to initiate an Options Assessment for a Participant in need of long-term care in a nursing home. The phone numbers for the Area Agencies on Aging can be found at: <http://www.aging.pa.gov/local-resources/Pages/AAA.aspx>

The Plan will cover therapeutic leave and reserve bed days according to PA Code 55, Chapter 1187.104.

To report admission of a Participant, Nursing Facilities should call the Plan's Utilization Management department within 48 hours of admission. Nursing Facilities can also fax notification of admission to **1-855-540-7068**. In the event that verification is subsequently needed to document that the Nursing Facility notified the Plan of the admission of one of its Participants, the Nursing Facility should follow up on the initial contact to the Plan with written correspondence to:

Keystone First Community HealthChoices
Utilization Management Department
200 Stevens Drive
Philadelphia, PA 19113

Obstetrical/Gynecological Services

Direct Access

Female Participants may self-refer to a participating general OB/GYN Provider for routine OB/GYN visits. A referral from the Participant's PCP is not required.

Bright Start® Maternity Program Overview

The Plan offers a perinatal Care Management program, called Bright Start Maternity Program, to pregnant Participants. Included in this program, is the Post- Partum Home Visit. Detailed information about the components of the maternity program can be found in Section X, Special Needs/Care Management.

The goal of the program is to reduce infant morbidity and mortality among Participants. Bright Start Maternity Program is comprised of nurses and administrative staff who actively seek to identify pregnant Participants as early as possible in their pregnancy and continue to follow them through eight weeks post- delivery.

Obstetrician's Role in Bright Start Maternity Program

OB network Providers play a very important role in the success of the Bright Start Maternity Program, particularly the early identification of pregnant Participants to the Bright Start Maternity Program. OB network Providers are responsible for the following:

- Following the American College of Obstetricians and Gynecologists (ACOG) standards of care for prenatal visits and testing
- Complying with the Plan's protocols related to referrals, OB packages Prior Authorization, inpatient admissions, and laboratory services
- Allowing Participants to self-refer to their office for all visits related to routine OB/GYN care without a referral from their PCP

Effective July 1, 2021, Keystone First CHC will only accept ONAF forms that are submitted through the Optum website. To register and get started submitting electronically visit: obcare.optum.com.

The OB Care User Guide and link to the Optum website is available at <https://www.keystonefirstchc.com/providers/resources/bright-start-program.aspx>.

Submit the ONAF form three times during the course of a Participant's pregnancy:

- 1. First prenatal visit**
 - A complete form, all sections should have minimally one item checked
- 2. 28-32 weeks gestation**
 - Any updates and a list of all prenatal visits completed to that point
- 3. Postpartum – 7-84 days post-delivery**
 - Delivery information and remainder of prenatal visits that have been completed

In order for the Plan to successfully assist our pregnant Participants, we look to partner and collaborate with our Plan's OB Providers. For support, resources, or further information on the Bright Start Maternity Program, please contact the Bright Start Maternity department at **1-800-521-6867**.

OB network Providers are encouraged to refer smoking mothers to the tobacco cessation program. Additional information on the tobacco cessation program is located in the Special Needs and Care Management Section of the Manual.

Ophthalmology Services

Non-Routine Eye Care Services

When a Participant requires **non-routine** eye care services resulting from accidental injury or trauma to the eye(s), or treatment of eye diseases, the Plan will pay for such services through the medical benefit. The PCP should initiate appropriate referrals and/or authorizations for all non-routine eye care services.

See "**Vision Care**" in this section of this Manual for a description of the Plan's routine eye care services. The Plan's routine eye care services are administered through Davis Vision. Routine eye exams and corrective lens Claims should not be submitted to the Plan for processing.

Questions concerning benefits available for Ophthalmology Services should be directed to the Provider Services department at **1-800-521-6007**.

Outpatient Laboratory Services

In an effort to provide high quality laboratory services in a managed care environment for our Participants, the Plan has made the following arrangements:

The Plan has selected Lab Corp as our preferred independent lab Provider

- The Plan encourages network Providers to perform venipuncture in their office. Providers should then contact Lab Corp to arrange pick-up service.
- For offices that do not have a Lab Corp account, the Participant should be directed to a Lab Corp Patient Service Center.
- Primary Care Practitioners and Specialist Providers may utilize any Plan-participating hospital outpatient laboratory or Lab Corp for lab tests or processing of lab specimens.
- The Plan highly recommends that pre-admission laboratory testing be completed by the Primary Care Practitioner. However, testing can be completed at the hospital where the procedure will take place and does not require a referral from the Plan.
- **STAT labs must only be utilized for urgent problems.** The ordering physician may give the Participant a prescription form or Plan procedure confirmation form to present to the participating facility. STAT laboratory services are defined as laboratory services that require completion and reporting of results within four (4) hours of receipt of the specimen.

- The PCP is responsible for including all demographic information when submitting laboratory testing request forms.

Outpatient Renal Dialysis

The Plan does not require a referral or Prior Authorization for Renal Dialysis services rendered at Freestanding or Hospital-Based outpatient dialysis facilities. It is important to note that the Plan's Epogen Policy for authorization procedures for doses greater than 50,000 units per month.

Free-Standing Facilities

The following services are payable without Prior Authorization or referrals for Free-Standing facilities:

- Training for Home Dialysis
- Back-up Dialysis Treatment
- Hemodialysis - In Center
- Home Rx for CAPD Dialysis (per day)
- Home Rx for CCPD Dialysis (per day)
- Home Treatment Hemodialysis (IPD)

Hospital Based Outpatient Dialysis

The Plan will reimburse Hospital Based Outpatient Dialysis facilities for all of the above services including certain lab tests and diagnostic studies that, according to Medicare guidelines, are billable above the Medicare composite rate. Please refer to Medicare Billing Guidelines for billable End Stage Renal Disease tests and diagnostic studies.

Associated Provider services (Nephrologist or other Specialist) require a referral that must be initiated by the PCP. Once the treatment plan has been authorized, the Specialist may "expand" the initial referral by contacting the Plan's Provider Services department at 1-800-521-6007 and selecting prompt #3.

The following services require Prior Authorization through the Plan's Utilization Management department:

- Supplies and equipment for home dialysis patients (Method II)
- Home care support services provided by an RN or LPN
- Transplants and transplant evaluations
- All inpatient dialysis procedures and services

Outpatient Testing

When a Specialist determines that additional diagnostic or treatment procedures are required during an office visit, which has been previously authorized by the Participant's PCP, there is no further referral required.

When a diagnostic test or treatment procedure not requiring Prior Authorization will be performed in an Outpatient Hospital/Facility, the specialist should note the Participant's information and

procedures to be performed on his/her office prescription form. Refer to “**Prior Authorization Requirements**” section of the Manual for a complete list of procedures requiring Prior Authorization.

When a patient presents to the hospital for any outpatient services not requiring a referral or Prior Authorization, he/she must bring a copy of the ordering health care Provider's prescription form.

Outpatient Therapies

Physical, Occupational, and Speech

Participants are entitled to 24 physical, 24 occupational, and 24 speech therapy outpatient visits (per discipline) within a calendar year. A referral from the Participant's PCP is required for the initial visit to the therapist. Initial visits are not considered part of the 24 visits. Please refer to the LTSS section of the manual for exceptions for eligible LTSS Participants.

Once the Participant exceeds the 24 visits (per discipline) of physical, occupational, and/or speech therapy, an authorization is required to continue services. The therapist must contact the Plan's Utilization Management department at 1-800-521-6622 to obtain an authorization.

Pharmacy Services

Pharmacy Phone Number: **1-866-907-7088**

Pharmacy Fax Number: **1-855-851-4058**

The Plan's Pharmacy Services department is responsible for all administrative, operational, and clinical service functions associated with providing Participants with a comprehensive pharmacy benefit.

All Participants have prescription benefits. There may be a co-payment associated with certain medications. Please refer to the "Participant Copayment Schedule" in Section I of this Manual and at <https://www.keystonefirstchc.com/pdf/participants/copays.pdf>.

Participants do not have any copays for naloxone. When administered during an overdose, naloxone blocks the effects of opioids on the brain and restores breathing within two to eight minutes.

For Opioid Treatment resource information and resources, including state, local and plan resources, visit Treatment resource information and resources including state, local and plan resources, visit <https://www.keystonefirstchc.com/providers/resources/opioid/index.aspx>

In general, Participants can receive up to a 34-day supply per prescription order or refill. Select generic medications are eligible to be filled for a 90-day supply.

Keystone First CHC has a proprietary retail pharmacy network to provide Participants a means to access their prescription drug benefit. Keystone First CHC and our business partners work to credential, communicate with and audit both independent and chain pharmacies providing products and services to our Participants.

Keystone First CHC's Drug Formulary

The Keystone First CHC's drug benefit has been developed with the Pennsylvania Department of Human Services to cover Medically Necessary prescription products. Keystone First CHC adheres to the Pennsylvania Department of Human Services (DHS) statewide preferred drug list (PDL) for drugs and classes that are included therein. The pharmacy benefit design provides for outpatient prescription services that are appropriate, Medically Necessary, and are not likely to result in adverse medical outcomes.

The Keystone First CHC Formulary and Prior Authorization process are key components of the benefit design. The medications included in the statewide PDL are reviewed and approved by the DHS Pharmacy and Therapeutics Committee. Medication classes that are not included in the state PDL are reviewed and approved by the Keystone First CHC's Pharmacy and Therapeutics Committee which includes physicians and pharmacists actively participating with Keystone First CHC as network Providers, as well as consumer representatives or representatives designated to act on behalf of consumers. The goal of the Formulary is to provide clinically efficacious, safe and cost-effective pharmacologic therapies based on prospective, concurrent, and retrospective Drug Utilization Review as well as peer reviewed medical literature.

Pennsylvania DHS's and Keystone First CHC's Pharmacy and Therapeutics Committees meet regularly to review and revise the Formulary. For medication classes that are not included in the statewide PDL, providers may request addition of a medication to the Formulary. Requests must include drug name, rationale for inclusion on the Formulary, role in therapy and Formulary medications that may be replaced by the addition. All requests should be forwarded in writing to:

**Keystone First CHC
Pharmacy and Therapeutics Committee
200 Stevens Drive
Philadelphia, PA 19113**

The most up-to-date Formulary information is available online in the Provider Center at <https://www.keystonefirstchc.com/providers/index.aspx>.

Medication Covered by Other Insurance

As an agent of the Commonwealth of Pennsylvania Medical Assistance Program, Keystone First is always the payor of last resort in the event that a Participant receives medical services or

medication covered by another payor source. All Claims where there are third-party resources must first be billed to the primary insurer. Claims for the unpaid balance should then be billed to Keystone First CHC.

Please submit all secondary claims for processing. The claim information is used for HEDIS reporting purposes and other quality initiatives.

Pharmacy Prior Authorization Process

To Obtain Prior Authorization:

The Pharmacy Services department at Keystone First CHC issues Prior Authorizations to allow processing of certain prescription Claims (more information on the types of drugs that require Prior Authorizations can be found later in this section) that would otherwise be rejected.

To contact the Pharmacy Services department

- Online:
 - www.keystonefirstchc.com
- By telephone:
 - **1-866-907-7088** between 8:30 a.m. and 6:00 p.m. Monday through Friday (EST); and after business hours, Saturday, Sunday and Holidays, the Participant Services department at **1-855-332-0729**.
- By fax:
 - **1-855-851-4058**

The Prior Authorization procedure is as follows:

- Utilizing criteria approved by both Keystone First CHC's Pharmacy and Therapeutics Committee and DHS, (hereafter referred to as "Approved Criteria"), a Keystone First CHC pharmacist reviews the request
 - When the Prior Authorization request meets the Approved Criteria, the request is approved and payment for the prescription may be authorized for a period when the Prior Authorization request meets the Approved Criteria, up to twelve months, or for the length of the prescriber's request, whichever is shorter
 - In the event of insufficient information provided by the prescriber, a Keystone First CHC pharmacist will attempt to contact the prescriber to obtain the necessary clinical information for review. In addition, the decision will comply with the following statutory and regulatory requirements:
 - 55 Pa. Code 1121 (The Pennsylvania Code)
 - Medical Assistance Bulletin 03-94-03
 - The Social Security Act
 - OBRA '90 guidelines
 - Any other applicable state and/or federal statutory/regulatory provisions

When the Prior Authorization request does not meet the Approved Criteria, the request is forwarded to a Keystone First CHC Medical Director to review each request and make and communicate a determination within 24 hours.

- In evaluating the request, the Medical Director generally relies upon information supplied by the prescribers, the Medical Director's medical expertise, and accepted clinical practice guidelines
- In the event of a denial, Keystone First CHC will notify the prescriber by fax, and the Participant by mail within 24 hours and will offer the prescriber a Formulary approved alternative. The correspondence will outline specifically all Participant and health care Provider Appeal rights. If the request is approved by the Medical Director, Keystone First CHC will notify the prescriber that the request has been approved
- The prescriber or PCP may discuss Keystone First CHC's decision with a Keystone First CHC Clinical Pharmacist or Medical Director during regular business hours (Monday through Friday 8:30am- 6:00pm). For after- hours urgent calls, call the Participant Services department. To speak with a Keystone First CHC Clinical Pharmacist or Medical Director, please call the Pharmacy Services department at 1-866-907-7088
- Prescribers and Participants may obtain Prior Authorization criteria related to a specific denial determination by submitting a written request for the criteria or by calling the Pharmacy Services department

To Request Ongoing Medication/Temporary Supplies:

If the request is for an ongoing medication, and the medication is covered by the Medical Assistance Program, Keystone First CHC will automatically authorize a 15-day temporary supply of the requested medication at the point-of-sale if Prior Authorization requirements do not allow the prescription to be filled upon presentation to the Pharmacy and if the pharmacist determines it safe for the Participant to take. If the request is for a new medication and the medication is covered by the MA Program, a 5-day temporary supply of medication will automatically be authorized at the point-of-sale if Prior Authorization requirements do not allow the prescription to be filled upon presentation to the Pharmacy and if the pharmacist determines it safe for the Participant to take.

- Keystone First CHC may review requests for Prior Authorization when a temporary 5- day or 15-day supply has been dispensed regardless of whether the prescriber formally submits a Prior Authorization request. For those requests that are approved by a Keystone First CHC pharmacist, Keystone First CHC will contact the prescribing Provider by fax to inform him or her of the approval within 24 hours of the request's submission. The Provider informs the Participant of the approval.

Pharmacies have been made aware of the temporary supply requirements. If you become aware of a specific pharmacy that is not dispensing a temporary supply, please contact the Pharmacy Services department at **1-866-907-7088**.

Drugs Requiring Prior Authorization

- All non-formulary medications
- All prescriptions that exceed plan limits
- All brand name medications with an available A-rated generic equivalent (see exceptions under Generic Medications below)
- Regimens that are outside the parameters of use approved by the FDA or accepted standards of care
- Early refills

Please note: additional drugs in the Formulary require Prior Authorization; consult the online Formulary for up-to-date Prior Authorization requirements. Medications without specific prior authorization criteria may be reviewed under other general criteria such as “Non-formulary Medication criteria”, “Quantity limit exception criteria”, or others as applicable.

Injectable and Specialty Medications

Specialty Drug Program

Specialty drugs are a specific group of medications that include unusually high-cost oral, inhaled, injectable or infused pharmaceuticals. These drugs are typically prescribed for a relatively narrow spectrum of diseases and conditions and are drugs that often require specific distribution and/or handling. Specialty medications may include treatments covered under both the pharmacy benefit and the medical benefit. These products may have very specific clinical criteria and prescribing guidelines that must be followed to ensure appropriate use and outcomes.

Compliance with these criteria is managed through the Prior Authorization process. Unless otherwise specified, specialty drugs managed by the Keystone First CHC Specialty Drug Program require Prior Authorization. Specialty drugs that are incidental to and administered during an inpatient hospital or hospital-based clinic stay are not managed through Keystone First CHC Specialty Drug Program and may not require Prior Authorization.

Health care Providers should use specific forms for specialty and injectable medications which can be found online at www.keystonefirstchc.com/providers/pharmacy/index.aspx. The order form must be completed in its entirety and faxed to the Keystone First CHC Specialty Drug Management Program at **1-855-851-4058**. Failure to submit all requested information could result in denial of coverage or a delay of approval as the result of insufficient information.

Providers should inform Keystone First CHC Participants that specialty medications may not be available through a retail pharmacy and that designated specialty pharmacies should be utilized. **Specialty medications can be filled at any specialty pharmacy in the Keystone First CHC specialty network and should indicate the requested specialty pharmacy on all prior**

authorization forms. The pharmacy specialty network listing is available on the pharmacy pages at <https://www.keystonefirstchc.com/providers/pharmacy/index.aspx>.

Participants can be directed to the Participant handbook and online for information about approved specialty pharmacies and a listing of specialty medications. Participants have the right to choose any network specialty pharmacy to provide medication and other ancillary services.

The provider authorization forms can be obtained by calling the Keystone First CHC Specialty Pharmacy Services department at **1-866-907-7088**. They can also be found online in the Provider Center at <https://www.keystonefirstchc.com/providers/index.aspx>. Please feel free to copy these forms as needed. The forms are updated as needed so please check the website for the latest updates.

To speak to a Keystone First CHC representative about the Specialty Drug Management Program, please call **1-866-907-7088**.

Bleeding Disorders Management Program Description

Keystone First CHC has a comprehensive management program for Participants requiring authorization for blood factor products. The Bleeding Disorders Program includes Utilization Review, Care Management and Specialty Pharmacy Network Management for Participants with the following disorders/diseases: Hemophilia A and B, von Willebrand Disease, Platelet Function Defects, as well as other rare deficiencies. The Clinical Prior Authorization department reviews all requests for factor products administered in a Participant's home or in a Hemophilia Treatment Center in an effort to ensure appropriate dosing of factor, compliance, minimize product overstocking, and monitor utilization.

The Bleeding Disorders Nurse Care Manager works with the bleeding disorders population to:

- Provide support to Participants needing information and care regarding their disorder.
- Educates Participants and their families based upon recommendations provided by the Medical and Scientific Advisory Council (MASAC) through the National Hemophilia Foundation (NHF).
- Coordinates services for health care issues, by working with PCPs and other Providers to ensure Participants get timely needed care.
- Locates community resources; and function as a liaison between the Participant, the specialty pharmacy Network, and the hemophilia treatment center/Provider.
- Communicates with the Participant's treating physician (and the Primary Care Practitioner if appropriate) when complications are identified that require intervention outside of the scope of the Bleeding Disorders Nurse Care Manager and documents these interactions accordingly in the appropriate system.
- Identifies problems/barriers to Keystone First CHC's Care Coordination Team for appropriate care management interventions.

- Assists the Participant in resolving care issues and/or barriers to services including, but not limited to pharmacy, equipment, PCP and Specialist physician access, outpatient services, home health care services and coordination of transportation for medical appointments.
- Is responsible for regular telephone contact and, if applicable, home site visits with the Participant and/or treatment team.
- Aligns its goals and objectives with those of the Hemophilia Treatment Centers (HTC) to ensure continuity and acuity of care.
- Is available 24/7 to Specialty Pharmacies Treating Physician/HTC's and Participants if needed.
- Ensure that factor dosage, and days of service are accurate.
- Review the previous month to compare and ensure the new request is accurate.

The Care Manager applies the Care Manager seven domains that represent the essential information that a Care Manager must know:

- Care Management Concepts
- Principles of Practice
- Healthcare Management and Delivery
- Healthcare Reimbursement
- Psychosocial Aspects of Client's Care
- Rehabilitation
- Professional Development and Advancement

The Procedure for Requesting Hemophilia Medications is as follows:

Completed Prior Authorization request form (including current weight). The form is available on the pharmacy prior authorization section of www.keystonefirstchc.com.

- Physician order/prescription (needed with every request)
- Administration/Bleed logs if available
- The Provider must submit a completed hemophilia factor order request form and a prescription from the doctor for all initial factor requests.
- If a Provider coordinates directly with a Specialty Pharmacy for request submission, the Specialty Pharmacy sends the request to PerformRx for review.
- Bleeding Disorder Nurse Care Manager Reviews and authorizes factor.
- Specialty Pharmacy timely delivers factor via UPS or other carrier.

All subsequent requests for refills require a completed hemophilia factor order form, a copy of the physician's current prescription, and the Participant's Administration/Bleed log in order to determine the appropriate amount of medication to be replaced.

Blood factor products that are subject to review include Factor VII (NovoSeven), Factor VIII, Factor IX, Factor FXIII and Anti-Inhibitor Coagulant Complex as well as the newly marketed monoclonal antibody Hemlibra. Medication may be approved on an as needed basis for patients requiring replacement medication or for treatment of episodic bleeding. Delivery of approved products to Participants is coordinated via authorized Specialty Pharmacy Providers.

Generic Medications

The use of generic drugs in place of brand name products is mandated by the Commonwealth of Pennsylvania when the brand name product has an FDA approved A-rated generic equivalent available. When an approved generic equivalent is available, all prescriptions denoting "Brand Necessary" require Prior Authorization. Some exceptions may apply if a brand name formulation has been designated as preferred on the statewide PDL.

A health care Provider requesting a brand product that requires prior authorization must include information to substantiate medical necessity for a brand medication, such as documentation of adverse effects of generic alternatives. For specific details, refer to the Pharmacy Prior Authorization Process section of the manual.

A limited number of brand name products that have generic equivalents may also be excluded from the above Prior Authorization requirement. These include some medications with a Narrow Therapeutic Index (NTI).

Over-the-Counter Medication

Certain generic over-the-counter medications* are covered by Keystone First CHC with a prescription from the prescribing health care Provider. These may include:

- Analgesics such as aspirin, acetaminophen and non-steroidal anti-inflammatory drugs
- Antacids
- Anti-diarrheas such as loperamide and kaolin-pectin combinations
- Anti-flatulents such as simethicone
- Antihistamines
- Antinauseants
- Bronchodilators
- Cough and cold preparations
- Contraceptives
- Hematinics not including long-acting products
- Insulin
- Laxatives and stool softeners
- Nasal preparations
- Ophthalmic preparations
- Single and multiple ingredients topical products such as antibacterials, anesthetics, anti-fungals, dermatological baths, rectal preparations, tar preparations (excluding soaps, shampoos, and cleansing agents), wet dressings, scabicides, corticosteroids (such as hydrocortisone 1% for rashes), and benzoyl peroxide.
- Oral electrolyte mixtures
- Some prenatal vitamins
- Tobacco cessation products
- Vitamins and minerals

*Covered over-the-counter medications can be found within the online formulary at <https://www.keystonefirstchc.com/providers/pharmacy/index.aspx>.

Diabetic Testing Supplies

Diabetic testing supplies are subject to the preferred drug list. Preferred products will be covered according to the following parameters with a written prescription from a Provider:

- Blood glucose monitors are covered with a prescription for Keystone First CHC Participants with diabetes.
- Participants are eligible for one blood glucose monitor per 365 days.
- Some continuous glucose monitors (GCMs) and supplies.
- Meters, strips, lancets and control solution may be prescribed for Participants with diabetes and filled at all participating network pharmacies.
 - Please refer to the [Pennsylvania Department of Human Services Statewide Preferred Drug List \(PDL\)](#) for the current preferred products and quantity limits.

For ALL other DME and medical supplies including diapers and diabetic supplies, please refer to the Durable Medical Equipment and Medical Supplies section of this Manual.

Non-Covered Medications

The following are non-covered medications under the MA Program, and therefore not covered by Keystone First CHC:

- Drugs for hair growth or other cosmetic purposes
- Drugs that promote fertility
- Non-legend drugs in the form of troches, lozenges, throat tablets, cough drops, chewing gum, mouthwashes and similar items with the exception of products for tobacco cessation
- Pharmaceutical services provided to a hospitalized person
- Single entity and multiple vitamin preparations except for those listed above
- Drugs and devices classified as experimental by the FDA or not approved by the FDA
- Placebos
- Non-legend soaps, cleansing agents, dentifrices, mouthwashes, douche solutions, diluents, ear wax removal agents, deodorants, liniments, antiseptics, irrigants, and other personal care and medicine chest items
- Non-legend aqueous saline solution
- Non-legend water preparations
- Non-legend drugs not covered by the MA Program
- Items prescribed or ordered by a health care Provider who has been barred or suspended from participating in the MA Program
- DESI drugs and identical, similar or related products or combinations of these products

- Legend or non-legend drugs when 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
- Prescriptions or orders filled by a pharmacy other than the one to which a recipient has been restricted because of improper utilization or abuse
- Non-legend impregnated gauze and any identical, similar, or related non-legend products
- Any pharmaceutical product marketed by a drug company which has not entered into a rebate agreement with the Federal Government as provided under Section 4401 of the Omnibus Reconciliation Act of 1990
- Drugs prescribed for the treatment of Sexual or Erectile Dysfunction (ED)

Information Available on the Web

Additional Online Resources:

Keystone First CHC has a dedicated Opioid Treatment resource web page that provides information and resources including state, local and plan resources. Visit the site at:

<https://www.keystonefirstchc.com/providers/resources/opioid/opioid-treatment.aspx>.

Podiatry Services

Plan Participants are eligible for all Medically Necessary podiatry services, including x-rays, with a referral written by the PCP to a podiatrist in the Network. It is recommended that the PCP use discretion in referring Participants for routine care such as nail clippings and callus removal, taking into consideration the Participant's current medical condition and the medical necessity of the podiatric services.

Podiatry Services/Orthotics

Network Providers may dispense any Medically Necessary orthotic device compensable under the MA Program upon receiving Prior Authorization from the Plan's Utilization Management department. Questions regarding an item should be directed to the Provider Services department at **1-800-521-6007**.

Provider Preventable Conditions (PPC) and Critical Incident Reporting Policy

The Plan's payment policy with respect to Provider Preventable Conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA defines PPCs to include two distinct categories: Health Care Acquired Conditions; and Other Provider- Preventable Conditions. It is The Plan's policy to deny payment for PPCs.

Health Care Acquired Conditions (HCAC) apply to Medicaid inpatient hospital settings only. An HCAC is defined as "condition occurring in any inpatient hospital setting, identified currently or in

the future, as a hospital-acquired condition by the Secretary of Health and Human Services under Section 1886(d)(4)(D) of the Social Security Act. HCACs presently include the full list of Medicare's hospital acquired conditions, except for DVT/PE following total knee or hip replacement in pediatric and obstetric patients.

Other Provider-Preventable Conditions (OPPC) is more broadly defined to include inpatient and outpatient settings. An OPPC is a condition occurring in any health care setting that: (i) is identified in the Commonwealth of Pennsylvania State Medicaid Plan; (ii) has been found by the Commonwealth to be reasonably preventable through application of procedures supported by evidence-based guidelines; (iii) has a negative consequence for the Participant; (iv) can be discovered through an audit; and (v) includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs (surgery on the wrong patient, wrong surgery on a patient and wrong site surgery).

For a list of PPCs for which the Plan will not provide reimbursement, please refer to the Appendix of this Manual.

Submitting Claims Involving a PPC

In addition to broadening the definition of PPCs, the ACA requires payers to make pre-payment adjustments. That is, a PPC must be reported by the Provider at the time a claim is submitted.

There are some circumstances under which a PPC adjustment will not be taken or will be lessened. For example:

- No payment reduction will be imposed if the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the Provider. Please refer to the Reporting a Present on Admission section for details.
- Reductions in Provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and the Plan can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.

Practitioner/Dental Providers

- If a PPC occurs, Providers must report the condition through the claims submission process. Note that this is required even if the Provider does not intend to submit a claim for reimbursement for the services. The requirement applies to Providers submitting claims on the CMS-1500 or 837-P forms, as well as and dental Providers billing via ADA claim form or 837D formats.

For professional service claims, please use the following claim type and format: Claim Type:

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D of the CMS 1500 claim form.

- Dental Providers must report a PPC on the paper ADA claim form using modifier PA, PB or PC on the claim line, or report modifiers PA, PB or PC in the remarks section or claim note of a dental claim form.

Claim Format:

- Report the E diagnosis codes, such as Y65.51, Y65.52 or Y65.53 in field 21 [and/or] field 24E of the CMS 1500 claim form.

Inpatient/Outpatient Facilities

- Providers submitting claims for facility fees must report a PPC via the claim submission process. Note that this reporting is required even if the Provider does not intend to submit a claim for reimbursement of the services. This requirement applies to Providers who bill inpatient or outpatient services via UB-04 or 837I formats.

For Inpatient facilities

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired. When submitting a claim which includes treatment as a result of a PPC, facility Providers are to include the appropriate ICD10diagnosis codes, including applicable external cause of injury or E codes on the claim in field 67 A – Q. Examples of ICD-10 and “E” diagnosis codes include:

- Wrong surgery on correct patient Y65.51;
- Surgery on the wrong patient, Y65.52;
- Surgery on wrong site Y65.53;
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 “Expired”.

For per-diem or percent of charge-based hospital contracts, claims including a PPC must be submitted via paper claim with the patient’s medical record. These claims will be reviewed against the medical record and payment adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim. All information, including the patient’s medical record and paper claim should be sent to:

**Medical Claim Review
c/o Keystone First Community HealthChoices
PO Box 7146
London, KY 40742**

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC DRG. Facilities need not submit copies of medical records for PPCs associated with this payment type.

For Outpatient Providers

Outpatient facility Providers submitting a claim that includes treatment required because of a PPC must include the appropriate ICD-10 diagnosis codes, including applicable external cause of injury or E codes on the claim in field 67 A – Q. Examples of ICD-10 and “E” diagnosis codes include:

- Wrong surgery on correct patient E876.5;
- Surgery on the wrong patient, E876.6; and
- Surgery on wrong site E876.7.

Reporting a Present on Admission PPC

If a condition described as a PPC leads to a hospitalization, the hospital should include the “Present on Admission” (POA) indicator on the claim submitted for payment. Report the applicable POA Indicator should be reported in the shaded portion of field 67 A – Q. DRG based facilities may submit POA via 837I in loop 2300; segment K3, data element K301.

Valid POA indicators are as follows:

“Y” = Yes = present at the time of inpatient admission

“N” = No = not present at the time of inpatient admission

“U” = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission

“W” = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not

“null” = Exempt from POA reporting.

Critical Incident Reporting

A critical incident is an occurrence of an event that jeopardizes the Participant’s health or welfare. Providers must comply with the reporting requirement established in the OAPSA and Adult Protective Services by reporting any of the following critical incidents:

- Death (other than by natural uses);
- Serious injury that results in emergency room visits, hospitalizations, or death;
- Hospitalization except in certain cases, such as hospital stays that were planned in advance;
- Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities;
- Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse include, but not necessarily limited to:
 - Physical abuse, defined as a physical act by an individual that may cause physical injury to a participant;
 - Psychological abuse, defined as an act, other than verbal, that may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade or demean a participant;

- Sexual abuse, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
- Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant;
- Neglect, which includes the failure to provide a participant the reasonable care that he or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect;
- Exploitation, which includes the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self or others;
- Restraint, which includes any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions and procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights;
- Service interruption, which includes any event that results in the participant's inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the Provider agency must have a plan for temporary stabilization; and
- Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

Providers must immediately report any of the critical incidents listed above by:

Reporting critical incidents via the Department's EIM System ([https://www.hhsapps-state.pa.us/eim/](https://www.hhsapps.state.pa.us/eim/))

Verbally report suspected Abuse, Neglect, and Exploitation by calling the Protective Services Hotline at **1-800-490-8505**. **For allegations of Serious Injury, Serious Bodily Injury, Sexual Abuse and Death, a written report is also required, according to APS and OAPSA.**

Note: Direct Service Providers must inform the Participant's Service Coordinator of the critical incident within 24 hours of an incident occurring. See below for additional information related to Direct Service Provider reporting.

Using the Enterprise Incident Management (EIM) system

Service Coordinators who file critical incidents must obtain a user ID from the Keystone First CHC Business Partner Administrator. To set up new user IDs, service coordination entities must:

- Create a new, unique email address for Keystone First CHC so they can file incidents in EIM for CHC Participants.

- Send a list of Service Coordinator names and unique email addresses to Keystone First CHC at: KFCHCCriticalIncident@keystonefirstchc.com.

Questions related to critical incidents and EIM can be sent to KFCHCCriticalIncident@keystonefirstchc.com.

Reporting a critical incident

Prior to entering a critical incident report in the EIM system, please search EIM to determine that a report has not already been initiated.

- It is mandatory to report any suspected abuse to Adult Protective Services (APS) or Older Adult Protective Services (OAPS) within 24 hours of the knowledge of an incident.
- The entity that first discovers or learns of the critical incident (if they are not present when it occurs) is responsible to report it.
- The Service Coordination or Provider agency that discovers or has independent knowledge of the critical incident must submit the critical incident report within 48 hours by directly entering the incident into the EIM system.
 - If the critical incident occurs over the weekend, a written report must be entered the first business day after the incident occurred.
- Incidents must be completed in EIM within 30 calendar days (or before) from the date of discovery.
- All information entered in EIM must be written in English.
- Each critical incident report should show:
 - Time and date of the incident and/or discovery of the incident.
 - What steps were taken immediately to ensure the Participant's health and welfare.
 - What fact-finding steps were taken, and what information was found.
 - What corrective steps were taken.
 - How the critical incident will be prevented from happening in the future.
 - Any changes to the PCSP because of the critical incident.
 - Coordinate whether back up supports need to be mobilized.
 - Contact with other parties who may need to assist or support the Participant (i.e., Protective Services, Emergency Medical services, law enforcement, etc.).

Direct Service Providers

Direct Service Providers must inform the Participant's Service Coordinator of the critical incident within 24 hours of an incident occurring. While a critical incident report must be submitted in the EIM system by the Service Coordination or Provider agency within 48 hours, Direct Services Providers must communicate with the Service Coordinator about the issue within 24 hours of the critical incident discovery. Direct Service Providers should take action to prevent further incidents and discuss options, concerns, and resolutions with the service coordinator and Participant.

All critical incident reports must include:

- Time and date of the incident and/or discovery of the incident.
- Reporter information.
- Participant demographics.
- Event details and type.
- Description of the incident.
- Actions taken to immediately secure the Participant's health and welfare.

Recipient Restriction Program

It is the function of DHS's Bureau of Program Integrity and the Plan to identify Participants who have misused, abused or committed possible Fraud in relation to the MA Program.

DHS's Bureau of Program Integrity and the Plan have established procedures for reviewing Participant utilization of medical services. The review of services identifies Participants receiving excessive or unnecessary treatment, diagnostic services, drugs, medical supplies, or other services. A Participant is subject for review if any of the following criteria are satisfied:

- Participant gets prescriptions filled at >2 pharmacy locations within one month
- Participant has prescriptions written by >2 physicians per month
- Participant fills prescriptions for > than 2 controlled substances per month
- Participant obtains refills (especially on controlled substances) before recommended days' supply is exhausted
- Duration of narcotic therapy is > 30 consecutive days without an appropriate diagnosis
- Prescribed dose outside recommended therapeutic range
- Same/Similar therapy prescribed by different prescribers
- No match between therapeutic agent and specialty of prescriber
- Fraudulent activities (forged/altered prescriptions or borrowed cards)
- Repetitive emergency room visits with little or no PCP intervention or follow-up
- Same/Similar services or procedures in an outpatient setting within one year

The Plan receives referrals of suspected Fraud, mis-utilization or abuse from a number of sources, including physician/pharmacy Providers, the Plan's Pharmacy Services department, Participant/Provider Services, Special Investigations Unit, Care Management/Care Coordination, Special Care Unit, Quality Assurance and Performance Improvement, Medical Affairs and the Department of Human Services (DHS). Network Providers who suspect Participant fraud, misuse or abuse of services can make a referral to the Recipient Restriction Program by calling the Plan's Fraud and Abuse Hotline at **1-866-833-9718**. All such referrals are reviewed for potential restriction.

If the results of the review indicate misuse, abuse or Fraud, the Participant will be placed on the Recipient Restriction Program, which means the Participant(s) can be restricted to a PCP, pharmacy and/or hospital/facility for a period of five (5) years. Restriction to one network Provider of a particular type will ensure coordination of care and provide for medical management.

The PCP office will receive a letter from the Plan identifying the restricted recipient's name and Plan ID number, and, as appropriate, the pharmacy where the recipient must receive his/her prescription medications, and/or the name of the hospital where the recipient must receive elective health care services.

The Participant will also receive a letter outlining the restriction. The Participant has the right to appeal the restriction. The restriction will follow the Participant even if the Participant leaves the Plan for another Medical Assistance Plan. The Participant can also request to be restricted to a PCP or hospital by calling Participant Services.

In an emergency situation, the restricted Participant may seek care at the nearest emergency room.

For more information concerning the Recipient Restriction Program, please refer to applicable Medical Assistance regulations (55 Pa. Code § 1101.91 and § 1101.92) located in Section XIII of this Manual.

Radiology Services

The following services, when performed as an outpatient service, require prior authorization by the Plan's radiology benefits vendor, National Imaging Associates Inc. (NIA)

- Positron Emission Tomography
- Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology /MPI
- Computed Axial Tomography/Computed tomography angiography (CT/CTA)
- Cardiac Computed Tomography Angiography (CCTA)

To request prior authorization, contact the Plan's radiology benefits vendor (NIA via their Provider web-portal at www.radmd.com or by calling 1-800-642-2602 Monday through Friday 8 a.m. – 8 p.m. (EST).

The ordering physician is responsible for obtaining a Prior Authorization number for the requested radiology service. Patient symptoms, past clinical history and prior treatment information will be requested by NIA and the ordering physician should have this information available at the time of the call.

Weekend, Holidays and After-Hours Requests*

Requests can be submitted online – The NIA web site is available 24 hours a day to Providers.

Weekend, holiday and after-hours requests for preauthorization of outpatient elective imaging studies may be called in to NIA and a message may be left (1-800-642-2602), which will be retrieved the following business day.

Requests left on voice mail:

- NIA will contact the requesting Provider's office within one business day of retrieval of the voice mail request to obtain necessary demographic and clinical information to process the request.
- NIA's hours are 8:00 a.m. – 8:00 p.m. Eastern Time, Monday through Friday, excluding holidays

Emergency room, Observation Care and inpatient imaging procedures do not require Prior Authorization.

Rehabilitation

If a Participant requires extended care in a non-hospital facility for rehabilitation purposes, the Plan's Utilization Management department will provide assistance by coordinating the appropriate placement, thus ensuring receipt of Medically Necessary care. A Utilization

Management Coordinator will conduct Concurrent and Retrospective Reviews for all inpatient rehabilitation cases. The Utilization Management department can be reached at **1-800-521-6622**.

Reporting Communicable Disease

All cases of reportable communicable disease that are detected or suspected in a Plan Participant either by a clinician or a laboratory must be reported to the Pennsylvania Department of Health (DOH) as required by 28 PA Code, Chapter 27. The full text of these rules can be found at: Communicable and Noncommunicable Diseases (Chapter 27).

Termination of Pregnancy

First and second trimester terminations of pregnancy require prior authorization and are covered in the following two circumstances:

1. The Participant's life is endangered if she were to carry the pregnancy to term; or
2. The pregnancy is the result of an act of rape or incest.

Life Threat

When termination of pregnancy is necessary to avert a threat to the Participant's life, a physician must certify in writing and document in the Participant's record that the life of the Participant would be endangered if the pregnancy were allowed to progress to term. The decision as to whether the Participant's life is endangered is a medical judgment to be made by the Participant's physician. This certification must be made on the Pennsylvania Department of Human Services' Physician's Certification for an Abortion (MA 3 form). The form must be completed in accordance with the instructions and must accompany the claims for reimbursement. All claims and certification forms will be retained by the Plan.

Rape or Incest

When termination of pregnancy is necessary because the Participant was a victim of an act of rape or incest the following requirements must be met:

- Using the **Pennsylvania Department of Human Services' Physician's Certification for an Abortion (MA 3 form)**, the physician must certify in writing that:
 - In the physician's professional judgment, the Participant was too physically or psychologically incapacitated to report the rape or incest to a law enforcement official or child protective services within the required timeframes (within 72 hours of the occurrence of a rape or, in the case of incest, within 72 hours of being advised by a physician that she is pregnant); or
 - The Participant certified that she reported the rape or incest to law enforcement authorities or child protective services within the required timeframes
- Using the **Pennsylvania Department of Human Services' Recipient Statement Form (MA 368 or MA 369 form)**, the physician must obtain the Participant's written certification that the pregnancy is a result of an act of rape or incest and:
 - the Participant did not report the crime to law enforcement authorities or child protective services; or
 - the Participant reported the crime to law enforcement authorities or child protective services
- The **Pennsylvania Department of Human Services' Physician's Certification for an Abortion and the Pennsylvania Department of Human Services' Recipient Statement Form** must accompany the claim for reimbursement. **The Physician's Certification for an Abortion and Recipient Statement Form** must be submitted in accordance with the instructions on the certification/form. The claim form, Physician's Certification for an Abortion, and Recipient Statement Form will be retained by the Plan.

Vision Care

Vision Benefit Administrator

The Plan's routine vision benefit is administered through Davis Vision. Inquiries regarding routine eye care and eyewear should be directed to the Davis Vision Provider Relations department at 1-800-773-2847 or you may want to visit the Web site at www.davisvision.com. Practitioners who are not part of the vision Network can call Davis Vision's Professional Affairs department at 1-800-933-9371 for general inquiries. Medical treatment of eye disease is covered directly by the Plan. These inquiries should be directed to the Plan's Provider Services department at 1-800-521-6007.

Eye Care Benefits

Routine eye exams are covered twice every calendar year, and copay may be applicable. Participants may receive up to two additional eye exams if the eye doctor completes a form. The Plan does not cover prescription eyeglasses or prescription contact lenses for Participants 21 years of age and older with the exception that there are special provisions for Participants with aphakia, and cataracts.

These Eye Care Special Provisions are:

- If a Participant has aphasia, he or she is eligible to receive two pairs of prescription eyeglasses or prescription contact lenses per year. The full cost of the prescription contact lenses will be covered at no cost.
- If the Participant has cataracts, he or she may receive prescription eyeglasses.

The Plan recognizes that optometrists are able to provide all services within the scope of their practice that are covered by the Pennsylvania Medical Assistance program, including benefit limits, category of aid restrictions as determined by the Plan. Optometrists may provide the following services:

- Evaluation and Management services
- General Optometry services (eye exams)
- The administration and prescription of drugs approved by the Secretary of Health

(Please note that Participants may self-refer for one routine eye exam per year. The Plan covers therapeutic optometry services through Davis Vision (unless the optometrist is in an ophthalmology group that bills through the Plan's claims process). Contact Davis Vision at **1- 800-773-2847** for questions regarding covered services and prior authorization requirements.)

Section IV: Participant Eligibility



Enrollment Process

Keystone First CHC is one of the health plans available to Medical Assistance (MA) recipients in DHS's Community HealthChoices program.

Once it is determined that an individual is an eligible MA recipient, a Community HealthChoices Enrollment Specialist assists the recipient with the selection of a Community HealthChoices (CHC) Managed Care Organization (MCO) and PCP. Once the recipient has selected a CHC- MCO and a PCP, the Community HealthChoices Enrollment Specialist forwards the information to DHS. The Plan is informed on a daily basis of eligible recipients who have selected the Plan as their CHC-MCO. The Enrollee is assigned an effective date by the DHS. The above process activates the release of a Plan ID card, a PCP notification letter, and welcome information to the Participant.

Identification (ID) Card

For ID cards issued before June 11, 2021, the plastic blue and white Keystone First CHC ID Card lists the following information:

- Participant's Name
- The Plan ID Number with a 3-digit alpha prefix (YXM)*
- Participant's Sex and Date of Birth
- State ID Number
- PCP's Name and Phone Number

*The ID card includes a three-digit alpha prefix to the Participant ID number. This 3-digit alpha prefix merely indicates that this is a program under the Plan. Please omit the alpha prefix when submitting all paper and electronic Claims, as well as when inquiring about Participant eligibility and/or Claims status telephonically at 1-800-521-6007 and/or electronically in the Provider Center at <https://www.keystonefirstchc.com/providers/index.aspx>.

Example of ID card issued before June 11, 2021, for Keystone First CHC Participants with MA coverage and receive LTSS.

						www.keystonefirstchc.com Multiplan® Call Participant Services at 1-855-522-6729 (TTY 1-855-522-6710) or visit our website at www.keystonefirstchc.com	
Participant Name: <Participant Name>		Sex: <Male/Female> DOB: <MM/DD/YYYY>		In area providers submit claims to: P.O. Box 7148 London, KY 40342-7110		In area providers: To verify member eligibility and coverage, or for prescription: 1-800-521-6007 For provider services: 1-800-521-6007	
Participant ID: YXM<123456789>		State ID: <123456789>		Out of area claims: Report out-of-area care to Keystone First CHC and your PCP within 45 days. File all claims with your local Blue Cross/Blue Shield Plan. Coverage of benefits and services may be limited outside of the Keystone First CHC service area.		Out of area providers: To verify member eligibility and coverage, or for prescription: 1-800-521-6007	
Primary Care Practitioner (PCP): <Last name, First name>		Rx BIN: XXXXXXXX Rx PCN: XXXXXXXXXX Some copays may apply.		Submit prescription claims to: PerformRx®/CHC P.O. Box 3308 Rossford, PA 19079		For pharmacy benefit administration: Participants: Call 1-888-907-1527. Pharmacies: Call 1-888-907-7088.	
PCP Phone Number: <PCP phone>				Keystone First CHC dental PCP: Any network dentist		Dental health, drug, and alcohol services: call the toll-free number for your county. If you do not know the number, call Participant Services at 1-855-522-6729.	
						Keystone First Community HealthChoices 200 Stevens Drive, Philadelphia, PA 19113	
						Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.	

Example of ID card issued before June 11, 2021, for dual eligible Keystone First CHC Participants enrolled in our D-SNP plan, Keystone First VIP Choice.



For ID Cards issued June 11, 2021, and after, the plastic blue and white Keystone First CHC ID Card lists the following information:

- Participant's Name
- The Plan ID Number with a 3-digit alpha prefix (YXM)*
- Participant's Sex and Date of Birth
- State ID Number

Example of ID card issued June 11, 2021, and after, for Keystone First CHC Participants with MA coverage and receive LTSS.



Example of ID card issued June 11, 2021, and after, for dual eligible Keystone First CHC Participants enrolled in our D-SNP plan, Keystone First VIP Choice.



- The ID Card includes a three-digit alpha prefix to the Participant ID number. This 3-digit alpha prefix merely indicates that this is a program under the Plan. Please omit the alpha prefix when submitting all paper and electronic Claims, as well as when inquiring about Participant eligibility and/or Claims status telephonically at 1-800-521-6007 and/or electronically in the Provider Center at <https://www.keystonefirstchc.com/providers/index.aspx>.

Continuing Care

Participants are allowed to continue ongoing treatment with a health care Provider who is not in the Plan's Network when any of the following occur:

- A new Plan Participant is receiving ongoing treatment from a health care Provider who is not in the Plan's Network
- A current Plan Participant is receiving ongoing treatment from a health care Provider whose contract has ended with the Plan for reasons that are "not-for-cause"

A Participant is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve months the Participant was treated by the Provider for a condition that requires follow-up care or additional treatment, or the services have been prior authorized.

- Participants with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the Provider, unless the appointment is for a well adult check-up.

The Plan allows:

Newly Enrolled Participants to receive ongoing treatment from a health care Provider who is not in the Plan's Network for up to 60 days from the date the Participant is enrolled in the Plan.

Newly Enrolled **Participants** who are pregnant on the effective date of Enrollment to receive ongoing treatment from an Obstetrician (OB) or midwife who is not in the Plan Network through the completion of postpartum care related to the delivery.

Current Participants who are receiving treatment from a health care Provider (physician, midwife or CRNP) whose contract with the Plan has ended, to receive treatment for up to 60 days from the date the Participant is notified by the Plan that the health care Provider will no longer be in the Plan's Network or for up to 60 days from the date the Provider's contract with the Plan ends – whichever is longer.

Current Participants receiving ongoing treatment from a network Provider other than a physician, midwife or CRNP, such as a health care facility or health care agency whose contract has ended with the Plan, to receive treatment for up to 60 days from the date the Plan notifies the Participant that the health care Provider will no longer be in the Plan's network, or for up to 60 days from the date the Provider's contract with the Plan ends – whichever is longer.

Current Participants in their second or third trimester receiving ongoing treatment from an OB or midwife whose contract with the Plan has ended with the Plan to continue treatment from that OB or midwife until the end of her postpartum care related to the delivery.

Ongoing treatment or services are reviewed on a case-by-case basis and include but are not limited to: pre-service or follow-up care related to a procedure or service and/or services that are part of a current course of treatment. If a Participant wants to continue treatment or services with a health care Provider who is not in the Plan's network: (1) the health care Provider must contact the Plan's Utilization Management department at **1-800-521-6622**; or (2) the Participant must contact Participant Services at **1-855-332-0729**.

Once the Plan receives a request to continue care, the Participant's case will be reviewed. The Plan will inform the health care Provider and the Participant by telephone whether continued services have been authorized. If for some reason continued care is not approved, the health care Provider and the Participant will receive a telephone call and a letter that includes the Plan's decision and information about the Participant's right to appeal the decision.

The health care Provider must receive approval from the Plan to continue care.

The Plan will not cover continuing care with a health care Provider whose contract has ended due to quality-of-care issues or who is not compliant with regulatory requirements or contract requirements, or if the Provider is not enrolled in the Medical Assistance program.

Nursing Facility Residents

A Participant who resides in a nursing facility (NF) located in the CHC zone on the implementation date must be allowed to receive NF services from the same NF until the earliest date any of the following occur:

- The Participant's stay in the NF ends
- The Participant is disenrolled from CHC
- The NF is no longer enrolled in the MA Program

A change in CHC-MCO, a temporary hospitalization, or therapeutic leave does not interfere with or terminate this continuity of care period as long as the participant remains a resident of the NF.

Participants who are admitted to a NF after the start date for the CHC-MCO, or who do not qualify for the extended continuity of care period, will receive the standard continuity of care available for all Medicaid Participants.

For all Participants, the CHC-MCO must comply with continuity of care requirements for continuation of Providers, services, and any ongoing course of treatment outlined in MA Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations.

If the NF leaves the network and a participant is not eligible to receive an extended continuity of care period, the Participant may continue to receive NF services, if eligible, from the NF for up to 60 days from whichever is greater:

- The date the Participant is notified by the CHC-MCO of the termination or pending termination of the Provider **or**
- The date of the Provider termination

Exception – Provider is being terminated for cause as described in 40 P.S. § 991.2117(b).

The CHC-MCO in which the Participant is enrolled must enter into an agreement or payment arrangement with the Participant's nursing facility to make payments for the Participant's Nursing Facility services during the continuity of care period, regardless of whether the Nursing Facility is in the CHC-MCO Network or joins the Network. The CHC-MCOs may require nonparticipating Nursing Facility to meet the same requirements as participating nursing facility with the exception that a CHC-MCO may not require nonparticipating health care Providers to undergo full credentialing.

Participants who are admitted to a nursing facility after the start date for the CHC-MCO or who do not qualify for the continuity of care period in this section, will receive the continuity care period described below, as applicable.

Waiver Participants. For a Participant who is receiving LTSS on the CHC- MCO start date through an HCBS Waiver program on his or her effective date of enrollment, the CHC-MCO must provide a continuity of care period for continuation of services provided under all existing HCBS Waiver service plans through all existing service Providers, including Service Coordination Entities that runs from the Participant's effective date of Enrollment for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later. If a Participant chooses to transfer to a different CHC-MCO during the initial 180-day continuity of care period, the receiving CHC- MCO must continue to provide the previously authorized services for 1) the greater of 60 days or the remainder of the 180 days or 2) until a

comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later. If a Participant chooses to transfer to a different CHC-MCO after the initial 180-day continuity of care period, the receiving CHC-MCO must continue to provide the previously authorized services for 60 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is earlier

PCSP Transition. The CHC-MCO must provide an electronic or hard paper copy of a Participant's existing Comprehensive Medical and Service Record, including PCSPs, to the CHC-MCO to which a Participant chooses to transfer. The CHC-MCO must expeditiously transfer the Nursing Facility information, electronically if possible, not to exceed five business days after notification of the transfer.

Other Care or Service Plan Transition. For Participants who are not receiving LTSS through an HCBS Waiver on the CHC-MCO Start Date at the time of his or her enrollment, the CHC-MCO must coordinate initially and on an ongoing basis a Participant's transition into CHC with entities that are providing care or Service Coordination to Participants at the time of their CHC Enrollment. Entities might include, but are not limited to, the OPTIONS program, OMAP's Special Needs Unit or Act 150 Program.

Verifying Eligibility

Each network Provider is responsible to ascertain a Participant's eligibility with the Plan before providing services. Plan Participants can be eligible for benefits as follows*:

- Recipients who are determined eligible for coverage with an MCO between the 1st and 15th of the month will be enrolled with the MCO effective the 1st of the following month
- Recipients who are determined eligible for coverage with an MCO between the 16th and the end of the month will be effective with the MCO the 15th of the following month. Re-enrolled Participants can be effective any day of the month, therefore, verification of eligibility is highly recommended prior to delivery of care
- Network Providers may not deny services to a Medical Assistance consumer during that consumer's fee-for-service eligibility window prior to the effective date of that consumer becoming enrolled in a Pennsylvania Community HealthChoices MCO
- In some instances, there may be a four-to-six week waiting period, known as the fee-for-service eligibility window, for the recipient to be effective with one of the MCOs, such as Keystone First CHC.

Verification of eligibility consists of a few simple steps; they are:

- As a first step, all Providers should ask to see the Participant's Plan Identification Card and the Pennsylvania EBT ACCESS Card.
- It is important to note that the Plan ID cards are not dated and do not need to be returned to the Plan should the Participant lose eligibility. Therefore, a card itself does not indicate a person is currently enrolled with the Plan.

Since a card alone does not verify that a person is currently enrolled in the Plan, it is critical to verify eligibility through any of the following methods:

1. **Internet:** NaviNet (www.navinet.net). This free, easy to use web-based application provides real-time current and past eligibility status and eliminates the need for phone calls to the Plan.
 - For more information or to sign up for access to NaviNet visit the Provider Center at <https://www.keystonefirstchc.com/providers/resources/navinet.aspx> or www.navinet.net or call NaviNet Customer Service at **1- 888-482-8057**.
2. **The Plan's Automated Eligibility Hotline 1-800-521-6007:**
 - Provides immediate real-time eligibility status with no holding to speak to a representative.
 - Call the Provider Services Automated Eligibility Hotline 24 hours/7 days a week, at 1-800-521- 6007:
 - Verify a Participant's coverage with the Plan by their Plan identification number, Social Security Number, name, birth date or Medical Assistance Identification Number
 - Obtain the name and phone number of the Participant's PCP
3. **PROMISe**
 - Visit: <https://tinyurl.com/DHSPromise>
 - MA HIPAA compliant PROMISe software (Provider Electronic Solutions Software) is available free-of-charge by downloading from the OMAP PROMISe website at <https://tinyurl.com/DHSPromise>
4. **Pennsylvania Eligibility Verification System (EVS):**
 - **1-800-766-5387**, 24 hours/7 days a week.
 - If a Participant presents to a Provider's office and states he/she is a Medical Assistance recipient, but does not have a PA EBT ACCESS card, eligibility can still be obtained by using the Participant's date of birth (DOB) and Social Security number (SS#) when the call is placed to EVS.
 - The plastic "Pennsylvania EBT ACCESS Card" has a magnetic strip designed for swiping through a point-of-sale (POS) device to access eligibility information through EVS

Monthly Panel List

Below is an example of the monthly panel available on NaviNet at <http://www.navinet.net> It is important to check panel rosters routinely to review Participants who are missing important services and adult preventative care visits.

Community HealthChoices-Keystone First CHC Sample Panel List

All information on this sample is fictitious

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
ID	Recipient#	DOB	Name	Plan	NFCE	Address	Phone	Age	Gender	Other Ins	Date Eff On Panel	V*	Provider Name/No	N*	Restriction	Language
1111	101010	5/2/1952	Abdul, Abba	Aligned	Y	2323 Warren St Phila PA 19100	215-999-9999	66	M		5/2/2002		J Brown 11223344	Y		English
2222	403030	2/1/1975	Abdul, Geraldine	CHC		414 Narth Ave Phila, PA 19100	215-999-9999	43	F		2/1/2001		R Kelly 1156677			
3333	607070	8/31/1986	Absent, Carol	CHC	Y	8787 Cookie Ln Phila, PA	215-999-9999	32	F		6/1/2001		B Hamster 11777577			
4444	704040	6/12/1990	Amber, Diane	CHC		3535 Creig St Phila, PA 19182	215-999-9999	28	M	Y	1/1/2000	Y	J Brown 1122334			
5555	505000	10/5/1949	Bratt Esther	Aligned		30 Wonder Rd Phila, PA 19181	215-777-7777	69	F	Y	7/1/1999		B Hamster 1122110	Y		

Panel Count = 5

1. Participant's Plan Identification Number
2. Participant's Medical Assistance Recipient Number
3. Participant's Date of Birth
4. Participant's Name
5. Participant's Plan Description
6. Nursing Facility Clinically Eligible Flag
7. Participant's Address
8. Participant's Phone Number
9. Participant's Age
10. Participant's Gender
11. Participant's Other Insurance
12. Participant's Effective Date with PCP
13. V* = Was Participant Seen Within Last 6 Months
14. Participant's Assigned PCP
15. N* = New Participant to PCP
16. Indicates a Participant restriction
17. Participant's preferred language

Change in Recipient Coverage During an Inpatient Stay/Nursing Facility

The following policy addresses responsibility when there is a change in a recipient's coverage during an inpatient stay.

1. When a Medical Assistance (MA) recipient is admitted to a hospital under the Fee-For-Service (FFS) delivery system and assumes the Plan coverage while still in the hospital, the FFS delivery system is responsible for the inpatient hospital bill. On the start date of the Plan coverage, the Plan is responsible for physician, Durable Medical Equipment (DME) and all other covered services not included in the inpatient hospital bill. If the MA recipient is transferred to another hospital after the Plan begin date, the FFS delivery system is responsible for the initial inpatient hospital bill from admission to discharge, and the Plan assumes responsibility for the subsequent hospital bill from point of admission to the hospital to which the MA recipient was transferred.
2. If MA recipient is covered by the Plan when admitted to a hospital and the recipient loses the Plan coverage and assumes FFS coverage while still in the hospital, the Plan is responsible for the stay with the following exceptions:
 - a. If the recipient is still in the hospital on the FFS coverage begin date, and the recipient's FFS coverage begin date is the first day of the month, the Plan is financially responsible for the stay through the last day of that month.
 - b. If the recipient is still in the hospital or Nursing Facility the FFS coverage begin date, and the recipient's FFS coverage begin date is any day other than the first day of the month, the Plan is financially responsible for the stay through the last day of the following month.

Starting with the FFS effective date, the FFS delivery system is responsible for physician, DME, and other bills not included in the hospital bill.

Exceptions:

- The FFS program is financially responsible for the stay beginning on the first day of the next month.
 - The FFS program is financially responsible for the stay beginning on the first day of the month following the next month.
3. When a recipient is covered by a CHC-MCO when admitted to a hospital and transfers to another CHC-MCO while still in the hospital, the losing CHC-MCO is responsible for that stay with the following exceptions. Starting with the gaining CHC-MCO's begin date, the gaining MCO is responsible for the physician, DME, and all other covered services not included in the hospital bill.
 - a. If the recipient is still in the hospital on the gaining CHC-MCO coverage begin date, and the recipient's gaining CHC-MCO coverage begin date is the first day of the month, the losing MCO is financially responsible for the stay through the last day of the month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the next month.
 - b. If the recipient is still in the hospital on the gaining CHC-MCO coverage begin date, and the recipient's gaining CHC-MCO coverage begin date is any day other than the first day of the month, the losing CHC-MCO is financially responsible for the stay through the last

day of the following month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the month following the next month.

4. If a Plan Participant loses MA eligibility while in an inpatient/residential facility, and is never determined retroactively eligible, the Plan is only responsible to cover the Participant through the end of the month in which MA eligibility ended.
 - a. A Participant covered by a CHC-MCO when admitted to a hospital loses and regains Medical Assistance eligibility while in the hospital (Participant is not discharged), resulting in a break in CHC-MCO coverage. The Department's Division of Medicaid Management Information Systems (MMIS) Operations becomes aware of the break in CHC-MCO coverage by the end of the month following the month in which it is lost.
 - b. MMIS Operations will reopen the Participant's CHC-MCO coverage retroactive to the day it was end-dated on eCIS and adjust the Capitation payment accordingly. The CHC-MCO continues to be financially responsible for the stay, including the physician, DME, and all other Covered Services.

Example:

- A Participant who is admitted to the hospital on March 10 loses Medical Assistance eligibility effective March 22 and regains it on April 9 retroactive to March 22. The CHC-MCO coverage on eCIS shows the Participant was end-dated March 31 and reopened in the CHC-MCO with a new CHC-MCO Start Date of April 9. On April 25, MMIS Operations becomes aware of the situation.
- Because MMIS Operations is aware of the loss of Medical Assistance eligibility within the month following the month in which it was lost, MMIS Operations reopens the CHC-MCO coverage retroactive to April 1, the day after the CHC-MCO end-date is posted on eCIS (March 31). The CHC-MCO continues to be financially responsible for the stay, including the physician, DME, and all other Covered Services.

There would be no FFS coverage in this example.

- c. A Participant covered by a CHC-MCO when admitted to a hospital loses and regains Medical Assistance eligibility while in the hospital (Participant is not discharged), resulting in a break in CHC-MCO coverage. MMIS Operations does not become aware of the break in CHC-MCO coverage by the end of the month following the month in which it is lost.

Example:

- A recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22 and regains it on April 9 retroactive to March 22. The CHC-MCO coverage on eCIS shows the recipient as end-dated March 31 and reopened in the CHC-MCO with a new begin date of April 9. Because MMIS Operations was not aware of the break in CHC-MCO coverage by the end of the month following the month in which it was lost, the CHC-MCO coverage is not reopened retroactive to the day it was end-dated on eCIS (March 31). The CHC-MCO is only

responsible for covering the Participant through the end of March, then again starting April 9 with a prorated capitation payment for the remainder of April. FFS Responsibility - FFS is responsible effective April 1 through April 8.

- d. A Participant covered by a CHC-MCO when admitted to a hospital loses Medical Assistance eligibility while in the hospital (Participant is not discharged). The Participant regains Medical Assistance eligibility retroactively after the month following the month in which the Medical Assistance eligibility was ended, regardless of when MMIS Operations became aware of the action.

Example:

- A Participant who is admitted to the hospital on March 10 loses Medical Assistance eligibility effective March 22. The Participant regains Medical Assistance eligibility on May 15 retroactive to March 22. The CHC-MCO coverage on eCIS shows the Participant was end-dated March 31 and reopened in the CHC-MCO with a new Start Date of May 15.
- Because the Medical Assistance eligibility was not reopened within the month following the month in which it was lost, the CHC-MCO coverage is not reopened retroactive to the day it was end-dated on eCIS (March 31). The CHC-MCO is only responsible to cover the Participant through the end of March.

FFS is responsible effective April 1st.

- e. A Participant covered by a CHC-MCO when admitted to a hospital loses Medical Assistance eligibility while in the hospital. The Participant is discharged from the hospital after the month in which the Medical Assistance eligibility was lost but before the Medical Assistance eligibility is regained by the Participant and reopened retroactively, regardless of when MMIS Operations became aware of the situation.

Example:

- A Participant who is admitted to the hospital on March 10 loses Medical Assistance eligibility effective March 22. The Participant is discharged from the hospital April 3. The Participant regains Medical Assistance eligibility on April 22 retroactive to March 22. The CHC-MCO coverage on eCIS shows the Participant was end-dated March 31 and reopened in the CHC-MCO with a new Start Date of April 22.
- Because the Participant was discharged from the hospital before the Medical Assistance eligibility was reopened, which resulted in a three (3)-day period of FFS coverage on eCIS, MMIS Operations does not reopen the CHC-MCO coverage retroactive to April 1. The CHC-MCO is only responsible for the stay through the end of March.

FFS is responsible effective April 1.

- f. **A hospitalized Participant never regains Medical Assistance eligibility.** If the Participant is never determined retroactively eligible for MA, the CHC-MCO is only responsible to cover the Participant through the end of the month in which Medical

Assistance eligibility ended. FFS is not responsible for coverage since the Participant has not regained Medical Assistance eligibility.

- A Participant who is covered by a PH-MCO when admitted to a hospital loses PH-MCO and assumes CHC-MCO while still in the hospital.

The losing PH-MCO is responsible for the hospital stay with the following exceptions. Starting with the gaining CHC-MCO's coverage begin date, the gaining CHC-MCO is responsible for the physician, DME and all other Covered Services not included in the hospital bill.

EXCEPTION #1: If the Participant is still in the hospital on the gaining CHC-MCO coverage begin date, and the Participant's gaining CHC-MCO coverage begin date is the first (1st) day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the next month.

Example: If a Participant is admitted to a hospital on June 21 and the gaining CHC-MCO coverage begin date is July 1, the gaining CHC-MCO assumes payment responsibility for the stay on August 1. The losing PH-MCO remains financially responsible for the stay through July 31.

EXCEPTION #2: If the Participant is still in the hospital on the gaining CHC-MCO coverage begin date, and the Participant's gaining CHC-MCO coverage begin date is any day other than the first day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the following month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the month following the next month.

Example: If a Participant is admitted to a hospital on June 21 and the gaining CHC-MCO coverage begin date is July 15, the gaining CHC-MCO assumes payment responsibility for the stay on September 1. The losing PH-MCO remains financially responsible for the stay through August 31.

6. A Participant who is covered by a CHC-MCO when admitted to a hospital loses CHC-MCO and assumes PH-MCO while still in the hospital.

The losing CHC-MCO is responsible for the hospital stay with the following exceptions. Starting with the gaining PH-MCO's coverage begin date, the gaining PH-MCO is responsible for the physician, DME and all other Covered Services not included in the hospital bill.

EXCEPTION #1: If the Participant is still in the hospital on the gaining PH-MCO coverage begin date, and the Participant's gaining PH-MCO coverage begin date is the first (1st) day of the month, the losing CHC-MCO is financially responsible for the stay through the last day

of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month.

Example: If a Participant is admitted to a hospital on June 21 and the gaining PH-MCO coverage begin date is July 1, the gaining PHC-MCO assumes payment responsibility for the stay on August 1. The losing CHC-MCO remains financially responsible for the stay through July 31.

EXCEPTION #2: If the Participant is still in the hospital on the gaining PH-MCO coverage begin date, and the Participant's gaining PH-MCO coverage begin date is any day other than the first day of the month, the losing CHC-MCO is financially responsible for the stay through the last day of the following month. The gaining PHMCO is financially responsible for the stay beginning on the first day of the month following the next month.

Example: If a Participant is admitted to a hospital on June 21 and the gaining PH-MCO coverage begin date is July 15, the gaining PH-MCO assumes payment responsibility for the stay on September 1. The losing CHC-MCO remains financially responsible for the stay through August 31.

Nursing Facilities

MA Provider Type/Specialty Type 03/31 (County Nursing Facility), 03/30 (Nursing Facility), 03/382 (Hospital Based Nursing Facility), and 03/040 (Certified Rehab Facility) or Medicare certified Nursing Facility

NF resident moves from HealthChoices (HC) to CHC

- HC-MCO will pay for up to 30 days
- HC-MCO will pay for day 31 through the date the eligibility determination is made if resident is found eligible to receive NF services
- CHC-MCO will pay beginning the day after resident is found eligible to receive NF services

NF resident moves from FFS to CHC

If the resident is determined eligible to receive NF services,

- FFS will pay for the retroactive period
- FFS will pay from date of application to the date eligibility is determined
- CHC-MCO will pay beginning the day after eligibility is determined

CHC Nursing Facility Ineligible (NFI) dual

- CHC-MCO will pay for up to 30 days (including hospital reserve bed days and therapeutic leave days)
- Once the NFI participant is found eligible for long-term care services, the NF can bill the CHC-MCO for providing services beyond 30 days.
- The CHC-MCO shall not pay for services that a participant is not eligible to receive.

Retroactive Eligibility

The CHC-MCO shall not be responsible for any payments owed to Providers for services that were rendered prior to the Participants' Start Date.

Incarcerated Participant Eligibility

The Plan is not responsible for any Participant who has been incarcerated in a penal facility, correctional institution (including work release). The Participant will be disenrolled from the Plan effective the day before placement in the institution.

Providers should contact the Plan's Provider Services upon identification of any incarcerated Participant at 1-800-521-6007.

Pennsylvania Electronic Benefits Transfer ACCESS Card

Individuals eligible for benefits from DHS are issued a Pennsylvania (PA) Electronic Benefit Transfer (EBT) ACCESS Card ("PA EBT ACCESS Card"). The recipient uses the PA EBT ACCESS Card to obtain benefits such as food stamps, subsidized housing, medical care, transportation, etc.

Medical Assistance eligible persons are enrolled in a Community HealthChoices MCO to receive health benefits. The MCO issues an identification card so the Participant can access medical benefits. The recipient uses the PA EBT ACCESS Card to "access" all other DHS benefits.

The plastic PA EBT ACCESS Card has a magnetic strip designed for swiping through a point-of-sale (POS) device to access eligibility information through the Eligibility Verification System (EVS). The Medical Assistance recipient's current eligibility status and verification of which MCO they may be participating with can be obtained by either swiping the PA EBT ACCESS Card or by calling the EVS phone number **1-800-766-5387**.

If a Participant presents to a Provider's office and states he/she is a Medical Assistance recipient, but does not have a PA EBT ACCESS Card, eligibility can still be obtained by using the Participant's date of birth (DOB) and Social Security number (SS#) when the call is placed to EVS.

EVS Phone Number 1-800-766-5387

Treating Fee-for-Service MA Recipients

Although the Plan operates and serves Participants within the Department of Human Services' (DHS's) mandatory Community HealthChoices Zones certain Medical Assistance (MA) recipients are eligible to access healthcare services through DHS's Fee-for-Service (FFS) delivery system.

DHS's goal is to ensure access to healthcare services to all eligible MA recipients. In some instances, there may be a four-to-six week waiting period, known as the FFS eligibility window, for the recipient to be effective with one of the CHC-MCOs.

Below are exceptions where eligible MA recipients would access healthcare services under the FFS delivery system, even if they reside in a mandatory Community HealthChoices zone:

- Newly eligible MA recipients while they are awaiting Enrollment into a CHC-MCO
- MA recipients who have a change in eligibility status to a recipient group that is exempt from participating in Community HealthChoices, effective the month following the month of the change
- MA recipients who have been admitted to a state-operated facility, i.e., Public Psychiatric Hospital, State Restoration Centers and Long Term Care Units located at State Mental Hospitals
- MA recipients admitted to State-owned and operated Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and privately operated Intermediate Care Facilities for Other Related Conditions (ICF/ORC)
- MA recipients enrolled in the Health Insurance Premium Payment (HIPP) Program
- MA recipients who are enrolled in the State Blind Pension (SBP) program

Eligible MA recipients meeting one or more of the above exceptions may access healthcare services from any health care Provider participating in the Medical Assistance Program by presenting their DHS-issued PA EBT ACCESS Card. Simply verify the recipient's eligibility via DHS's website at <https://tinyurl.com/DHSPromise>, or the Eligibility Verification System (EVS) at **1-800-766-5387**.

For additional information on MA Bulletin 99-13-05, which is a reminder from DHS that not all Medical Assistance recipients in Southeastern Pennsylvania are in Community HealthChoices, please visit: <https://tinyurl.com/dhs-pa-MA-bulletin-99-13-0>.

Loss of Benefits

A Participant can be disenrolled from the Plan if:

- The Participant is no longer on Medical Assistance. (The Participant should have been notified in writing that his/her case is closed. If the Participant's case re-opens in less than six months, the Participant will be automatically re-enrolled into the Plan.)
- The Participant moves to another part of the state. The Participant should go to the County Assistance Office to see if he/she is still eligible for Medical Assistance
- The Participant moves out of Pennsylvania. The Participant must find out about Medicaid in the new state of residence
- The Participant is admitted to a nursing facility outside the state of Pennsylvania
- The Participant is convicted of a crime and is in jail
- The Participant commits medical fraud or intentional misconduct and all appeals to DHS have been completed

Participants who do not agree with the loss of health coverage must follow the Complaint or Grievance Procedures as outlined in the Participant Handbook or in the Complaints, Grievance and Fair Hearings Procedures in Section VIII of this Manual.

Participants may voluntarily disenroll from the Plan without giving specific reasons. To disenroll from the Plan, the Participant must speak with an Enrollment Specialist by calling **1-844-824-3655 (TTY 1-833-254-0690)**.

Section V: Provider Services



NaviNet – www.navinet.net

Using NaviNet reduces the time spent on paperwork and allows you to focus on more important tasks – patient care. NaviNet is a “one-stop” service that supports your office’s clinical, financial and administrative needs. If you are not already a NaviNet user, it is simple to start the process. Log on to www.navinet.net to register or call 1-888-482-8057 to speak to NaviNet Customer Service.

NaviNet Supports Pre-Visit Functions

- **Eligibility and Benefits Inquiry**
 - Real-time access to Participant eligibility and benefits
 - Access to your approved authorizations
- **Care Gaps**
 - A summary of the age/sex/condition appropriate health screens that a Participant should have
- **Care Gap Alerts***
 - Care Gap notification that appears when checking Participant eligibility
 - View and print for Participants coming into your office. Place them with responsibilities
- **Care Gap Reports***
 - Customizable reports that can be used to target at risk Participants
 - Can be downloaded and faxed back to the Plan with updated information
- **Participant Clinical Summary***
 - A virtual snapshot of a patient’s relevant clinical facts and demographic information in a user-friendly format. Participant clinical summaries enable your practice to secure a more complete view of established patients and provide valuable information on new patients.
 - The summary can be exported into EMR systems (CCD format). Participant Clinical Summaries include the following information:
 - Demographic information
 - Chronic conditions
 - ER Visits (within the past 6 months)
 - Inpatient Admissions (within the past 12 months)
 - Medications (within the past 6 months)
 - Office Visits (within the past 12 months)

**Note: Your NaviNet Security Administrator will need to turn on access to this information for designated users in their NaviNet security profile, as this summary contains extensive personal health information.*

NaviNet Supports Patient/Provider Visits

- Care Gaps (see Pre-Visit section above)
 - Use the care gap reports to provide your patients with appropriate and needed health screenings
 - Maximize your opportunity for incentive dollars
- Participant Clinical Summary (see Pre-Visit section above)

- Prior Authorization Submission through Medical Authorizations on NaviNet Provider Portal (for detailed information, Frequently Asked Questions and training materials on Medical Authorizations, visit Plan Central on NaviNet.

Access Medical Authorizations, a web-based functionality that enables you to:

- Request inpatient, outpatient, home care and DME services
- Submit extension of service requests
- Request prior authorization
- Verify elective admission authorization status
- Receive admission notifications and view authorization history
- Submit clinical review for auto approval of requests to service electronic referrals

NaviNet Supports Claims Management Functions

NaviNet functionality allows your practice to:

- Check the status of submitted claims
- View claim EOBs
- Perform claim adjustments

NaviNet Supports Back Office Functions

- Panel Roster
 - Provides easy and immediate access
 - Contains panel report plus historical reports for the past six months
 - Reports can be imported into Excel for sorting and/or mailing to targeted patients
 - Reports can be integrated with your practice management system

Electronic Data Interchange (EDI) Technical Support Hotline

The Plan has an EDI Technical Support Unit within the Information Solutions department to handle the application, set-up and testing processes for electronic Claim submission. Please contact EDI Technical Support at edi.kfchc@keystonefirstchc.com with any EDI inquiries, questions, and/or electronic billing concerns. More detailed information is available in the Claims Filing Instructions at <https://www.keystonefirstchc.com/providers/claims-billing/index.aspx>.

Some benefits of electronic billing include:

- Faster transaction time for Claims
- Reduction in data entry errors on Claims processed
- The ability to receive electronic reports showing receipt of Claims by the insurance plan

The Plan's Payer ID is **42344**.

ELECTRONIC FUNDS TRANSFER (EFT) AND ELECTRONIC REMITTANCE ADVICE (ERA)

EFT simplifies the payment process by:

- Providing fast, easy and secure payments
- Reducing paper
- Eliminating checks lost in the mail
- Not requiring you to change your preferred banking partner

Enroll through our EFT partner, ECHO

For detailed information and instructions visit the Claims and billing section at

<https://www.keystonefirstchc.com/providers/claims-billing/index.aspx> or call **1-888-834-3511**.

ERA – Call s ECHO’s customer service to sign up for electronic remittance advice:

1-888-471-3920.

Provider Claims Service Unit

The Provider Claim Services Unit (PCSU) is a specialized unit of the Claims department. This unit assists Providers with payment discrepancies and makes on-line adjustments to incorrectly processed Claims.

Some of the Claims-related services include:

- Review of Claim status (Note: Claim status inquiries can also be done online at www.navinet.net).
- Research on authorization, eligibility and coordination of benefits (COB) issues related to Denied Claims
- Clarification of payment discrepancies
- Adjustment(s) to incorrectly processed Claims
- Assistance in reading remark, denial and adjustment codes from the Remittance Advice

Additional administrative services include:

- Explanation of Plan policies in relation to Claim processing procedures
- Explanation of referral and authorization issues related to Claim payment
- Information on billing and Claim requirements
- Assistance in obtaining individual network Provider numbers for network Providers new to an existing Plan group practice

Call the Provider Services Unit at **1-800-521-6007** as the first point of contact to resolve claims issues. For claims issues that can’t be resolved through Provider Claims Services, contact your Provider Account Executive.

Provider Network Management

Provider Network Management is responsible for building and maintaining a robust Provider network for Participants. Provider Network Management is responsible for negotiating contracts

with hospitals, physicians, ancillary, DME and other Providers to assure our Network can treat the full range of MA covered benefits in an accessible manner for our Participants.

The primary contact for network Providers with the Plan should be through Provider Services (**1-800-521-6007**). For any issues that cannot be resolved through standard operating departments, the provider's assigned Provider Account Executive would be the appropriate contact. Account Executives are responsible for orientation, continuing education, and diplomatic problem resolution for all network Providers. An Account Executive will act as your liaison with the Plan. Account Executives visit network Provider locations to conduct in-service/orientation meetings with network Providers and their staff both pro-actively and in response to network Provider issues involving policy and procedure, reimbursement, compliance, etc.

Account Executives also perform a practice environment evaluation and review medical record keeping practices of PCPs and OB/GYNs who are being credentialed for participation with the Plan.

Provider Account Executives also perform an ADA site visit, practice environment evaluation and review medical record keeping practices of PCPs and OB/GYNs who are joining the network. *Provider Network Management will conduct a site visit and medical record keeping review for all PCP, OB/GYN, general and pediatric dentists applying to participate in the network. Scores for these reviews must be 85% or greater.

Provider network management, in collaboration with the Utilization Management department, negotiates rates for Non-Participating Providers and facilities when services have been determined to be Medically Necessary and are Prior Authorized by the Plan.

Call your Account Executive:

- To arrange for orientation or in-service meetings for network Providers or staff
- For service calls
- To respond to any questions or concerns regarding your participation with the Plan
- To report any changes in your status, e.g.:
 - Phone number
 - Address
 - Tax ID Number
 - Additions/deletions of physicians affiliated with your practice

Network Providers should contact their Account Executive or Provider Services with changes to their demographic information. Network Providers may verify their demographic data at any time using the "real-time" Provider Network directory at

<https://www.keystonefirstchc.com/participants/eng/find-provider/index.aspx>.

Requests for changes to address, phone number, tax I.D., or additions and/or deletions to group practices must be made on the Provider Change Form. The form is available in the forms section of the Provider Center on the Plan Web site at <https://www.keystonefirstchc.com/providers/manual-forms/index.aspx>. Change forms can be mailed to:

Keystone First Community HealthChoices
Provider Network Management Department
200 Stevens Drive Philadelphia, PA 19113

OR

Faxed to **1-215-937-5343**

Provider Services Department

The Plan's Provider Services department operates in conjunction with the Provider Network Management department, answering network Provider concerns and offering assistance. Both departments make every attempt to ensure all network Providers receive the highest level of service available.

The Provider Services department are responsible for, but not limited to the following:

- Assisting providers with Participant enrollment and eligibility status questions.
- Explaining benefits and payment policies.
- Assisting providers with prior authorization and referral procedures.
- Assisting providers with claims submissions and payment procedures.
- Explaining to providers their rights and responsibilities as a health plan provider.
- Handling, recording, and tracking provider complaints, disputes, and grievances properly and timely.
- Routing Calls to appropriate persons, including escalation to Clinical staff. Assisting providers with Patient Centered Specialty Practice and the Person-Centered Planning Tool by transferring the provider to the Clinical staff.
- Cooperating with OLTL and other Department hotlines, which are intended to address clinically related systems issues encountered by Participant Advocates or Providers (for Community HealthChoices).

The Provider Services department can be reached twenty-four (24) hours a day, seven (7) days a week.

Call the Provider Services department at 1-800-521-6007

- To verify Participant eligibility/benefits
- To request forms or literature
- To ask policy and procedure questions
- To report Participant non-compliance
- To obtain the name of your Provider Account Executive
- To request access to centralized services such as:
 - Outpatient laboratory services
 - Behavioral Health Services
 - Dental Services
 - Vision

Participant Services

The Participant Services department helps our Participants to understand and obtain the benefits available to them. Participant Services Representatives are available twenty-four (24) hours a day, seven (7) days a week. Participant Services Representatives also provide ongoing support and education to the Plan Participants, focusing on communicating with our Participants concerning their utilization of the Plan and managed care principles, policies and procedures. Call the Participant Services department at **1-855-332-0729** to:

- Access on-call nurses after hours
- Assist Participants looking for behavioral health information
- Assist with accessing transportation
- Help educate Participants on how to access eligible benefits
- Get more information on Special Needs or Disease Management
- Ask for health education materials in Participant's preferred language and formats or request assistance with arranging interpretation services
- Help a Participant choose or change a PCP or other network Provider
- Request a list of network Providers
- Learn what Participants should do if a health care Provider sends a bill.

**Section VI: Primary Care Practitioner (PCP) & Specialist
Office Standards & Requirements**



Practitioner & Provider Responsibilities

Responsibilities of All Providers

Providers who participate in the Plan have responsibilities, including but not limited to:

- Be compliant with all applicable Federal and/or state regulations.
- Treat Participants in the same manner as other patients.
- Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, infectious or reportable diseases, etc.
- Comply with all applicable disease notification laws in Pennsylvania.
- Provide information to the Plan and/or the Department of Human Services (DHS) as required.
- Inform Participants about all available treatment options, regardless of cost or whether such services are covered by the Plan. Provide patient medical records/charts as needed when a Participant is seeking care from a specialist or changing Primary Care Practitioners.
- As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs Participants such as accommodations for
- the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDs, self-referrals for women's health services, family planning services, etc.
- Not refuse an assignment or transfer a Participant or otherwise discriminate against a Participant solely on the basis of religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability (as required in part by Section 504 of the Rehabilitation Act, which prohibits discrimination of individuals with disabilities), participation in any governmental program, source of payment, or marital status or type of illness or condition, except when that illness or condition may be better treated by another Provider type.
- Ensure that ADA requirements are met, including use of appropriate technologies in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the Participant's special needs.
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Provider Agreement (to which this Provider Manual and any revisions or updates are incorporated by reference).
- Accept the Plan payment or third-party resource as payment-in-full for covered services.
- Comply fully with the Plan's Quality Improvement, Utilization Management,
- Integrated Care Management, Credentialing and Audit Programs.
- Comply with all applicable training requirements as required by the Plan, DHS and/or CMS.
- Promptly notify the Plan of claims processing payment or encounter data reporting errors.
- Maintain all records required by law regarding services rendered for the applicable period of time, making such records and other information available to the Plan or any appropriate government entity in accordance with those laws and the Provider Agreement.

- Treat and handle all individually identifiable health information as confidential in accordance with all applicable laws and regulations, including HIPAA Administrative Simplification and HITECH requirements.
- Immediately notify the Plan of adverse actions against license or accreditation status.
- Maintain liability insurance in the amount required by the terms of the Provider Agreement.
- Notify the Plan of the intent to terminate the Provider Agreement as a participating Provider within the timeframe specified in the Provider Agreement and provide continuity of care in accordance with the terms of the Provider Agreement and DHS requirements.
- In the event of termination from the Plan for any reason Provider will fully cooperate in arranging for the transfer of copies of Participant medical records to other Participating Providers.
- Verify Participant eligibility immediately prior to service.
- Obtain all required signed consents prior to service.
- Obtain prior authorization for applicable services.
- Maintain hospital privileges or a collaborative agreement with a Provider with hospital privileges, when hospital privileges are required for the delivery of the covered service.
- Provide prompt access to records for review, survey or study if needed.
- **Report known or suspected elder or domestic abuse and/or neglect to local law authorities and have established procedures for these cases.**
- Inform Participant(s) of the availability of the Plan's interpretive services and encourage the use of such services, as needed.
- Notify the Plan, in accordance with the terms of the Provider Agreement, of any changes in business ownership, business location, legal or government action, or any other situation affecting or impairing the ability to carry out duties and obligations under the Provider Agreement.
- Maintain oversight of non-physician practitioners as mandated by State and Federal law.
- Agree that claims data, medical records, practitioner and Provider performance data, and other sources of information, may be used by the Plan to measure and improve the health care delivery services to Participants.

PCP Role and Requirements

The PCP is the Participant's starting point for access to all health care benefits and services available through the Plan. Although the PCP will certainly treat most of a Participant's health care concerns in his or her own practice, the Plan expects that PCPs will refer appropriately for both outpatient and inpatient services while continuing to manage the care being delivered.

Keystone First CHC allows any Participant who is an Indian, as defined in 42 CFR § 438.14(a), and who is both enrolled in Keystone First CHC and eligible to receive services from an Indian Tribe, Tribal Organization, or Urban Indian Organization I/T/U health care Provider ("I/T/U HCP") PCP participating in the Keystone First CHC network, to choose that participating I/T/U HCP as their PCP, as long as the I/T/U HCP has capacity to provide the services.

PCPs are responsible for:

- Providing primary and preventive care, acting as the Participant’s advocate, and providing, recommending and arranging for services.
- Documenting all care rendered in a complete and accurate Encounter record that meets or exceeds DHS data specifications.
- Maintaining continuity of each Participant’s healthcare.
- Communicating effectively with the Participant by using specialized interpretive services for Participants who are deaf and blind, and oral interpreters for those Participants with LEP when needed. Interpreter services must be free of charge to the Participant and the PCP cannot require family Participants to be used for interpretation.
- Making referrals for specialty care and other Medically Necessary services, both in and out-of-plan.
- Maintaining a current medical and other service record for the Participant, including documentation of all services provided to the Participant by the PCP, as well as any specialty or referral services.
- Coordinating Behavioral Health Services by working with BH-MCOs.
- To have the ability to perform or directly supervise the ambulatory primary care services for Participants.
- Attending at least one Provider education training session conducted by the Plan.

PCPs play an integral role in for Participants that are eligible for LTSS services and should notify the Service Coordinator when there is a change in condition, hospital admission, change in caregiver status and assist in identifying the subtle changes that could prevent an admission to the hospital or nursing facility. Providers are vital PCPT participants with valuable input to ensure that the Participant successfully meets their goals.

Keystone First CHC’s approach is to assist Participants with identifying Participants of a Person-Centered Planning Team, which is comprised of individuals who are important to the Participant because they can offer support, guidance, information, and assistance during the development of Person-Centered Service Plans. PCPs, Service Providers, advocates, Care Managers, clergy and caregivers are just a few examples of potential Participants of the Person-Centered Planning Team.

All of the instructional materials provided to our Participants stress that they should always seek the advice of their PCP before accessing medical care from any other source. It is imperative that the PCP and his or her staff foster this idea and develop a relationship with the Participant, which will be conducive to continuity of care.

PCPs are required to contact:

- New Participants who have not had an office visit within the first six (6) months of being on the PCP’s panel;
- Participants who have not had an office visit during the previous twelve (12) months (See “Access Standards for PCPs” in this section of the Manual)

Additionally, PCPs are required to:

- Document reasons for non-compliance and the PCP's efforts to bring Participant's care into compliance; and
The Plan PCP, or the PCP's qualified, designated on-call Providers, should be accessible 24 hours per day, seven days per week, for urgent or emergency care: at the office site during all published office hours, and by answering service after hours.

When the PCP uses an answering service or answering machine to intake calls after normal hours, the call must be answered within ten (10) rings, and the following information must be included in the message:

- Instructions for reaching the PCP
- Instructions for obtaining emergency care

Appointment scheduling should allow time for the unexpected urgent care visit. (See "Access Standards for PCPs" in this section of the Manual)

PCPs should perform routine health assessments as appropriate to a patient's age and sex and maintain a complete individual Participant medical record of all services provided to the Participant by the PCP, as well as any specialty or referral services.

PCPs must communicate effectively with Participants by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with LEP when needed by the Participant. Services must be free of charge to the Participant and PCPs cannot require family Participants to be used for interpretation. Refer to the Cultural Responsiveness section of the manual for complete details.

Participants have the right to access all information contained in the medical record unless access is restricted for medical reasons.

Mandatory Abuse and Neglect Reporting

Providers must be alert for the signs of suspected abuse and neglect, and as mandatory reporters under the law know their legal responsibility to report such suspicions.

All Providers are mandatory reporters of abuse and neglect, including:

- Assisted Living Facility
- Domiciliary Care Home
- Home Health Care Agency
- Intermediate Care Facility for Individuals with Intellectual Disabilities or with Other Related Conditions
- Nursing Facility
- Older Adult Daily Living Center
- Personal Care Home
- Residential Treatment Facility
- An organization or group of people that uses public funds and is paid, in part, to provide care and support to adults in a licensed or unlicensed setting

A report can be made on behalf of the adult whether they live in their home or in a care facility such as a nursing facility, group home, hospital, etc. Reporters may remain anonymous and have legal protection from retaliation, discrimination, and civil and criminal prosecution. The statewide Protective Services hotline is available 24 hours a day.

APS

For individuals 18 years of age or older but under 60 years of age Contact Protective Services Hotline at 1-800-490-8505

OAPSA

For individuals 60 years of age and older
Contact Protective Services Hotline at **1-800-490-8505**

In 2010, the APS Law, Act 70 of 2010, was enacted to provide protective services to adults between 18 and 59 years of age who have a physical or mental impairment that substantially limits one or more major life activities. The APS Law establishes a program of protective services in order to detect, prevent, reduce and eliminate abuse, neglect, exploitation and abandonment of adults in need.

The OAPSA, which was amended by Act 13 of 1997, mandates reporting requirements on suspected abuse. Any employee or administrator of a facility who suspects abuse is mandated to report the abuse. All reports of abuse should be reported to the local Area Agency on Aging and licensing agencies. If the suspected abuse is sexual abuse, serious physical injury, serious bodily injury, or suspicious death as defined under OAPSA, the law requires additional reporting to the Department of Aging and local law enforcement.

DEFINITIONS OF ABUSE REQUIRING ADDITIONAL REPORTING:

1. Sexual Abuse—intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest. Sexual Harassment requires reporting to the AAA only.
2. Serious Physical Injury—an injury that causes a person severe pain or significantly impairs a person's physical functioning, either temporarily or permanently.
3. Serious Bodily Injury—an injury which creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of a body Participant or organ.
4. Suspicious Death—a death that would arouse suspicion or is questionable.

FACILITIES (DEFINED BY OAPSA)

- Adult Daily Living Centers

- Personal Care Homes
- Assisted Living Residences
- Birth Centers
- Community Homes for Individuals with Mental Retardation
- Community Residential Rehabilitation Services
- Department of Public Welfare (DPW) Nursing Facilities
- DPW-licensed and DPW operated residential facilities for adults
- Domiciliary Care Homes
- Family Living Homes
- *Home Care Registry
- **Home Health Care Organization or Agency
- Hospices
- Intermediate Care Facilities for the Mentally Retarded (private and state)
- Long Term Care Nursing Facilities
- Long Term Structured Residences
- Personal Care Homes
- State Mental Hospitals

*A Home Care Registry or “Registry” is further defined to include those agencies licensed by the Department of Health any organization or business entity that supplies, arranges or refers independent contractors to provide activities of daily living or instrumental activities of daily living or specialized care in the consumer’s place of residence or other independent living environment for which the registry receives a fee, consideration or compensation of any kind.

**Home Health Care Agency is further defined to include those agencies licensed by the Department of Health and any public or private organization which provides care to a care- dependent individual in their place of residence.

Statewide Elder Abuse Hotline: 1-800-490-8505

Any person who believes that an older adult is being abused, neglected, exploited or abandoned may call the elder abuse hotline. The hotline is open 24 hours a day.

Completing Medical Forms

In accordance with DHS policy, if a medical examination or office visit is required to complete a form, then you may not charge the Plan Participants a fee for completion of the form. Payment for the medical examination or office visit includes payment for completion of forms.

However, you may charge the Plan Participants a reasonable fee for completion of forms if a medical examination or office visit is not required to complete the forms. Examples include forms for Driver Licenses, Camp and/or School applications, Working Papers, etc. *You must provide the*

Plan Participants with advance written notice that a reasonable fee will be charged for completing forms in such instances. However, if a Plan Participant states that it will be a financial hardship to pay the fee, you must waive the fee.

The following physical examinations and completion of related forms are not covered by the Plan:

- Federal Aviation Administration (Pilot's License)
- Return to work following work related injury (Worker's Compensation)

PCP Reimbursement

PCP Fee-For-Service Reimbursement

Fee-for-service PCP reimbursement is a payment methodology used by the Plan. If contracted under this methodology, practitioners are required to bill for all services performed in the primary care office. Reimbursement is in accordance with the Fee-for-Service Compensation schedule that is included in the Provider's contract.

From time to time, the Plan implements pay for performance or other payment programs and will offer such programs to eligible Providers.

The Plan is responsible for reporting utilization data to DHS, on at least a monthly basis. It is therefore necessary that PCP Encounter information be received by the Plan on a regular basis. PCPs are required to submit an Encounter for every visit with a Participant whether or not the Encounter contains a billable service. Additional information on Encounter reporting requirements can be found in the later part of this section. PCPs can earn additional compensation when the Plan is able to identify that they are treating medically complex Participants. To this end, it is important that all Encounters submitted contain all the diagnoses that have been confirmed by the PCP.

The PCP Office Visit

It is imperative that PCPs verify Participant eligibility prior to rendering services to the Plan Participants. For complete instructions on looking up eligibility, please refer to the "Participant Eligibility" Section of the Manual for additional information on verifying eligibility.

As a PCP, it is also necessary to complete and submit a CMS-1500 Form or an EDI Claim (electronic Claim submission) for each Participant Encounter (each time a Participant receives services. See "Encounter Reporting" in this section of the Manual for more information concerning Participant Encounters.

Participants must obtain a referral from their assigned PCP in order to access most Network Specialists, provided the Participant obtains services within the Network. Participants may self-refer for vision, dental care, obstetrical and gynecological (OB/GYN) services, and Family Planning Services. Participants are not restricted to choose a network Provider for Family Planning services. Participants may access chiropractic services in accordance with the process set forth in Medical

Assistance Bulletin 15-07-01, and physical therapy services in accordance with the Physical Therapy Act (63 P.S. §§ 1301 et seq.). For further information on authorizations and referrals, see the "Referral Process" section of the Manual.

Forms/Materials Available

The Plan forms are available on the Provider Center at <https://www.keystonefirstchc.com/providers/manual-forms/index.aspx>, including but not limited to:

- Online Provider Directory
- Hospital notification of emergency admission
- Provider change form
- Obstetrical Needs Assessment form (ONAF)

Access Standards for PCPs

The Plan has established standards to assure accessibility of medical care services. The standards apply to PCPs. PCPs are expected to adhere to the following standards for appointment availability for medical care services, and other additional requirements.

The Plan PCPs are expected to meet the following standards regarding appointment availability and response to Participants:

Appointment Accessibility Standards

Appointment Accessibility Standards	
Medical Care:	The Plan Standard:
Preventive Care must be scheduled <i>(health assessment/general physical examinations and first examinations)</i>	Within 3 weeks of the Participant's Enrollment
Routine Primary Care must be scheduled	Within 10 business days of the Participant's call
Non-Urgent Sick Visits must be scheduled	Within 72 hours of the Participant's call
Urgent Medical Condition Care must be scheduled or referred to an Urgent Care Clinic	Within 24 hours of the Participant's call
Emergency Medical Condition Care must be seen	Immediately upon the Participant's call or referred to an emergency facility

After-Hours Accessibility Standards	
Medical Care:	The Plan Standard:

After-hours Care by a PCP or a covering PCP must be available *	24 hours/7 days per week
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The Plan PCP, or the PCP's qualified, designated on-call Providers, should be accessible 24 hours per day, seven days per week, for urgent or emergency care: at the office site during all published office hours, and by answering service after hours.

When the PCP uses an answering service or answering machine to intake calls after normal hours, the call must be answered within ten (10) rings, and the following information must be included in the message:

- Instructions for reaching the PCP
- Instructions for obtaining emergency care

The following are requirements for Participants who require specific services and/or have Special Needs. The Plan asks that PCPs contact all new panel Participants for an initial appointment. The Plan has Special Needs and Care Management Programs that also reach out to Participants in the following categories. The Plan expects that PCPs will cooperate in scheduling timely appointments. It is important for the PCP to inform the Plan if he/she learns that a Participant is pregnant to assure appropriate follow up. Please call 1-800-521-6007 to refer a Participant to the Plan's Bright Start Maternity Program and/or for assistance in locating an OB/GYN practitioner. (OB/GYN services do not require a referral.)

Initial Examination for Participants	Appointment Scheduled with a PCP or Specialist
with HIV/AIDS	No later than 7 days of the effective date of Enrollment, unless the Participant is already being treated by a PCP or Specialist.
who receive Supplemental Security Income (SSI)	Within 3 weeks of the Participant's Enrollment

Participants who are pregnant	Appointment Scheduled with a OB/GYN practitioner
Pregnant women in their 1 st trimester	Within 10 business days of the Plan learning the Participant is pregnant.
Pregnant women in their 2 nd trimester	Within 5 business days of the Plan learning the Participant is pregnant.
Pregnant women in their 3 rd trimester	Within 4 business days of the Plan learning the Participant is pregnant.
High-risk Pregnant Women	Within 24 hours of the Plan learning the Participant is pregnant or immediately if an Emergency Medical Condition exists.

Additional Requirements of PCPs

1. The average waiting time for scheduled appointments must be no more than 30 minutes unless the PCP encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. In such cases, waiting time should not exceed one (1) hour
2. Patients must be scheduled at the rate of six (6) patients or less per hour
3. The PCP must have a "no show" follow-up policy. Two (2) notices of missed appointments and a follow-up telephone call should be made for any missed appointments* and documented in the medical record. When an LTSS Participant misses an appointment, the PCP must contact the Service Coordinator in order for the Service Coordinator to conduct affirmative outreach.
4. Number of regular office hours must be greater than or equal to 20 hours per week
5. Telephonic response time (call back) for non-emergency conditions should be less than two (2) hours
6. Telephonic response time (call back) for emergency conditions must be less than 30 minutes
7. Participant medical records must be maintained in an area which is not accessible to those not employed by the practice. Network Providers must comply with all applicable laws and regulations pertaining to the confidentiality of Participant medical records, including, obtaining any required written Participant consents to disclose confidential medical records.
8. 24 hour/ 7 days per week coverage must be available via the PCP for urgent and Emergency Medical Condition care. **An answering machine message that does not answer the call by 10 rings or provide instructions on how to reach the PCP does not constitute coverage.** For example, it is not acceptable to have a message on an answering machine that instructs the Participant to go to the emergency room for care without providing instructions on how to reach the PCP.
9. PCPs must comply with all Cultural Responsiveness standards. Please refer to **"PCP & Specialist Office Standards"** in this Section of the Manual, as well as the **"Regulatory Provisions"** Section of the Manual for additional information on Cultural Responsiveness.

*** As a reminder, Medical Assistance Providers are prohibited from billing Medical Assistance recipients for missed appointments, also known as "No Show". Please refer to Medical Assistance Bulletin 99-10-14 entitled "Missed Appointments" in the appendix of this manual.**

Please refer to "PCP & Specialist Office Standards" in this section of the Manual for further information on the following practitioner standards:

- Medical Record Standards
- Physical Office Layout

Encounter Reporting

Encounter — Any Covered Service provided to a Participant, regardless of whether it has an associated Claim.

Encounter Data — A record of any Covered Service provided to a Participant and includes Encounters reimbursed through Capitation, FFS, or other methods of payment regardless of whether a payment is due or made.

Completion of Encounter Data

PCPs must complete and submit a CMS-1500 form or file an electronic Claim every time Plan Participant receives services. Completion of the CMS-1500 form or electronic Claim is important for the following reasons:

- It allows the Plan to gather statistical information regarding the medical services provided to the Plan's Participants, which better support our statutory reporting requirements
- It allows the Plan to identify the severity of illnesses of our Participants
- It allows the Plan to report HEDIS/Quality data to DHS.

The Plan can accept Encounter Claim submissions via paper or electronically (EDI). For more information on electronic Claim submission and how to become an electronic biller, please refer to the "EDI Technical Support Hotline" topic in the Manual or the Claims Filing Instructions in Section VII.

In order to support timely statutory reporting requirements, we encourage Providers to submit Encounter information within 30 days of the Encounter. However, all Encounters (Claims) must be submitted within 180 calendar days after the services were rendered or compensable items were provided.

The following mandatory information is required on the CMS-1500 form for a primary care visit:

- The Plan Participant's ID number
- Participant's name
- Participant's date of birth
- Other insurance information: company name, address, policy and/or group number, and amounts paid by other insurance, copy of EOBs
- Information advising if patient's condition is related to employment, auto accident, or liability suit
- Name of referring physician, if appropriate
- Dates of service, admission, discharge
- Primary, secondary, tertiary and fourth ICD-10-CM diagnosis codes, coded to the highest level of specificity.
- Authorization or referral number
- CMS place of service code
- HCPCS procedures, service or supplies codes; CPT I and/or CPT II, procedure codes with appropriate modifiers
- Charges
- Days or units/NDC when applicable
- Physician/supplier federal tax identification number or Social Security Number

- National Practitioner ID (NPI) and Taxonomy Code
- Individual the Plan assigned practitioner number
- Name and address of facility where services were rendered
- Physician/supplier billing name, address, zip code, and telephone number
- Invoice date

Please see "Claims Filing Instructions" in Section VII of the Manual for additional information for the completion of the CMS form.

****LTSS Providers (DHS Provider Type 59): IMPORTANT INFORMATION FOR PROVIDERS***
BILLING FOR CHC LTSS SERVICES: When billing for LTSS services, please do not use an NPI number. Instead, use your Plan Provider ID in place of an NPI number.

The Plan monitors Encounter data submissions for accuracy, timeliness and completeness through Claims processing edits and through network Provider profiling activities. Encounters can be rejected or denied for inaccurate, untimely and incomplete information. Network Providers will be notified of the rejection via a remittance advice and are expected to resubmit corrected information to the Plan. Network Providers may be subject to sanctioning by the Plan for failure to submit 100% of Encounters, including Encounters for capitated services. Network Providers may also be subject to sanctioning by the Plan for failure to submit accurate Encounter data in a timely manner.

The Provider Services department can address questions concerning Encounter Reporting by calling **1-800-521-6007**.

Transfer of Non-Compliant Participants

By PCP request, any Participant whose behavior would preclude delivery of optimum medical care may be transferred from the PCP's panel. The Plan's goal is to accomplish the uninterrupted transfer of care for a Participant who cannot maintain an effective relationship with his/her PCP.

A written request on your letterhead asking for the removal of the Participant from your panel must be sent to the Provider Services department that includes the following:

- The Participant's full name and the Plan identification number
- The reason(s) for the requested transfer
- The requesting PCP's signature and the Plan identification number

Transfers will be accomplished within 30 days of receipt of the written request, during which time the PCP must continue to render any needed emergency care.

The Provider Services department will assign the Participant to a new PCP and will notify both the Participant and requesting PCP when the transfer is effective. The Provider Services department Telephone Number is **1-800-521-6007**.

Requesting a Freeze or Limitation of Your Participant Panel

The Plan recognizes that a PCP will occasionally need to limit the volume of patients in his/her practice in the interest of delivering quality care.

The Plan must have 90 days advance written notice of any request to change panel status.

For example, a panel limitation or freeze request received on May 1 would become effective on August 1. When requesting to have Participants added to panels where age restriction or panel limitations exist, the Plan must be notified in writing on the PCP office's letterhead.

Policy Regarding PCP to Participant Ratio

PCP sites may have up to 1,000 MA recipients (cumulative across all Community HealthChoices plans) per each full-time equivalent PCP at the site. For example, if a primary care site has seven full-time equivalent PCPs, they can have up to 7,000 MA recipients (cumulative across all Community HealthChoices plans).

Letter of Medical Necessity (LOMN)

In keeping with the philosophy of managed care, PCPs may be requested to supply supporting documentation to substantiate medical necessity when:

- Services require Prior Authorization
- Services include treatment or diagnostic testing procedures that are not available through accepted medical practice
- Services are not provided by a network Provider or facility
- Initial documentation submitted is insufficient for the Plan to make a determination

This is not an all-inclusive listing of circumstances for which supporting medical documentation may be requested. Additional supporting documentation may also be requested at the discretion of the Plan's Medical Director or his/her designee.

Supporting medical documentation should be directed to the Utilization Management staff person managing the case of the Participant in question, or to the Medical Director or his/her designee, as appropriate. At a minimum, all supporting medical documentation should include:

- The Participant's name and the Plan identification number
- The diagnosis for which the treatment or testing procedure is being sought
- The goals of the treatment or testing for which progress can be measured for the Participant
- Other treatment or testing methods, which have been tried but have not been successful along with the duration of the treatment
- Where applicable, what treatment is planned, if any, after the patient has received the therapy or testing procedure that is being requested

PCP Responsibilities Under the Patient Self Determination Act

In 1990, the Congress of the United States enacted the Patient Self-Determination Act. Since 1992, Pennsylvania law has allowed both the "living will" and "durable power of attorney" as methods for patients to relay advance directives regarding decisions about their care and treatment.

PCPs should be aware of, and discuss, the Patient Self-Determination Act with their adult patients. Specific responsibilities of the PCP are:

- Discuss the patient's wishes regarding advance directives on care and treatment during routine and/or episodic office visits when appropriate
- Document the discussion in the patient's medical record and whether or not the patient has executed an advance directive
- Provide the patient with written information concerning advance directives if asked
- Do not discriminate against the individual based on whether or not she/he has executed an advance directive
- Ensure compliance with the requirements of Pennsylvania state law concerning advance directives

The Plan provides our Participants with information about the Patient Self-Determination Act. Information regarding this topic can be found in Section XI of the Manual entitled "Participant Rights and Responsibilities."

Preventive Health Guidelines

The Preventive Health Guidelines were adopted from the U.S. Preventive Services Task Force. The contents of these guidelines were carefully reviewed and approved by peer Providers at the Plan's Clinical Quality Improvement Committee. As with all guidelines, the Plan Preventive Health Guidelines are based on recommendations from the U.S. Preventive Services Task Force and are not intended to interfere with a health care Provider's professional judgment. You can call your Provider Account Executive to request hard copies of the Preventive Health Guidelines.

Clinical Practice Guidelines

The Plan has adopted clinical practice guidelines for use in guiding the treatment of the Plan Participants, with the goal of reducing unnecessary variations in care. The Plan's clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual.

The Plan's Clinical Practice Guidelines are available in the Provider Center at, <https://www.keystonefirstchc.com/providers/index.aspx> or call your Provider Account Executive to request a copy.

In support of the above guidelines, the Plan has Disease Management and Care Management programs available to assist you in the education and management of your patient with chronic diseases. For information, a copy of the above clinical guidelines, or to refer a Plan Participant for Disease or Care Management Services, call Provider Services at **1-800-521-6007** and ask for the Special Needs department.

Specialty Care Providers

The Specialist Office Visit

Plan Participants receive Specialist services from network Providers via a referral from their PCP's office. Participants must obtain a referral from their assigned PCP in order to access most Network Specialists, provided the Participant obtains services within the Network. Participants may self-refer for vision, dental care, obstetrical and gynecological (OB/GYN) services, and Family Planning Services. Participants are not restricted to choose a network Provider for Family Planning services. Participants may access chiropractic services in accordance with the process set forth in Medical Assistance Bulletin 15-07-01, and physical therapy services in accordance with the Physical Therapy Act (63 P.S. §§ 1301 et seq.). For further information on authorizations and referrals, see the "Referral Process" section of the Manual. Specialist services are reimbursed on a fee-for-service basis at the Provider's contracted rate.

Prior to rendering services, Specialists should always verify Participant eligibility, which can be done by checking "Participant Eligibility" through NaviNet online at www.navinet.net or by calling Provider Services at **1-800-521-6007**. For more information, please refer to "Referral & Authorization Requirements" in Section III of this Manual. Specialists should provide timely communication back to the Participant's PCP regarding consultations, diagnostic procedures, test results, treatment plan and required follow up care. It is necessary for all network Providers to adhere to the applicable office standards as outlined in "PCP & Specialist Office Standards" in this Section.

Reimbursement/Fee-for-Service Payment

The Plan will reimburse all contracted specialists at fee-for-service rates described in the network Provider's individual the Plan Specialty Care Provider Agreement.

Please refer to "Claims Filing Instructions" in Section VII of the Manual for complete billing instructions. Should you determine the need for diagnostic testing or procedures requiring authorization, please contact the Plan's Utilization Management department at **1-800-521-6622** to obtain authorization.

Specialist Services

Specialists shall provide Medically Necessary covered services to the Plan Participants referred by the Participant's PCP. These services include:

- Ambulatory care visits and office procedures
- Arrange or provide inpatient medical care at a Plan participating hospital
- Consultative Specialty Care Services 24 hours a day, 7 days a week

Mandatory Abuse and Neglect Reporting

All Providers must be alert for the signs of suspected abuse and neglect, and as mandatory reporters must know their legal responsibility to report such suspicions. To make a report call: **Statewide Elder Abuse Hotline: 1-800-490-8505.**

A report can be made on behalf of the adult whether they live in their home or in a care facility such as a nursing facility, group home, hospital, etc. Reporters may remain anonymous and have legal protection from retaliation, discrimination, and civil and criminal prosecution. The statewide Protective Services hotline is available 24 hours a day.

APS

For individuals 18 years of age or older but under 60 years of age Contact Protective Services Hotline at **1-800-490-8505**

OAPSA

For individuals 60 years of age and older
Contact Protective Services Hotline at **1-800-490-8505**

In 2010, the APS Law, Act 70 of 2010, was enacted to provide protective services to adults between 18 and 59 years of age who have a physical or mental impairment that substantially limits one or more major life activities. The APS Law establishes a program of protective services in order to detect, prevent, reduce and eliminate abuse, neglect, exploitation and abandonment of adults in need.

The OAPSA, which was amended by Act 13 of 1997, mandates reporting requirements on suspected abuse. Any employee or administrator of a facility who suspects abuse is mandated to report the abuse. All reports of abuse should be reported to the local Area Agency on Aging and licensing agencies. If the suspected abuse is sexual abuse, serious physical injury, serious bodily injury, or suspicious death as defined under OAPSA, the law requires additional reporting to the Department of Aging and local law enforcement.

DEFINITIONS OF ABUSE REQUIRING ADDITIONAL REPORTING:

- Sexual Abuse—intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest. Sexual Harassment requires reporting to the AAA only.
- Serious Physical Injury—an injury that causes a person severe pain or significantly impairs a person’s physical functioning, either temporarily or permanently.
- Serious Bodily Injury—an injury which creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of a body Participant or organ.
- Suspicious Death—a death that would arouse suspicion or is questionable.

Statewide Elder Abuse Hotline: 1-800-490-8505

Any person who believes that an older adult is being abused, neglected, exploited or abandoned may call the elder abuse hotline. The hotline is open 24 hours a day.

Specialist Access & Appointment Standards

The average office waiting time should be no more than 30 minutes, or no more than one (1) hour when the network Provider encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. Scheduling procedures should ensure:

- Emergency appointments immediately upon referral
- Urgent Care appointments within twenty-four (24) hours of referral
- Routine appointments within 30 days of the referral
- After-hours care by the Provider or a covering specialists must be available 24/7

Network Providers must have a "no-show" follow-up policy. Two (2) notices of missed appointments and a follow-up telephone call should be made for any missed appointments and documented in the medical record. When an LTSS Participant misses an appointment, the PCP or specialist must contact the Service Coordinator in order for the Service Coordinator to conduct affirmative outreach.

Payment in Full

As outlined in the Pennsylvania Department of Human Services' Medical Assistance bulletin 99- 99-06 entitled "Payment in Full", the Plan strongly reminds all Providers of the following point from the bulletin:

Providers requiring Medicaid recipients to make cash payment for Medicaid covered services* or refusal to provide medically necessary services to a Medicaid recipient for lack of pre-payment for such services are illegal and contrary to the participation requirements of the Pennsylvania Medical Assistance program.

***Covered services include products, office visits, urine drug screens, counseling referrals, etc., used to treat opioid dependence.**

Additionally, the Pennsylvania Code, 55 Pa. Code § 1101.63 (a) statement of policy regarding full reimbursement for covered services rendered specifically mandates that:

- All payments made to Providers under the MA program plus any copayment required to be paid by a recipient shall constitute full reimbursement to the Provider for covered services rendered.
- A Provider who seeks or accepts supplementary payment of another kind from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment.

To review the complete MA Bulletin 99-99-06, "Payment in Full", visit the Provider Center at <https://www.keystonefirstchc.com/providers/communications/dhs-bulletins-and-news.aspx>.

Cost-Sharing Exemption for Indians; No Reduction in Payments.

A Participant who is an Indian, as defined in 42 CFR § 438.14(a), and who is eligible to receive or has received an item or service furnished by an Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services, as defined in 42 CFR § 447.51, is exempt from any premiums or other cost sharing imposed by the Department.

Confidentiality of Medical Records

Patient medical records must be maintained in an area that is not accessible to those not employed by the practice. Network Providers must comply with all applicable laws and regulations pertaining to the confidentiality of Participant medical records, including obtaining any required written Participant consents to disclose confidential medical records. Please refer to "Medical Record Standards" in this section of the Manual for further information on the maintenance of medical records.

Letters of Medical Necessity (LOMN)

In keeping with the philosophy of managed care, health care Providers may be requested to supply supporting documentation to substantiate medical necessity when:

- Services require Prior Authorization
- Services include treatment or diagnostic testing procedures that are not available through accepted medical practice
- Services are not provided by a network Provider or facility
- Initial documentation submitted is insufficient for the Plan to make a determination

This is not an all-inclusive listing of circumstances for which supporting medical documentation may be requested. Additional supporting documentation may also be requested at the discretion of the Medical Director or his/her designee.

Supporting medical documentation should be directed to the Utilization Management staff that is managing the case of the patient in question, or to the Medical Director or his/her designee, as appropriate. At a minimum, all supporting medical documentation should include:

- The Participant's name and the Plan ID number
- The diagnosis for which the treatment or testing procedure is being sought
- The goals of the treatment or testing for which progress can be measured for the Participant
- Other treatment or testing methods which have been tried but have not been successful, along with the duration of the treatment
- Where applicable, what treatment is planned, if any, after the patient has received the therapy or testing procedure, which is being requested

Specialist Responsibilities under the Patient Self Determination Act

In 1990, the Congress of the United States enacted the Patient Self-Determination Act. Since 1992, Pennsylvania law has allowed both "living wills" and "durable power of attorney" as methods for patients to relay advance directives regarding decisions about their care and treatment.

Specialists should be aware of and discuss the Patient Self-Determination Act with their adult patients. Specific responsibilities of the specialist are outlined below:

- Discuss the patient's wishes regarding advance directives on care and treatment during routine and/or episodic office visits when appropriate
- Document the discussion in the patient's medical record, and whether or not the patient has executed an advance directive
- Provide the patient with written information concerning advance directives if asked
- Do not discriminate against the individual based on whether or not he/she has executed an advance directive
- Ensure compliance with the requirements of Pennsylvania state law concerning advance directives

The Plan provides our Participants with information about the Patient Self-Determination Act. Information regarding this topic can be found in "Participant Rights and Responsibilities" in Section XI of the Manual.

Specialist as a PCP for Participants

Refer to the Special Needs and Care Management Section for complete details. Providers who are willing to serve/care for Participants should contact their Provider Account Executive.

PCP & OB/GYN Office Standards

Physical Environment

The Plan conducts an initial office site visit to all potential PCP and OB/GYN sites during the credentialing process. Each practice/site location of all PCPs and OB/GYNs must receive a site visit re-evaluation every three years. The Credentialing Committee considers the results of the office site visit in making a determination as to whether the health care Provider will be approved for participation in the Plan's Network. The office site visit is intended to collect information about Provider performance in the following areas:

- Facility Information
- Safety
- Provider Accessibility
- Emergency Preparedness
- Treatment Areas
- Medication Administration
- Infection Control
- Medical Record Keeping Practices
- General Information

The following are examples of standards that must be met for Plan network participation:

1. Office must have visible signage and must be handicapped-accessible*
2. Office hours must be posted
3. Office must be clean and presentable
4. Office must have a waiting room with chairs
5. Office must have an adequate number of staff/personnel to handle patient load, with an assistant available for specialized procedures
6. Office must have at least two examination rooms that allow for patient privacy
7. Office must have the following equipment:
 - a. Examination table
 - b. Otoscope
 - c. Ophthalmoscope
 - d. Sphygmomanometer
 - e. Thermometers
 - f. Needle disposal system
 - g. Accessible sink/hand washing facilities
 - h. Bio-hazard disposal system
8. There must be a system in place to properly clean/decontaminate and sterilize reusable equipment. Bio-medical equipment must be part of an annual preventive maintenance program
9. Office must have properly equipped (handicapped-accessible) restroom facilities, readily accessible to patients
10. There are safeguards to maintain Confidentiality/security of medical records and patient identifiable information (as they relate to visual and computer access, office conversations, only authorized personnel have access to record).
11. Must have written procedures for medical emergencies and a written evacuation plan. During patient hours, at least one staff person must be CPR-certified
12. The office must be equipped with at least one fire extinguisher that is properly serviced and maintained
13. Must have blood-borne pathogen exposure control plan
14. Medications must be stored in a secure place away from public areas. Refrigerators used for medication storage must have a thermometer. Controlled substances must be locked, and prescription pads must be kept in a secure place

* Title III of the Americans with Disabilities Act (ADA, 42 U.S.C. 12101 et seq.) states that places of public accommodation must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations (such as health care Providers) must specifically comply with, among other things, requirements related to effective physical accessibility, communication with people with hearing, vision, or speech disabilities, and other access requirements. For more information, you can go to the Department of Justice's ADA home page <https://www.ada.gov/index.html>.

Inspections will be conducted of the office of any Provider who provides services on site at the Provider's location and who seeks to participate in the Provider Network to determine whether the

office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with 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.

If the office or facility is not accessible under the terms of this paragraph, the PCP may participate in the Provider Network provided that the PCP: 1) requests and is determined to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within one hundred-eighty (180) days after the barrier was identified.

Medical Record Standards

Complete and consistent documentation in patient medical records is an essential component of quality patient care. The Plan adheres to medical record requirements that are consistent with national standards on documentation and applicable laws and regulations. Compliance with the Plan's medical record standards and preventive health guidelines are evaluated, not less than every 2 years, based on a random selection process and/or as determined by the Plan for Primary Care Practitioners (PCP), Obstetrics and Gynecology (OB/GYN) Providers, high-impact/high-volume specialists and other Providers as deemed appropriate. Providers are notified of Plan medical standards through the Provider newsletter and website. PCPs and Specialists also receive a copy of the standards at the time of their initial and subsequent site visit.

The Plan performs a medical record review every two years on a random selection of Providers. The medical records are audited using these standards.

The following is a list of our standards.

- Medical records are organized and maintained in a consistent manner, and the records are kept secure, confidential, and only authorized staff have access.
- Staff receive training on Participant information confidentiality.
- Patient's name or identification number is included on each page of record.
- All entries are legible, initialed or signed and dated by the author.
- Personal and biographical data are included in the record.
- All services are provided by a PCP or allied health professional under the supervision of a PCP.
- Current and past medical history and age-appropriate physical exams are documented including serious accidents, operations, hospitalizations and illnesses.
- Reports of operative procedures and excised tissues.
- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA".
- Information regarding personal habits such as smoking, and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.

- Ancillary and diagnostic tests ordered, and reports from therapeutic services for which a Participant was referred by a practitioner.
- Documentation of discussions of a living will or other advance directive for patients 65 years or older.
- Patient's chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded. Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis, including therapies and other prescribed regimens.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the network Provider and updated as needed.
- Health care education provided to patients, family Participants or designated caregivers is noted in the record and periodically updated as appropriate.
- Screening and preventive care practices are in accordance with the Plan's Preventive Health Guidelines.
- An immunization record appropriate history has been made in the medical record.
- Requests for consultations are consistent with clinical assessment/physical findings.
- Laboratory and other studies are ordered, as appropriate.
- Laboratory and diagnostic reports reflect network Provider review.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented.
- There is evidence of continuity and coordination of care between PCPs and Specialists.
- Document all therapies and other prescribed regimens.
- Document disposition and follow up.
- Document referrals and results.
- Services provided as per the PCSP for Participants who have one.
- Service Coordination contact notes as applicable.
- Practitioners are required to achieve a medical record score of 90% or greater to meet the Plan's standards.
- Practitioners that do not achieve the score of 90% will have re-audit within 120 days to ensure that the deficiencies area corrected.
- Results for practitioners not achieving a passing score of 90% on the re-audit are presented to the Plan's Credentialing Committee for review and recommendations. The Practitioner will be notified of the Committee's recommendations within ten (10) business days. The Plan's Quality Management department will provide oversight of Committee's recommendations and any Correction Action Plan's requested for specific practitioner practices.

Medical Record Retention Responsibilities

Medical records must be preserved and maintained for a minimum of five (5) years from termination of the health care Provider's agreement with the Plan or as otherwise required by law or regulatory requirement. Medical records may be maintained in paper or electronic form; electronic medical records (EMR) must be made available in paper form upon request.

EMR notes must be individual, specific and unique to the visit for the patient and representative of all of the services rendered on the specific date of service. For EMR, Providers are required to have the audit tracking function turned "on", which will allow tracking of anyone who touches the EMR.

"While EMR cloning may appear to save time, the U.S. Office of the Inspector General (OIG) is currently reviewing duplication standards in hospital charting and has stated that the use of duplicate entries "may be associated with improper payments." Medicare defines cloning as multiple entries in a patient chart that are identical or similar to other entries in the same chart. The independent Medicare administrative contractor (MAC) who reviews charts for appropriateness of service has been directed by the Centers for Medicare and Medicare Services (CMS) to identify "suspected fraud, including inappropriate copying of health information" under the Benefit Integrity/Medical Review Determinations mandate. MACs can deny payments on the grounds that cloning is a "misrepresentation of the medical necessity required for services rendered." This is an absence of explicit, individual information. The Center for Government Services (CGS) states, "For Medicare, the medical necessity of a service is the overarching criterion for payment," but necessity is considered fraudulent if cloning of past medical services, lab and x-ray results, and medical notes from previous days, are simply reinserted into a new day's progress note to justify need." <http://www.cmsdocs.org/news/emr-cloning-a-bad-habit>.

"Documentation to support services rendered needs to be patient specific and date of service specific. These auto-populated paragraphs provide useful information such as the etiology, standards of practice, and general goals of a particular diagnosis. However, they are generalizations and do not support medically necessary information that correlates to the management of the particular patient. Credit cannot be granted for information that is not patient specific and date of service specific" ~ Noridian Medicare Part B bulletins.

"Ultimately, the issue arises because each individual visit is billed, and needs to be documented in the medical records as such, as a unique/distinct visit." Ahima <http://library.ahima.org/doc?oid=300257#.WO4sDP6Qw3U>.

Section VII: Claims



Claims Filing Instructions

The Plan's Claims Filing Instructions can be accessed online in the Provider Center at <https://www.keystonefirstchc.com/providers/claims-billing/index.aspx>.

The Claims Filing Instructions contains current information and is periodically updated as needed. If you prefer a hard copy of the Claims Filing Instructions, please contact your Provider Account Executive or call **1-800-521-6007**.

National Provider Identification Number

The National Provider Identifier (NPI) is a Federally-issued 10-digit unique standard identification number that all physical health Providers must use when submitting electronic claims.

Electronic claims submitted by physical health Providers without an NPI will be rejected back to the Provider via their EDI clearinghouse. Network physical health Providers who submit claims via paper CMS 1500 or UB-04 are also required to include their NPI on their claims.*

The Plan strongly encourages network Providers to continue to submit claims with their Plan Provider (Legacy) ID, in addition to the required NPI number.**

How to Apply for Your NPI

Health care Providers may apply for their NPI in one of the following ways:

- Complete the web-based application at <https://nppes.cms.hhs.gov>. This process takes approximately 20 minutes to complete
- Call the Enumerator call center at 1-800-465-3203 or TTY 1-800-692-2326 to request a paper application
- E-mail customerservice@npienumerator.com to request a paper application
- Request a paper application by mail:
NPI Enumerator
7125 Ambassador Road
Suite 100
Windsor Mill, MD 21244-2751

NOTE: The most time-efficient method of getting an NPI is the web-based application process.

**IMPORTANT INFORMATION FOR PROVIDERS BILLING FOR CHC LTSS*

SERVICES: LTSS Providers (DHS Provider Type 59) are not required to bill with an NPI.

Please **do not bill with an NPI number**. Enter your Plan Provider (Legacy) ID **only** in box 33b.

To comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of Providers (Code of Federal Regulations: 42CFR, §455.410), Providers participating with the Plan must participate in the Pennsylvania Medical Assistance Program.

All Providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made.

Important note: This applies to non-participating out-of-state Providers as well.

This means all Providers must enroll and meet applicable Medical Assistance Provider requirements of DHS and receive a Pennsylvania Promise ID (MMIS/PPID). The enrollment requirements for facilities, physicians and practitioners include registering every service location with DHS and having a different service location extension for each location.

DHS fully intends to terminate Medical Assistance enrollment of all non-compliant Providers. The Plan will comply with DHS's expectation that non-compliant Providers will also be terminated from out network, since medical assistance enrollment is a requirement for participation with the Plan.

Enroll by visiting: <https://www.dhs.pa.gov/providers/Providers/Pages/PROMISE-Enrollment.aspx>
The Department of Human Services (DHS) also requires that Providers obtain an NPI and share it with them.

Prospective Claims Editing Policy

The Plan's claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC). Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include but are not limited to: legislative or regulatory mandates, a Provider's contract, and/or a Participant's eligibility to receive covered health care services.

Claim Filing Deadlines

Original Claims

Original Claims must be submitted to the Plan within 180 calendar days from the date services were rendered or date compensable items were provided.

Re-submission of Rejected Claims

Re-submission of rejected Claims must occur within 180 calendar days from the date of service or date compensable items were provided.

Re-submission of Denied Claims

Re-submission of previously Denied Claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date of service or date compensable items were provided. For more information on billing requirements, please see the Claims Filing Instructions in the Provider Center at <https://www.keystonefirstchc.com/providers/claims-billing/index.aspx>.

Submission of Claims Involving Third Party Liability

If a Participant has other insurance coverage in addition to the Plan coverage, the other insurance carrier (the “Primary Insurer”) must consider the health care Provider’s charges before the Claim is submitted to the Plan. Therefore, health care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health care Providers then may bill the Plan for the Claim by submitting the Claim along with a copy of the Primary Insurer’s EOB. Claims with EOBs from Primary Insurers must be submitted within 60 days of the date of the Primary Insurer's EOB.

Please note – If a claim is paid and it is later discovered there was other insurance, the Plan will recover all reimbursement paid to the Provider.

Failure to Comply with Claim Filing Deadlines

The Plan will not grant exceptions to the Claim filing timeframes outlined in this section. Failure to comply with these timeframes will result in the denial of all Claims filed after the filing deadline. Late Claims paid in error shall not serve as a waiver of the Plan’s right to deny any future Claims that are filed after the deadlines or as a waiver of the Plan’s right to retract payments for any Claims paid in error.

Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a Participant's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than the Plan. TPL does not affect the Participant's Medicaid eligibility. Participants may report other health care coverage (TPL) by calling Keystone First CHC Participant Services at 1-855-332-0729.

COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as the Plan, are always the **payer of last resort**. This means that all other insurance carriers (the “Primary Insurers”) must consider the health care Provider’s charges before a Claim is submitted to the Plan. Therefore, before billing the Plan when there is a Primary Insurer, health care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health care Providers then may bill the Plan for the Claim by submitting

the Claim along with a copy of the Primary Insurer's EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the section above.

Reimbursement for Participants with Third Party Resources

Medicare as a Third-Party Resource

For Medicare services that are covered by the Plan, the Plan will pay, up to the Plan contracted rate, the lesser of:

- The difference between the Plan contracted rate and the amount paid by Medicare, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by Medicare and the Plan will not exceed the Plan's contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, the Plan will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance (MA) Fee-For-Service rate.

For Medicare physical health services that are neither covered the Plan nor the MA Fee-For- Service Program, the Plan will pay cost-sharing amounts to the extent that the combined payment made under Medicare for the service and the payment made by the Plan do not exceed 80% of the Medicare approved amount.

The Plan's referral and authorization requirements are applicable if the services are covered by Medicare and the Participant's Medicare benefits have been exhausted.

Commercial Third-Party Resources

For services that have been rendered by a network Provider, the Plan will pay, up to the Plan's contracted rate, the lesser of:

- The difference between the Plan's contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by the Primary Insurer and the Plan will not exceed the Plan's contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, the Plan will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance Fee-For-Service rate.

Health care Providers must comply with all applicable the Plan referral and authorization requirements.

Program Integrity

The Program Integrity department is responsible for identifying and recovering claims overpayments for the population which Keystone First CHC serves. The department performs several operational activities to ensure the accuracy of claim payments.

As a Provider participating in Keystone First CHC's network, you are responsible to know and abide by all applicable state and federal laws and regulations and by the fraud, waste, and abuse requirements of Keystone First CHC's contract with the Pennsylvania Department of Human Services. Violations of these laws and regulations may be considered fraud, waste or abuse against the Medical Assistance program. Some of the federal fraud and abuse laws physicians must be familiar with include the False Claims Act (31 U.S.C. §§3729-3733) ("FCA"), the Anti- Kickback Statute (42 U.S.C. §1320a-7b(b)), the Physician Self-Referral Law, also known as the Stark law (42 U.S.C. §1395nn), and the federal Exclusion Statute (42 U.S.C. §1320a-7).

The Plan is obligated to ensure the effective use and management of public resources in the delivery of services to its Participants. The Plan does this in part through its Program Integrity department, whose programs are designed to ensure the accuracy of claims payments and the detection and prevention of fraud, waste, and abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of the Plan, regarding payments or the recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your Provider contract, and with state and federal law.

Examples of these Program Integrity initiatives include:

- Prospective (Pre-claims payment)
 - Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services ("CMS"), the American Medical Association ("AMA"), state regulatory agencies or the Plan medical/claim payment policy) are applied to prepaid claims.
 - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
 - Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe.
 - Coordination of Benefits ("COB") - Process to verify third party liability to ensure that the Plan is only paying claims for Participants where the Plan is responsible, i.e., where there is no other health insurance coverage.
 - Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions,

such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.

- Retrospective (Post-claims payment)
 - Third Party Liability (“TPL”)/Coordination of Benefits (“COB”)/Subrogation – As a Medicaid plan, the Plan is by federal statute the payer of last resort. The effect of this rule is that the Plan may recover its payments if it is determined that a Participant had other health insurance coverage at the time of the service.
 - Please also see Section 7 Claims for further description of TPL/COB/Subrogation.
 - Data Mining – Using paid claims data, the Plan identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
 - Medical Record /Itemized Bill Review – a medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. The scope of the validation may encompass any or all of the procedures, diagnosis or diagnosis-related group (“DRG”) billed by the Provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.
 - Please note if medical records are not received within the requested timeframe, the Plan will recoup funds from the Provider. Your failure to provide the necessary medical records to validate billing creates a presumption that the claim as submitted is not supported by the records.
- Credit Balance Issues
 - Credit balance review service may be conducted in-house at the Provider’s facility to assist with the identification and resolution of credit balances at the request of the Provider.
 - Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you may be requested to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

Prior authorization is not a guarantee of payment for the service authorized. The Plan reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the Participant’s eligibility changes between the time authorization was issued and the time the service was provided.

Claims Cost Containment Unit

The Claims Cost Containment Unit is responsible for the manual review of overpaid claims submitted by the Program Integrity department for potential recovery. Claims submitted to the

Claims Cost Containment Unit for review are outside of the Subrogation and Check Reconciliation areas. Some examples of identified “waste” include:

- Incorrect billing from Providers causing overpayment
- Overpayment due to incorrect set-up or update of contract/fee schedules in the system
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments
- Overpayments resulting from incorrect revenue/ procedure codes, retro TPL/Eligibility

The Claims Cost Containment Unit is also responsible for the manual review of Provider initiated overpayments. Providers who self-identify claim overpayments may submit their inquiries for review to the following address:

Claims Repayment Research Unit
PO Box 7146
London, Kentucky 40742-7146

Refunds for Claims Overpayments or Errors

Keystone First CHC and DHS encourage Providers to conduct regular self-audits to ensure accurate payment. Medicaid Program funds that were improperly paid or overpaid must be returned. If the Provider’s practice determines that it has received overpayments or improper payments, the Provider is required to adhere to the following requirements: In accordance with 42 U.S.C. §1320a-7k(d), in most cases, overpayments must be reported and returned to Keystone First CHC within sixty (60) days of identification. Section 6402(a) of the Affordable Care Act establishes that an overpayment retained beyond the timeframe established in 42 U.S.C. §1320a-7k(d) is an obligation per the federal False Claims Act (“FCA”). Providers who improperly retain an overpayment may be subject to liability, including penalties and damages, under the FCA.

1. Contact Keystone First CHC Provider Claim Services at 1-800-521-6007 to arrange the repayment. There are two ways to return overpayments to Keystone First CHC:
 - Have Keystone First CHC deduct the overpayment/improper payment amount from future claims payments, or
 - Return the overpayments directly to Keystone First CHC:
 - Use the Provider Claim Refund form when submitting return payments to Keystone First CHC. The form can be found on the Provider Center at <https://www.keystonefirstchc.com/providers/manual-forms/index.aspx> under Forms.
 - Mail the completed form and refund check for the overpayment/improper payment amount to:
Claims Repayment Research Unit Keystone First CHC
PO Box 7146
London, KY 40742-7146

Note: Please include the Participant’s name and ID, date of service, and Claim ID

2. Providers may follow the “Pennsylvania Medical Assistance (MA) Provider Self-audit Protocol” to return improper payments or overpayments. Access the DHS voluntary protocol process via the following web address:

<https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx>

Special Investigations Unit – Preventing, Detecting, and Investigating Fraud, Waste and Abuse

Special Investigations Unit

Keystone First CHC has an established a Program Integrity department with a proven record in preventing, detecting, investigating, and mitigating fraud, waste, and abuse. Our existing program has been developed in accordance with 42 CFR § 438.608, 42 CFR Part 455, the governing contracts between the Plan and the Commonwealth of Pennsylvania, and applicable federal and state laws. The Program Integrity department has cross-functional teams that support its activities to ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with the requirements as set forth in 42 C.F.R. Part 438, Subpart H (Certifications and Program Integrity) and 42 C.F.R. § 457.950(a)(2).

The Special Investigations Unit (SIU) is housed within the Program Integrity department. The SIU team is responsible for detecting fraud, waste, and abuse throughout the claims payment processes for the Plan. The SIU staff includes experienced investigators and analysts, including Certified Professional Coders, Certified Fraud Examiners, and Accredited Health Care Fraud Investigators.

Among other things, the SIU conducts the following activities:

- Reviews and investigates all allegations of fraud, waste and abuse.
- Takes corrective actions for any supported allegations after thorough investigation, including recovering overpayments that result from fraud, waste, or abuse.
- Reports confirmed misconduct to the appropriate parties and/or agencies.

Definitions of Fraud, Waste and Abuse (FWA)

Fraud –Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The Fraud can be committed by many entities, including the CHC-MCO, a contractor, a subcontractor, a Provider, or a Participant.

Waste – The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

Abuse –Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the MA Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or agreement obligations and the requirements of state or federal law and regulations for healthcare in a managed care setting, committed by the CHC-MCO, a subcontractor, Provider, or Participant, among others.

The mandatory Fraud, Waste, and Abuse Provider Training presentation can be found on our website at <https://www.keystonefirstchc.com/providers/claims-billing/fwa.aspx>.

After you have completed the training, please complete the attestation at <https://www.surveymonkey.com/r/577CX62>.

Recipient Fraud: Someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits and for example, 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: For example, 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.

Fraud, Waste & Abuse – Summary of Relevant Laws and Examples

Under the Community HealthChoices program, Keystone First CHC receives state and federal funding for payment of services provided to our Participants. In accepting Claims payment from Keystone First CHC, health care Providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud or Abuse against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to www.pacode.com/secure/data/055/partIIIitoc.html for more information regarding Fraud or abuse, including “Provider Prohibited Acts” that are specified in §1101.75. Providers are responsible to know and abide by all applicable state and federal regulations.

Keystone First CHC is dedicated to eradicating Fraud and Abuse from its programs and cooperates in Fraud and Abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Section of the Pennsylvania Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the federal Office of Inspector General of the

U.S. Department of Health and Human Services, as well as the Bureau of Program Integrity of the Pennsylvania Department of Human Services. As part of Keystone First CHC's responsibilities, the Program Integrity department, and the SIU in particular, is responsible for identifying and recovering overpayments. The SIU performs several operational activities to detect and prevent fraudulent and/or abusive activities.

Bureau of Program Integrity Retrospective Review

The Department of Human Services, Bureau of Program Integrity (Department), is responsible for the retrospective monitoring and review of services for compliance with Medical Assistance (MA) regulations. Providers within the managed care plans networks are enrolled by the Department into the Medical Assistance Program and their records, claims/encounters are subject to retrospective review in accordance with 55 Pa. Code §§ 1101.51(e) and 1101.71(a).

Rebuttals

Any Provider rebuttal in relation to the Bureau of Program Integrity's (BPI) initiated Retrospective Reviews Process, are to be filed within the timeframes outlined within BPI's preliminary findings letter.

Provider Corrective Action Plan (PCAP)

As a result of the retrospective reviews that have been initiated by the Department of Human Services, Bureau of Program Integrity Division; Keystone First CHC must submit a Provider Corrective Action Plan to the Department to resolve any network Provider's regulatory violations as cited in the final findings notice from BPI.

At the conclusion of the retrospective review of a Provider in which area(s) of noncompliance have been identified, the Department will issue a final findings letter that may require the submission of a Provider Corrective Action Plan (PCAP) to the Department.

Upon receiving confirmation from the Department of the required PCAP, Keystone First CHC's Provider Network Management team will work with the Provider to develop a corrective action plan that addresses the area(s) of noncompliance and all applicable federal and state regulations identified in the Department's final findings letter. The PCAP will reiterate program deficiencies, specify an efficient path toward overall improvement, monitor imposed changes (making adjustments as necessary) and advance accurate and expedient program delivery.

- Keystone First CHC will send the PCAP to the Department for approval within sixty (60) calendar days of the Plan's receipt of the final findings letter.
- If approval is received from the Department the PCAP will be tracked and monitored for compliance for a period of at least (90) calendar days.
- If a denial is received from the Department with an indication of revision to the PCAP, the Keystone First CHC Provider Network Management team will work with the Provider to address all of the Department's concerns. The revised PCAP will be
- submitted to the Department upon receipt.
- Once the Keystone First CHC Provider Network Management team has validated that all action items within the PCAP has been completed, the PCAP will be closed.

The Federal False Claims Act

The False Claims Act (FCA) is a federal law that prohibits knowingly presenting, or causing to be presented, a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. Penalties for violating the FCA include damages in the amount of up to three times the amount of the false claim plus civil penalties of \$11,803 to \$23,607 per false claim.

When the Plan submits claims data to the government for payment (for example, submitting Medicaid claims data to the Pennsylvania Department of Human Services), we must certify that the data is accurate to the best of our knowledge. We are also responsible for claims data submitted on our behalf from our subcontractors, and we monitor their work to ensure compliance.

The FCA contains a whistleblower provision to encourage individuals to report misconduct involving false claims. The whistleblower provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The whistleblower provisions of the FCA protects individuals from retaliation that results from filing an action under the FCA, investigating a false claim, or providing testimony for or assistance in a federal FCA action.

The Federal Fraud Enforcement and Recovery Act

The Fraud Enforcement and Recovery Act of 2009 (FERA) was passed by Congress to enhance the criminal enforcement of federal fraud laws, including the FCA. Penalties for violations of FERA are comparable to penalties for violation of the FCA.

Among other things, FERA:

- Expands potential liability under the FCA for government contractors like Keystone First.
- Expands the definition of a false or fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like Keystone First.
- Expands the definition of a false record to include any record that is material to a false or fraudulent claim.
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

Pennsylvania has not yet enacted a false claims statute similar to the federal FCA. Pennsylvania does, however, have anti-fraud laws that impose criminal and civil penalties for false claims and false statements.

The Pennsylvania Fraud and Abuse Controls, 62 P.S. §§ 1407, 1408

This law, 62 P.S. § 1407, applies to Medicaid Providers and prohibits the submission of false or fraudulent claims to Pennsylvania's Medical Assistance programs as well as the payment of kickbacks in connection with services paid in whole or in part by a Medical Assistance program. A

violation of the law is a criminal felony offense that carries with it penalties of imprisonment of up to 7 years, fines, and mandatory exclusion from Pennsylvania's Medical Assistance programs for 5 years. In addition to criminal penalties, the law authorizes the Pennsylvania Department of Human Services to institute a civil action against a Provider and seek as damages two times the amount of excess benefits or payments paid plus interest.

Pennsylvania has another anti-fraud law, 62 P.S. § 1408, that prohibits anyone from making false claims or false statements in connection with an application for Medical Assistance benefits or payments. Depending upon the nature of the violation, criminal penalties range from felony to misdemeanor offenses. In addition, the Pennsylvania Department of Human Services may institute a civil action against a person who violates this section and seek as damages the amount of the benefits obtained. The Pennsylvania Department of Human Services may also impose a penalty in the amount of \$1,000 against any such person for each violation of the law.

The Pennsylvania Whistleblower Law, 43 P.S. §§ 1421 to 1428

The Pennsylvania Whistleblower Law provides protection from discrimination and retaliation to a person who witnesses or has evidence of wrongdoing or waste while employed and who makes a good faith report of the wrongdoing or waste, verbally or in writing, to one of the person's superiors, to an agent of the employer, or to an appropriate authority.

No employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee or a person acting on behalf of the employee makes a good faith report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste by a public body or an instance of waste by any other employer as defined in the act. In addition, no employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee is requested by an appropriate authority to participate in an investigation, hearing or inquiry held by an appropriate authority or in a court action. A person who, under color of an employer's authority, violates this act shall be liable for a civil fine of not more than \$10,000.

In addition, a whistleblower that is retaliated against may bring an action in court and seek the following relief: reinstatement, the payment of back wages, full reinstatement of fringe benefits and seniority rights, actual damages, or any combination of these remedies. A court shall also award the whistleblower all or a portion of the costs of litigation, including reasonable attorney's fees, if the whistleblower prevails in the civil action.

Examples of fraudulent/abusive/wasteful activities:

- Billing for services not rendered or not Medically Necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not Medically Necessary

- Misrepresenting the services rendered
- Submitting a Claim for Provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services
- Failure to perform services required under a capitated contractual arrangement
- Misrepresentation of dates and times of service
- Misuse of Electronic Medical Records such as cloning and copying so records are identical not unique and specific as required
- Failing to have supporting documentation for billed services
- Duplicate payments, incorrect COB calculations, incorrect contract reimbursement

Reporting and Preventing Fraud, Waste and Abuse (FWA)

If you, or any entity with which you contract to provide health care services on behalf of Keystone First CHC beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact Keystone First CHC by:

- Calling the toll-free Fraud Waste and Abuse Hotline at **1-866-833-9718**;
- E-mailing to FraudTip@amerihealthcaritas.com; or,
- Mailing a written statement to Special Investigations Unit, Keystone First CHC, 3875 West Chester Pike, Newtown Square, PA 19073.

Below are examples of information that will assist Keystone First CHC with an investigation:

- Contact Information (e.g., name of individual making the allegation, address, telephone number);
- Name and Identification Number of the Suspected Individual;
- Source of the Complaint (including the type of item or service involved in the allegation);
- Approximate Dollars Involved (if known);
- Place of Service;
- Description of the Alleged Fraudulent or Abuse Activities;
- Timeframe of the Allegation(s).

Providers may also report suspected fraud, waste, and abuse directly to the Pennsylvania Department of Human Services through one of the following methods:

- Phone: 1-844-DHS-TIPS (1-844-344-8477)
- On-line: <http://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx>
- Fax: 1-717-772-4655, Attn: MA Provider Compliance Hotline
- Mail: Department of Human Services
Office of Administration Bureau of Program Integrity

P.O. Box 2675
Harrisburg, PA 17105-2675

What to Expect as a Result of SIU Activities

The SIU must review all complaints that are received and, as a result, you may be asked to provide certain information in order for the SIU to thoroughly look at all complaints. The SIU utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from Keystone First CHC, or on behalf of Keystone First CHC, regarding recovery of potential overpayments and/or requesting medical records for review. Should you have any questions regarding a letter received, please use the contact information provided in the letter to expedite a response to your question or concerns

- You may also be contacted by the SIU Intake Unit to verify a complaint you filed.
- You may be contacted by an investigator in regard to a complaint they are investigating which may or may not concern you.
- As a Provider you may be requested to provide medical records for review. This request will be sent via a letter explaining the process to submit the records. Keep in mind that per your Provider agreement, you are required to provide the records for review.
-

Provider agrees to cooperate with Keystone First Community HealthChoices in maintaining and providing to Keystone First Community HealthChoices or the Department, at no cost to them, medical records, financial data, administrative materials and other records related to services to Participants as may be reasonably requested by Keystone First Community HealthChoices and/or the Department.

After an investigation is completed there are a number of things that may occur such as a determination that the complaint was unfounded or a referral to: (1) the Bureau of Program Integrity for the Pennsylvania Department of Human Services, (2) the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section or (3) the federal Office of Inspector General for further investigation. You may receive an overpayment letter that outlines what was found and if monies are owed. You could also receive an education letter that outlines proper procedures that are to be followed for future reference. You could be placed on prepayment review.

Claim Disputes and Appeals

The Plan's goal is to assure smooth transactions and interactions with our Provider Network community. There are some common reasons for rejection or denial of Claims and simple methods to correct them without initiating a Claims Dispute, which is described in more detail at the end of this Section. See the definitions below and instructions on the simplest method to correct/re-submit the Claim.

Common Reasons for Claim Rejections & Denials

Rejected Claims

Rejected Claims are defined as Claims with invalid or missing data elements. Rejected Claims are returned to the health care Provider or EDI source without registration in the Claim processing system. Since rejected Claims are not registered in the Claim processing system, the health care Provider must re-submit corrected Claims within 180 calendar days from the date of service or date compensable items provided. This requirement applies to Claims submitted on paper or electronically. Rejected Claims are different than Denied Claims, which are registered in the Claim processing system but do not meet requirements for payment under Plan guidelines. Resubmit rejected Claims following the same process you use for original Claims - within 180 days of date of service or date compensable items provided.

Claims Denied for Missing Information

Claims that pass the initial pre-processing edits and are accepted for adjudication but DENIED because required information for payment under Plan guidelines is missing must be resubmitted for correction. These are Claims that can be resubmitted and re-adjudicated once missing information is supplied. Health care Providers have 365 calendar days from the date of service or date compensable items were provided to re-submit a corrected Claim.

Claims denied for missing information can be re-submitted to the following address. Please clearly indicate Corrected Claims* on the Claim form:

**Keystone First Community HealthChoices
Attn: Claim Disputes
P.O. Box 7146
London, KY 40742-7146**

Providers using electronic data interchange (EDI) can submit “professional” corrected claims* electronically rather than via paper to the Plan.

* A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original claim number.

Please refer to the Claims and Billing section at <https://www.keystonefirstchc.com/providers/claims-billing/index.aspx> for more information.

Adjusted Claims

Claims with issues where resolution does not require complete re-submission of a Claim can often be easily adjusted. Adjusted Claims cannot involve changing any fields on a Claim (for example an incorrect code) and can often be corrected over the phone. Adjusted Claims usually involve a dispute about amount/ level of payment or could be a denial for no authorization when the network Provider has an authorization number. **If a network Provider has Claims needing**

adjustment and there is a manageable volume of Claims (five or less), the network Provider can call the Plan's Provider Claim Services Unit (PCSU) at 1-800-521-6007 to report payment discrepancies. Representatives are available to review Claim information and make on-line adjustments to incorrectly processed Claims.

Payment Limitations

No payment will be made for Emergency Room services if:

- The Participant is not eligible for benefits on the date of service
- The Participant is admitted to an SPU, Observation or Inpatient setting within 24 hours of the Emergency Room stay. In such cases, Emergency Room charges should be reported on the SPU, Observation or Inpatient bill. See the Emergency Admissions, Surgical Procedures and Observations Stays topic in Section III for notification requirements
- The service was provided outside of the United States or its territories.

If your Claim issues are not resolved following the steps outlined above, the procedure outlined in Section VIII may be followed. If the network Provider disagrees with Keystone First CHC's Dispute decision, the network Provider may file a Formal Provider Appeal.

Repeated re-submission of a Claim does not preserve the right to Appeal if the 365-day timeframe is exceeded.

**Section VIII: Provider Dispute/Appeal Procedures;
Participant Complaints, Grievances, and Fair Hearings**



Provider Dispute/Appeal Procedures

Providers have the opportunity to request resolution of Disputes or Formal Provider Appeals that have been submitted to the appropriate internal Keystone First CHC department.

Informal Provider Disputes Process

Network Providers may request informal resolution of Disputes submitted to Keystone First CHC through its Informal Provider Dispute Process.

What is a Dispute?

A Dispute is a verbal or written expression of dissatisfaction by a network Provider regarding a Keystone First CHC decision that directly impacts the network Provider. Disputes are generally administrative in nature and do not include decisions concerning medical necessity. Disputes may focus on issues concerning the Plan services and processes, other health care Providers, Participants or claims.

Examples of Disputes include, but are not limited to:

- Service issues with Keystone First CHC, including failure by Keystone First CHC to return a network Provider's calls, frequency of site visits by Keystone First CHC's Provider Account Executives and/or lack of Provider Network orientation/education by Keystone First CHC
- Issues with Keystone First CHC processes, including failure to notify network Providers of policy changes, dissatisfaction with Keystone First CHC's Prior Authorization process, dissatisfaction with Keystone First CHC's referral process and dissatisfaction with Keystone First CHC's Formal Provider Appeals Process
- Contracting issues, including dissatisfaction with Keystone First CHC's reimbursement rate, incorrect payments paid to the network Provider and incorrect information regarding the network Provider in Keystone First CHC's Provider database

Filing a Dispute

Network Providers wishing to register a Dispute should contact the Provider Services department at 1-800-521-6007 or contact his/her Provider Account Executive. Written Disputes should be mailed to the address below and must contain the words "Informal Provider Dispute" at the top of the request:

**Keystone First Community HealthChoices
Informal Provider Disputes
P.O. Box 7146
London, KY 40742-7146**

For accurate and timely resolution of issues, network Providers should include the following information:

- Provider Name
- Provider Number
- Tax ID Number
- Number of Claims involved
- Claim numbers, as well as a sample of the Claim(s)
- A description of the denial issue

If numerous Claims are impacted by the same administrative issue, Keystone First CHC has developed a spreadsheet format for submission of larger Claims projects. The spreadsheet and accompanying claims should be sent to the Providers assigned Account Executive. If several Claims have been denied for the same reason, these may all be included in a single letter/E-mail with an attached list of Claims or spreadsheet. **An electronic version of the spreadsheet is highly preferred. Do not combine multiple denials for different reasons in the same letter/spreadsheet.**

The spreadsheet format can be found in the appendix or online in the Provider Center at <https://www.keystonefirstchc.com/pdf/providers/claims-project-submission-form.pdf>.

On-Site Meeting

Network Providers may request an on-site meeting with a Provider Account Executive, either at the network Provider's office or at Keystone First CHC to discuss the Dispute. Depending on the nature of the Dispute, the Provider Account Executive may also request an on-site meeting with the network Provider. The network Provider or Provider Account Executive must request the on-site meeting within seven (7) calendar days of the filing of the Dispute with Keystone First CHC. The Provider Account Executive assigned to the network Provider is responsible for scheduling the on-site meeting at a mutually convenient date and time.

Time Frame for Resolution

Keystone First CHC will investigate, conduct an on-site meeting with the network Provider (if one was requested), and issue the informal resolution of the Dispute within sixty (60) calendar days of receipt of the Dispute from the network Provider. The informal resolution of the Dispute will be communicated to the network Provider by the same method of communication in which the Dispute was registered (e.g., if the Dispute is registered verbally, the informal resolution of the Dispute is verbally communicated to the network Provider and if the Dispute is registered in writing, the informal resolution of the Dispute is communicated to the network Provider in writing).

Relationship of Informal Provider Dispute Process to the Plan's Formal Provider Appeals Process

The purpose of the Informal Provider Dispute Process is to allow network Providers and Keystone First CHC to resolve Disputes registered by network Providers in an informal manner that allows network Providers to communicate their Dispute and provide clarification of the issues presented through an on-site meeting with Keystone First CHC. Network Providers may appeal most Disputes not resolved to the Provider's satisfaction through the Informal Provider Dispute Process to the Keystone First CHC's Formal Provider Appeals Process. The types of issues that may not be reviewed through Keystone First CHC's Formal Provider Appeals Process are listed in the "Formal Provider Appeals Process" section of this Manual. Appeals must be submitted in writing to the Plan's Provider Appeals department. Procedures for filing an appeal through Keystone First CHC's Formal Provider Appeals Process, including the mailing address for filing an appeal, are set forth in the "Formal Provider Appeals Process" Section. The filing of a Dispute with Keystone First CHC's Informal Provider Dispute Process is not a prerequisite to filing an appeal through Keystone First CHC's Formal Provider Appeals Process.

In addition to the Informal Provider Dispute Process and the Formal Provider Appeals Process, health care Providers may, in certain instances, pursue a Participant Complaint or Grievance appeal on behalf of a Participant. A comprehensive description of the Keystone First CHC's Participant Complaint, Grievance and Fair Hearings Process is located in this Section of the Manual. Additionally, information on the relationship with Keystone First CHC's Informal Provider Dispute and Formal Provider Appeal Processes can be found in "Relationship of Provider Formal Appeals Process to Provider Initiated Participant Appeals" and "Requirements for Grievances filed by Providers on Behalf of Participants" in this Section of the Manual.

Formal Provider Appeals Process

Both Network and Non-Participating Providers may request formal resolution of an appeal through the Plan's Formal Provider Appeals Process. This process consists of two levels of review and is described in greater detail below.

What is an Appeal?

An appeal is a written request from a health care Provider for the reversal of a denial by Keystone First CHC, through its Formal Provider Appeals Process, with regard to two (2) major types of issues. The two (2) types of issues that may be addressed through Keystone First CHC's Formal

Provider Appeals Process are:

- Disputes not resolved to the network Provider's satisfaction through Keystone First CHC's Informal Provider Dispute Process
- Denials for services already rendered by the health care Provider to a Participant including denials that
 - do not clearly state the health care Provider is filing a Participant Complaint or Grievance on behalf of a Participant (even if the materials submitted with the Appeal contain a Participant consent)

Examples of appeals include, but are not limited to:

- The health care Provider submits a Claim for reimbursement for inpatient services provided at the acute level of care, but Keystone First CHC reimburses for a non-acute level of care because the health care Provider has not established medical necessity for an acute level of care.
- A Home Care Provider has made a total of ten (10) home care visits but only seven (7) visits were authorized by Keystone First CHC. The home care Provider submits a Claim for ten (10) visits and receives payment for seven (7) visits.
- Durable Medical Equipment (DME) that requires Prior Authorization by Keystone First CHC is issued to a Participant without the health care Provider obtaining Prior Authorization from Keystone First CHC (e.g., bone stimulator). The health care Provider submits a Claim for reimbursement for the DME and it is denied by Keystone First CHC for lack of Prior Authorization.
- Participant is admitted to the hospital as a result of an emergency room visit. The inpatient stay is for a total of fifteen (15) hours. The hospital Provider submits a Claim for reimbursement at the one-day acute inpatient rate but Keystone First CHC reimburses at the observation rate, in accordance with the hospital's contract with Keystone First CHC.

Types of issues that may not be appealed through Keystone First CHC's Formal Provider Appeals Process are:

- Claims denied by the Plan because they were not filed within Keystone First CHC's 180-day filing time limit; claims from network Providers denied for exceeding the 180-day filing time limit may be appealed through the Plan's Informal Provider Dispute Process outlined in this Manual.
- Denials issued as a result of a Prior Authorization review by Keystone First CHC (the review occurs prior to the Participant being admitted to a hospital or beginning a course of treatment); denials issued as a result of a Prior Authorization review may be appealed by the Participant, or the health care Provider, with written consent of the Participant, through the Plan's Participant Complaint and Grievance Process outlined in the Section titled Complaints, Grievances and Fair Hearings for Participants following the Provider Appeal Process.
- Health care Provider terminations based on quality-of-care reasons may be appealed in accordance with Keystone First CHC Provider Sanctioning Policy outlined in Section IX; and credentialing/recredentialing denials may be appealed as provided in the credentialing/recredentialing requirements outlined in Section IX.

First Level Appeal Review

Filing a Request for a First Level Appeal Review

Health care Providers may request a First Level Appeal review by submitting the request in writing within sixty (60) calendar days of: (a) the date of the denial or adverse action by the Plan or the Participant's discharge, whichever is later or (b) in the case where a health care Provider filed an

Informal Provider Dispute with the Plan, the date of the communication by the Plan of the informal resolution of the Dispute and (c) the appeal is not related to a claims issue. The request must be accompanied by all relevant documentation the health care Provider would like the Plan to consider during the First Level Appeal review.

Requests for a First Level Appeal Review should be mailed to the appropriate Post Office Box below and must contain the words "First Level Outpatient Formal Provider Appeal", or "First Level Inpatient Formal Provider Appeal", as appropriate at the top of the request:

Inpatient Appeal:

Provider Appeals Department
Keystone First CHC
P.O. Box 80111
London, KY 40742 - 0111

Outpatient Appeal:

Provider Appeals Department
Keystone First CHC
P.O. Box 80113
London, KY 40742 - 0113

Physician Review of a First Level Appeal

The First Level Appeal Review is conducted by a board-certified Physician employed by Keystone First CHC who was not involved in the decision making for the original denial or prior appeal review of the case. The Physician Reviewer will issue a determination to uphold, modify or overturn the denial based on:

- Clinical judgment
- Established standards of medical practice
- Other information including but not limited to:
 - Keystone First CHC medical and administrative policies
 - Information submitted by the health care Provider or obtained by Keystone First CHC through investigation
 - The network Provider's contract with Keystone First CHC
 - Keystone First CHC's contract with DHS and relevant Medicaid laws, regulations and rules

Time Frame for Resolution of a First Level Appeal

Health care Providers will be notified in writing of the determination of the First Level Appeal review, including the clinical rationale, within sixty (60) calendar days of the Plan's receipt of the health care Provider's request for the First Level Appeal review. If the health care Provider is dissatisfied with the outcome of the First Level Appeal review, the health care Provider may request a Second Level Appeal review. See the "Second Level Appeal Review" topic in this Section of the Manual.

Second Level Appeal Review

Filing a Request for a Second Level Appeal Review

Health care Providers may request a Second Level Appeal by submitting the request in writing within thirty (30) calendar days of the date of Keystone First CHC's First Level Appeal determination letter. The request for a Second Level Appeal Review must be accompanied by any additional information relevant to the Appeal that the health care Provider would like the Plan to

consider during the Second Level Appeal Review. Requests for a Second Level Appeal Review of an Appeal should be mailed to the appropriate Post Office Box below and must contain the words "Second Level Outpatient Formal Provider Appeal" or "Second Level Inpatient Formal Provider Appeal", as appropriate, at the top of the request.

**Inpatient Appeal:
Provider Appeals
Department
Keystone First CHC
P.O. Box 80111
London, KY 40742 - 0111**

**Outpatient Appeal:
Provider Appeals
Department
Keystone First CHC
P.O. Box 80113
London, KY 40742 - 0113**

Appeals Panel Review of a Second Level Appeal

An external board-certified Physician Reviewer, who is contracted but not employed by the Plan and who was not involved in the decision-making for the original denial, or prior appeal review of the issue, will review the appeal. Within five (5) business days the Physician Reviewer will issue a recommendation.

Upon receipt of the external Physician's Second Level Appeal recommendation, a written summary of the Second Level Appeal recommendation is submitted to the Appeals Panel, which consists of at least 3 persons and includes $\frac{1}{4}$ peer representation with members selected from the following:

- Physician who is employed by Keystone First CHC (peer representative).
- Senior Vice President of Provider Network Management or his/her designee;
- Director of Operations or his/her designee; and
- Manager of Appeals or his/her designee.

All supporting documentation submitted at the First Level Appeal review will be available along with the summary of the Appeal, the First Level Appeal outcome and all additional information submitted by the health care Provider at the time of the Second Level Appeal request will be presented to all members of the Appeals Panel in advance of and during the Appeals Panel meeting. The external Physician's recommendation is presented and the Appeals Panel makes the final decision during the Appeals Panel meeting.

The Appeals Panel will issue a determination including clinical rationale, to uphold, modify, or overturn the original determination based upon:

- Clinical judgment
- Established standards of medical practice
- Other information including but not limited to:
 - Keystone First CHC medical and administrative policies
 - Information submitted by the Provider or obtained by Keystone First CHC through investigation
 - The network Provider's contract with Keystone First CHC

- Keystone First CHC's contract with DHS and relevant Medicaid laws, regulations and rules

Time Frame for Resolution

Health care Providers will be notified in writing of the determination of the Second Level Appeal Review within sixty (60) calendar days of Keystone First CHC's receipt of the health care Provider's request for a Second Level Appeal Review. The outcome of the Second Level Appeal Review is final.

Participant Complaints, Grievances and Fair Hearings

Complaints

A complaint is a dispute or objection regarding a particular Provider or the coverage, operations, or management of the Plan, which has not been resolved by the Plan and has been filed with the Plan or with the Pennsylvania Insurance Department's (PID's) Bureau of Managed Care (BMC), including but not limited to:

- A denial because the requested service or item is not a covered service; which does not include BLE;
- The failure of the Plan to provide a service or item in a timely manner, as defined by the Department;
- The failure of the Plan to decide a Complaint or Grievance within the specified time frames;
- A denial of payment by the Plan after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;
- A denial of payment by the Plan after a service or item has been delivered because the service or item provided is not a covered service for the Participant; or
- A denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

The term does not include a Grievance.

First Level Complaint Process

1. The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a first level Complaint either in writing or orally. The Plan must commit oral requests to writing if not confirmed in writing by the Participant and must provide the written Complaint to the Participant or Participant's representative for signature. The signature may be obtained at any point in the process, and failure to obtain a signed Complaint may not delay the Complaint process.
2. If the first level Complaint disputes one of the following, the Participant must file a Complaint within sixty (60) days from the date of the incident complained of or the date the Participant receives written notice of a decision:
 - a. The denial because the service or item is not a Covered Service;

- b. The failure of the Plan to provide a service or item in a timely manner, as defined by the Department;
- c. The failure of the Plan to decide a Complaint or Grievance within the specified time frames;
- d. A denial of payment after the service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;
- e. A denial of payment after the service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
- f. A denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities,

For all other Complaints, there is no time limit for filing a first level Complaint.

- 3. A first level Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service may continue to receive the disputed service or item at the previously authorized level pending resolution of the first level Complaint, if the first level Complaint is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.
- 4. Upon receipt of the Complaint, the plan will send the Participant and Participant's representative, if the Participant has designated one in writing, a first level Complaint acknowledgment letter, using the template specified by the Department.
- 5. The first level Complaint review for Complaints **not involving a clinical issue** must be conducted by a first level Complaint review committee, which must include one or more employees of the Plan who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
- 6. The first level Complaint review for Complaints **involving a clinical issue** must be conducted by a first level Complaint review committee, which must include one or more employees of the Plan who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The first level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the first level Complaint.
- 7. A committee member who does not personally attend the first level Complaint review meeting may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.
- 8. The Plan will afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
- 9. The Plan will must give the Participant at least ten (10) days advance written notice of the first level Complaint review date, using the template specified by the Department. The Plan

will be flexible when scheduling the review to facilitate the Participant's attendance. If the Participant cannot appear in person at the review, the Plan will provide an opportunity for the Participant to communicate with the first level Complaint review committee by telephone or videoconference.

10. The Participant may elect not to attend the first level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Participant was present.
11. If a Participant requests an in-person first level Complaint review, at a minimum, a member of the first level Complaint review committee must be physically present at the location where the first level Complaint review is held and the other Participants of the first level Complaint review committee must participate in the review through the use of videoconferencing.
12. The decision of the first level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered in the initial determination of the issue.
13. The first level Complaint review committee must complete its review of the Complaint as expeditiously as the Participant's health condition requires.
14. The first level Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.
15. The Plan must send a written notice of the first level Complaint decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date of receipt of the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Participant.
16. If the Complaint disputes one of the following, the Participant may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:
 - a. a denial because that the service or item is not a Covered Service;
 - b. the failure of the Plan to provide a service or item in a timely manner, as defined by the Department;
 - c. the failure of the Plan to decide the Complaint or Grievance within the specified time frames;
 - d. a denial of payment by the Plan after the service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;
 - e. a denial of payment by the Plan after the service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
 - f. a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

The Participant or Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the Plan's first level Complaint decision.

The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an external review in writing with PID's BMC within fifteen (15) days from the date the Participant receives written notice of the Plan's first level Complaint decision.

For all other Complaints, the Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a second level Complaint either in writing or orally within forty-five (45) days from the date the Participant receives written notice of the Plan's first level Complaint decision.

Second Level Complaint Process

1. The Plan will permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a second level Complaint either in writing or orally for any Complaint for which a Fair Hearing and external review is not available.
2. Upon receipt of the second level Complaint, the Plan will send the Participant and Participant's representative, if the Participant has designated one in writing, a second level Complaint acknowledgment letter, using the template specified by the Department.
3. The second level Complaint review for Complaints not involving a clinical issue must be performed by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
4. The second level Complaint review for Complaints involving a clinical issue must be conducted by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The second level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the second level Complaint.
5. At least one-third of the second level Complaint review committee Participants may not be employees of the Plan or a related subsidiary or Affiliate.
6. A committee member who does not personally attend the second level Complaint review may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.

7. The Plan will afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
8. The Plan will give the Participant at least fifteen (15) days advance written notice of the second level review date, using the template specified by the Department. If the Participant cannot appear in person at the review, the Plan will provide an opportunity for the Participant to communicate with the second level Complaint review committee by telephone or videoconference. The Plan will must be flexible when scheduling the review to facilitate the Participant's attendance.
9. The Participant may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Participant was present.
10. If a Participant requests an in-person second level Complaint review, at a minimum, a member of the second level Complaint review committee must be physically present at the location where the second level Complaint review is held and the other Participants of the second level Complaint review committee must participate in the review through the use of videoconferencing.
11. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered previously. The decision of the second level Complaint review committee must be based solely on the information presented at the review.
12. The testimony taken by the second level Complaint review committee (including the Participant's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Complaint record.
13. The second level Complaint review committee must complete its review of the second level Complaint as expeditiously as the Participant's health condition requires.
14. The Plan will send a written notice of the second level Complaint decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider, and prescribing Provider, if applicable, within forty-five (45) days from the date of receipt of the second level Complaint.
15. The Participant or the Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization of the representative to be involved and/or act of the Participant's behalf, may file in writing a request for an external review of the second level Complaint decision with PID's BMC within fifteen (15) days from the date the Participant receives the written notice of the Plan's second level Complaint decision.

External Complaint Process

1. If a Participant files a request for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service, the Participant must continue to receive the disputed service or item at the previously authorized level pending

resolution of the external review, if the request for external review is hand-delivered or post- marked within ten (10) days from the mail date on the written notice of the Plan's first or second level Complaint decision.

2. Upon the request of PID's BMC, the Plan will transmit all records from the Plan's Complaint review to the requesting department within thirty (30) days from the request in the manner prescribed by that department. The Participant, the Provider, or the Plan may submit additional materials related to the Complaint.

Expedited Complaint Process

1. The Plan will conduct expedited review of a Complaint if the Plan determines that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or if a Participant or Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, provides the Plan with a certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification must include the Provider's signature.
2. A request for an expedited review of a Complaint may be filed in writing, by fax, orally, or by email.
3. Upon receipt of an oral or written request for expedited review, the Plan will inform the Participant of the right to present evidence and testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.
4. If the Provider certification is not included with the request for an expedited review and the Plan cannot determine based on the information provided that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, the Plan will inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The Plan will make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Participant's request for expedited review, the Plan will decide the Complaint within the standard time frames. The Plan will make a reasonable effort to give the Participant prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.
5. A Participant who files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service must continue to receive the disputed service or item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is made orally, hand delivered, faxed, emailed, or post-marked within ten (10) days from the mail date on the written notice of decision.

6. Expedited review of a Complaint must be conducted by a Complaint review committee that includes a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint. The Participants of the expedited Complaint review committee may not have been involved in and not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
7. The Plan will prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.
8. The Plan will issue the decision resulting from the expedited review in person or by phone to the Participant, the Participant's representative, if the Participant has designated one in writing, service Provider and prescribing Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter. In addition, the Plan must mail written notice of the decision to the Participant, the Participant's representative, if the Participant has designated one in writing, the Participant's service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.
9. The Participant or the Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the Plan's expedited Complaint decision.
10. The Participant, or the Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Complaint review with the Plan within two (2) business days from the date the Participant receives the Plan's expedited Complaint decision. A Participant who files a request for an expedited Complaint review that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Complaint review.
11. A request for an expedited external Complaint review may be filed in writing, by fax, orally, or by email
12. The Plan will follow PID's BMC guidelines relating to submission of requests for expedited external Complaint reviews.
13. The Plan will not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Participant's request for expedited review of a Complaint.

Grievance Requirements

Grievance: A request to have a Plan or utilization review entity reconsider a decision concerning the Medical Necessity and appropriateness of a Covered Service. A Grievance may be filed regarding a Plan's decision to 1) deny, in whole or in part, payment for a service or item; 2) deny or issue a limited authorization of a requested service or item, including a determination based on the type or

level of service or item; 3) reduce, suspend, or terminate a previously authorized service or item; 4) deny the requested service or item but approve an alternative service or item; and 5) deny a request for a BLE.

The term does not include a Complaint.

Grievance Process

1. The Plan will permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Grievance either in writing or orally. The Plan must commit oral requests to writing if not confirmed in writing by the Participant and must provide the written Grievance to the Participant or the Participant's representative for signature. The signature may be obtained at any point in the process, and the failure to obtain a signed Grievance may not delay the Grievance process.
2. A Participant must file a Grievance within sixty (60) days from the date the Participant receives written notice of decision.
3. A Participant who files a Grievance to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for review of the Grievance is made orally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.
4. Upon receipt of the Grievance, the Plan will send the Participant and Participant's representative, if the Participant has designated one in writing, a Grievance acknowledgment letter, using the template specified by the Department.
5. A Participant who consents to the filing of a Grievance by a Provider may not file a separate Grievance. The Participant may rescind consent throughout the process upon written notice to the Plan and the Provider.
6. In order for the Provider to represent the Participant in the conduct of a Grievance, the Provider must obtain the written consent of the Participant and submit the written consent with the Grievance. A Provider may obtain the Participant's written permission at the time of treatment. The Plan must assure that a Provider does NOT require a Participant to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:
 - a. The name and address of the Participant, the Participant's date of birth and identification number;
 - b. If the Participant is a minor, or is legally incompetent, the name, address, and relationship to the Participant of the person who signed the consent;
 - c. The name, address, and Plan identification number of the Provider to whom the Participant is providing consent;
 - d. The name and address of the Plan to which the Grievance will be submitted;
 - e. An explanation of the specific service or item which was provided or denied to the Participant to which the consent will apply;
 - f. The following statement: "The Participant or the Participant's representative may not submit a Grievance concerning the service or item listed in this consent form

unless the Participant or the Participant's representative rescinds consent in writing. The Participant or the Participant's representative has the right to rescind consent at any time during the Grievance process.”;

- g. The following statement: “The consent of the Participant or the Participant's representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process.”;
 - h. The following statement: “The Participant or the Participant's representative, if the Participant is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The Participant or the Participant's representative understands the information in the Participant's consent form.”; and
 - i. The dated signature of the Participant, or the Participant's representative, and the dated signature of a witness.
7. The Grievance review must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.
 8. At least one-third of the Grievance review committee may not be employees of the Plan or a related subsidiary or Affiliate.
 9. The Grievance review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.
 10. A committee member who does not personally attend the Grievance review may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.
 11. The Plan must afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
 12. The Plan must give the Participant at least ten (10) days advance written notice of the review date, using the template specified by the Department. The Plan will be flexible when scheduling the review to facilitate the Participant's attendance. If the Participant cannot appear in person at the review, the Plan will provide an opportunity for the Participant to communicate with the Grievance review committee by telephone or videoconference.
 13. The Participant may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Participant was present.
 14. If a Participant requests an in-person Grievance review, at a minimum, a member of the Grievance review committee must be physically present at the location where the Grievance review is held, and the other Participants of the Grievance review committee must participate in the review through the use of videoconferencing.
 15. The decision of the Grievance review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's

16. representative without regard to whether such information was submitted or considered in the initial determination of the issue. The decision of the Grievance review committee must be based solely on the information presented at the review.
17. The testimony taken by the Grievance review committee (including the Participant's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Grievance record.
18. The Grievance review committee must complete its review of the Grievance as expeditiously as the Participant's health condition requires.
19. The Plan will send a written notice of the Grievance decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date the Plan received the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Participant.
20. The Participant may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review.
21. The Participant or Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the Plan's Grievance decision.
22. The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, may file a request with the Plan for an external review of a Grievance decision by a certified review entity (CRE) appointed by PID's BMC. The request must be filed in writing or orally within fifteen (15) days from the date the Participant receives the written notice of the Plan's Grievance decision.

External Grievance Process:

1. The Plan will process all requests for external Grievance review. The Plan will follow the protocols established by PID's BMC in meeting all time frames and requirements necessary in coordinating the request and notification of the decision to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider, and prescribing Provider.
2. A Participant who files a request for an external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is made orally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of the Plan's Grievance decision.
3. Within five (5) business days of receipt of the request for an external Grievance review, the Plan will notify the Participant, the Participant's representative, if the Participant has designated one in writing, the Provider if the Provider filed the request for the external Grievance, and PID's BMC that the request for external Grievance review has been filed.

4. The external Grievance review must be conducted by a CRE certified by PID's BMC to conduct External Grievance Reviews.
5. Within two (2) business days from receipt of the request for an external Grievance review, PID's BMC will randomly assign a CRE to conduct the review and notify the Plan and assigned CRE of the assignment.
6. If PID's BMC fails to select a CRE within two (2) business days from receipt of a request for an external Grievance review, the Plan may designate a CRE to conduct a review from the list of CREs approved by PID's BMC. The Plan may not select a CRE that has a current contract or is negotiating a contract with the Plan or its Affiliates or is otherwise affiliated with the Plan or its Affiliates.
7. The Plan will forward all documentation regarding the Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to the CRE conducting the external Grievance review. The Plan must transmit this information within fifteen (15) days from receipt of the Participant's request for an external Grievance review.
8. Within fifteen (15) days from receipt of the request for an external Grievance review by the Plan, the Participant or the Participant's representative, or the Participant's Provider, may supply additional information to the CRE conducting the external Grievance review for consideration. Copies must also be provided at the same time to the Plan so that the Plan has an opportunity to consider the additional information.
9. Within sixty (60) days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review must issue a written decision to the Plan, the Participant, the Participant's representative, PID's BMC and the Provider (if the Provider filed the Grievance with the Participant's consent), that includes the basis and clinical rationale for the decision. The standard of review must be whether the service or item is Medically Necessary and appropriate under the terms of this Agreement.
10. The external Grievance decision may be appealed by the Participant, the Participant's representative, or the Provider to a court of competent jurisdiction within sixty (60) days from the date the Participant receives notice of the external Grievance decision.

Expedited Grievance Process

1. The Plan must conduct expedited review of a Grievance if the Plan determines that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process or if a Participant or Participant representative, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, provides the Plan with a certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification must include the Provider's signature.
2. A request for expedited review of a Grievance may be filed either in writing, by fax, by email, or orally.

3. The expedited review process is bound by the same rules and procedures as the Grievance review process with the exception of timeframes, which are modified as specified in this section.
4. Upon receipt of an oral or written request for expedited review, the Plan must inform the Participant of the right to present evidence and testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.
5. If the Provider certification is not included with the request for an expedited review and the Plan cannot determine based on the information provided that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, the Plan must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The Plan must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Participant's request for expedited review, the Plan must decide the Grievance within the standard time frames as set forth in this Exhibit. The Plan must make a reasonable effort to give the Participant prompt oral notice that the Grievance is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.
6. A Participant who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.
7. Expedited review of a Grievance must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.
8. At least one-third of the expedited Grievance review committee may not be employees of the Plan or a related subsidiary or Affiliate.
9. The expedited Grievance review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.
10. The Plan must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Grievance record.
11. The Plan must issue the decision resulting from the expedited review in person or by phone to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Provider within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter. In addition, the Plan must mail written notice of the

decision to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Provider within two (2) business days of the decision, using the template specified by the Department.

12. The Participant or the Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the Plan's expedited Grievance decision.
13. The Participant, or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Grievance review with the Plan within two (2) business days from the date the Participant receives the Plan's expedited Grievance decision. A Participant who files a request for an expedited external Grievance review to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Grievance review.
14. A request for an expedited external Grievance review may be filed in writing, by fax, orally, or by email
15. The Plan must follow PID's BMC guidelines relating to submission of requests for expedited external reviews.
16. The Plan may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports a Participant's request for expedited review of a Grievance.

Department's Fair Hearing Requirements

Fair Hearing: A hearing conducted by the Department's Bureau of Hearings and Appeals (BHA) or a Department designee.

Fair Hearing Process

1. A Participant must file a Complaint or Grievance with the Plan and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the Plan fails to provide written notice of a Complaint or Grievance decision within the time frames specified in this Exhibit, the Participant is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.
2. The Participant or the Participant's representative may request a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the Plan's first level Complaint decision or Grievance decision for any of the following:
 - a. the denial, in whole or part, of payment for a requested service or item based on lack of Medical Necessity;
 - b. the denial of a requested service or item because the service or item is not a Covered Service;
 - c. the reduction, suspension, or termination of a previously authorized service or item;
 - d. the denial of a requested service or item but approval of an alternative service or item;
 - e. the failure of the Plan to provide a service or item in a timely manner, as defined by the Department;

- f. the failure of a Plan to decide a Complaint or Grievance within the specified time frames;
 - g. the denial of payment after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;
 - h. the denial of payment after a service or item has been delivered because the service or item is not a Covered Service for the Participant;
 - i. the denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.
3. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless the Plan failed to provide written notice of the Complaint or Grievance decision within the time frames specified in this Exhibit. Requests must be sent to:

Department of Human Services
OLTL/Forum Place 6th FL
CHC Complaint, Grievance and Fair Hearings
P.O. Box 8025
Harrisburg, Pennsylvania 17105-8025

4. A Participant who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
5. Upon receipt of the request for a Fair Hearing, BHA or the Department's designee will schedule a hearing. The Participant and the Plan will receive notification of the hearing date by letter at least ten (10) days before the hearing date, or a shorter time if requested by the Participant. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.
6. The Plan is a party to the hearing and must be present. The Plan, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. BHA's decision is based solely on the evidence presented at the hearing. The absence of the Plan from the hearing will not be reason to postpone the hearing.
7. The Plan must provide Participants, at no cost, with records, reports, and documents, relevant to the subject of the Fair Hearing.
8. BHA will issue an adjudication within ninety (90) days of the date the Participant filed the first level Complaint or the Grievance with the Plan, not including the number of days before the Participant requested the Fair Hearing. If BHA fails to issue an adjudication within ninety (90) days of receipt of the request for the Fair Hearing, the Plan must comply with the requirements at 55 Pa. Code § 275.4 regarding the provision of interim assistance upon the request for such by the Participant. When the Participant is responsible for delaying the

hearing process, the time limit by which final administrative action must be taken prior to interim assistance being afforded will be extended by the length of the delay attributed to the Participant.

9. BHA's adjudication is binding on the Plan unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of the BHA adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the Plan.

Expedited Fair Hearing Process

1. A Participant or the Participant's representative may file a request for an expedited Fair Hearing with the Department either in writing or orally.
2. A Participant must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.
3. BHA will conduct an expedited Fair Hearing if a Participant or a Participant's representative provides the Department with a signed written certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Fair Hearing process or if the Provider provides testimony at the Fair Hearing which explains why using the usual time frames would place the Participant's health in jeopardy.
4. A Participant who files a request for an expedited Fair Hearing to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.
5. Upon the receipt of the request for an expedited Fair Hearing, BHA or the Department's designee will schedule a hearing.
6. The Plan is a party to the hearing and must be present. The Plan, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The absence of the Plan from the hearing will not be reason to postpone the hearing.
7. The Plan must provide the Participant, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.
8. BHA has three (3) business days from the receipt of the Participant's oral or written request for an expedited review to process final administrative action.
9. BHA's adjudication is binding on the Plan unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the Plan

Provision of and Payment for Service or Item Following Decision

1. If the Plan, BHA, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or Fair Hearing process, the Plan must authorize or provide the disputed service or item as expeditiously as the Participant's health condition requires but no later than seventy- two (72) hours from the date it receives notice that the decision was reversed. If the Plan requests reconsideration, the Plan must authorize or provide the disputed service or item pending reconsideration unless the Plan requests a stay of the BHA decision, and the stay is granted.
2. If the Plan, BHA, or the Secretary reverses a decision to deny authorization of a service or item, and the Participant received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, the Plan must pay for the service or item that the Participant received.
3. If a Participant requests both an external appeal/review and a Fair Hearing, and the decisions rendered as a result of the external review and Fair Hearing are in conflict with one another, the Plan must abide by the decision most favorable to the Participant. In the event of a dispute or uncertainty regarding which decision is most favorable to the Participant, the Plan must submit the matter to the Department's Grievance and Appeals Coordinator for review and resolution.

**Section IX: Quality Assurance Performance Improvement,
Credentialing, and Utilization Management**



Quality Assurance and Performance Improvement

Quality Assurance and Performance Improvement (QAPI) is an integrative process that links together the knowledge, structure and processes throughout a Managed Care Organization to assess and improve quality. This process also assesses and improves the level of performance of key processes and outcomes within an organization. Opportunities to improve care and service are found primarily by examining the systems and processes by which care, and services are provided.

Purpose and Scope

The purpose of the QAPI Program is to provide the infrastructure for the continuous monitoring, evaluation, and improvement in care and service. The QAPI Program is broad in scope and encompasses the range of clinical and service issues relevant to Participants. The scope includes quality of clinical care, quality of service, and preventive health services. The QAPI Program continually monitors and reports analysis of aggregate data, intervention studies and measurement activities, programs for populations with Special Needs and surveys to fulfill the activities under its scope. The QAPI Program centralizes and uses performance monitoring information from all areas of the organization and coordinates quality improvement activities with other departments.

Objectives

The objectives of the QAPI Program are to systematically develop, monitor and assess the following activities:

- Maximizing utilization of collected information about the quality of clinical care, medical health outcomes and service, and identifying clinical and service improvement initiatives for targeted interventions
- Ensuring adequate physical health, and delegated service practitioner and provider availability, accessibility, and diversity to effectively serve the membership including LTSS and HCBS
- Maintaining timely and thorough credentialing/re-credentialing processes to ensure the plan's network is comprised of qualified practitioners
- Overseeing the provision of quality services by delegated entities
- Communicating priorities and performance status to participating practitioners through provider profiling and information dissemination
- Coordinating services between various levels of care, network practitioners, and community resources to ensure continuity of care and promote optimal physical, psychosocial and functional wellness
- Designing and implementing programs to coordinate care and maximize health outcomes for participants with complex and/or special health needs
- Optimizing utilization management to ensure care rendered is based on established clinical criteria, and clinical practice guidelines, and complies with contractual, regulatory and accrediting agency standards
- Employing assessments and interventions to identify and correct over-, under- and mis-utilization of participant benefits and services to ensure participant benefits are not underutilized

- Utilizing results of participant and practitioner/provider satisfaction measures when identifying and prioritizing quality activities
- Implementing and evaluating condition management local, regional, and national programs and community partnerships to effectively address chronic illnesses affecting the membership
- Designing and implementing outreach and health education activities that lead to healthy lifestyles
- Maintaining compliance with evolving NCQA accreditation standards
- Communicating results of clinical medical and service measures and quality initiatives to practitioners, providers and participants
- Identifying and implementing activities that promote participant safety in the least-restrictive environment
- Documenting and reporting monitoring activities (internal and delegated) to appropriate committees
- Analyzing data, including social determinants of health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to participants
- Facilitating the delivery of culturally competent health care to reduce health care disparities
- Coordinating care and transitions of care for participants who receive multiple services, whose benefits end, and during transitions from pediatric to adult care
- Evaluating the effectiveness of the QI program

An annual QAPI work plan is derived from the QAPI Program goals and objectives. The work plan provides a roadmap for achievement of program goals and objectives, and is also used by the QM department as well as the various quality committees as a method of tracking progress toward achievement of goals and objectives

QAPI Program effectiveness is evaluated on an annual basis. This assessment allows the Plan to determine how well it has deployed its resources in the recent past to improve the quality of care and service provided to the Plan Participants. When the program has not met its goals, barriers to improvement are identified and appropriate changes are incorporated into the subsequent annual QI work plan. Feedback and recommendations from various committees are incorporated into the evaluation

Quality Assurance and Performance Improvement Program Authority and Structure

The Plan's Quality Assurance and Performance Improvement Committee (QAPIC) provides leadership in the Plan's efforts to measure, manage and improve quality of care and services delivered to Participants and to evaluate the effectiveness of the Plan's QAPI Program through measurable indicators.

Quality Assurance and Performance Improvement Committee (QAPIC)

The (QAPIC) coordinates the Plan's efforts to measure manage and improve quality of care and services delivered to the Plan Participants and evaluates the effectiveness of the QAPI Program. It is responsible for directing the activities of all clinical care delivered to Participants. The following committees report up through the QAPIC.

- Corporate Drug Utilization Review Committee (DUR)
- Compliance and Privacy Committee
- Pharmacy and Therapeutics (P&T) Committee
- Quality of Services Committee (QSC)

Corporate Drug Utilization Review Committee

The Corporate Drug Utilization Review (DUR) Committee ensures appropriate medication therapy, while permitting appropriate professional judgement to individualized medication therapy is occurring.

Compliance & Privacy Committee

The Pennsylvania (PA) Regulatory Compliance & Privacy Committee oversees the health plans efforts to comply with all State and federal laws and regulations relating to fraud, waste, and abuse in the Medicaid program, as well as contractual requirements outlined in the Pennsylvania HealthChoices and Community HealthChoices agreements. The PA Regulatory Compliance & Privacy Committee serves to ensure integrity in reporting inappropriate conduct, fraudulent activities, and abusive patterns. The PA Regulatory Compliance & Privacy Committee creates accountability for distributing regulatory information and monitoring organizational performance against set standards.

Pharmacy and Therapeutics (P&T) Subcommittee

The P&T Subcommittee is responsible for evaluating the clinical efficacy, safety, and cost-effectiveness of medications in the treatment of disease states through product evaluation and drug formulary recommendations. The Subcommittee also uses drug prescription patterns to develop Network Provider educational programs.

Quality of Service Committee (QSC)

The QSC reports up through the QAPIC and is responsible for measuring and improving services rendered to Participants and Providers in the Participant Services, Claims, Provider Services, and Provider Network Management departments. The Credentialing, Provider Appeal, and Participant Advisory, and Cultural and Linguistically Appropriate Services (CLAS) Committees report to the QSC.

Credentialing Committee

The Credentialing Committee is a peer review committee whose purpose is to review Providers' credentialing/recredentialing application information in order to render a decision regarding qualification for participation into the Plan's Network.

Provider Appeal Subcommittee

The Provider Appeal Subcommittee reports to the QSC. The purpose of the committee is to review second-level provider appeal submissions. The committee may uphold, modify or overturn the original decision. The committee reviews and makes a determination on all second-level provider appeals. The Committee also monitors service appeal indicators, reviews trends to identify interventions and develop action plans as needed.

Participant Advisory Committee (PAC)

The Participant Advisory Committee purpose is to provide its PAC Participants with an effective means to consult with each other and, when appropriate, coordinate efforts and resources for the benefit of the entire CHC population in the zone and/or populations with LTSS needs.

Cultural and Linguistically Appropriate Services (CLAS) Committee

The CLAS Program provides organizational direction to cultural and linguistic responsive efforts and reports to the QSC on a quarterly basis. The health plans CLAS Program is intended to satisfy the contractual as well as NCQA Multicultural Healthcare Distinction and Health Equity Plus requirements to have a CLAS Committee. Activity and outcomes are reported using internal tools in addition to the reporting tools. The QSC provides direction and oversight for the CLAS Committee.

Additional committees that are a part of the Keystone First Community HealthChoices include the Recipient Restriction Subcommittee, Operational Compliance Committee and the Behavioral Health/ Physical Health MCO P&T Committees as described below.

Recipient Restriction Subcommittee

The Recipient Restriction Subcommittee is responsible for identifying, evaluating, monitoring, and tracking potential misutilization, Fraud and abuse by Participants.

Operational Compliance Committee

The purpose of the Operational Compliance Committee (OCC) is to assist the Chief Compliance Officer and the Privacy Officer with the implementation and maintenance of the Corporate Compliance and Privacy Programs as well as ensure compliance with the Agreement.

Confidentiality

Documents related to the investigation and resolution of specific occurrences involving complaints or quality of care issues are maintained in a confidential and secure manner. Specifically, Participants' and health care Providers' right to confidentiality are maintained in accordance with

applicable laws. Records of quality improvement and associated committee meetings are maintained in a Confidential and secure manner.

Credentialing/Recredentialing Requirements

Provider Practitioner Requirements

The Plan maintains and adheres to all applicable State and federal laws and regulations, DHS requirements, and NCQA accreditation standards governing credentialing and recredentialing functions.

The Department will recoup from the Plan any and all payments made to a Provider that does not meet the enrollment and credentialing criteria for participation or is used by the Plan in a manner that is not consistent with the Provider's licensure.

The following types of practitioners require initial credentialing and recredentialing (at a minimum of every 36 months):

Audiologists	Oral Surgeons	Registered Dieticians
Certified Nurse Midwives	Physicians (DOs and MDs)	Speech Therapists/Speech & Language Pathologists*
Chiropractors	Physicians Assistants	Substance Abuse Treatment
CRNPs	Physical Therapists*	Therapeutic Optometrists
Dentists (DDS and DMD)	Podiatrist	
Occupational Therapists*	Practitioners	

*Only private practice practitioners who have an independent relationship with the Plan require credentialing.

Locum tenens employed by a healthcare system, or a hospital would be required to be credentialed by that organization or for that organization by another credible body. If the Provider will be serving for a longer term, greater than 60 days, and credentialing is not delegated to the organization, or its surrogate, the Plan will credential those locum tenens identified by the organization.

The following criteria must be met as applicable, in order to evaluate a qualified health care practitioner:

- A current, active and unrestricted Individual Medicaid number along with service location numbers for each address contracted with the Plan (applications submitted without an active Medicaid or MMIS/PPID number must be accompanied by a copy of the enrollment application (individual and/or service location applications);
- An individual and group NPI number
- A current unrestricted state license, not subject to probation, proctoring requirements or disciplinary action to specialty.
- A copy of the license must be submitted along with the application
- A valid DEA certificate, if applicable. The DEA certificate must have an address listed in the State where the practitioner is treating Participants. The DEA certificate is non- transferrable by

location. If the practitioner has chosen not to prescribe, they must submit a letter notifying us that they will not be prescribing and have not obtained a DEA license.

- Education and training that supports the requested specialty or service, as well as the degree credential of the health care practitioner
- Foreign trained health care practitioners must submit an Education Commission for Foreign Medical Graduates (ECFMG) certificate or number within the application
- Board Certificate, if applicable.
- The following board organizations are recognized by the Plan for purposes of verifying specialty board certification:
 - American Board of Medical Specialties – ABMS
 - American Medical Association - AMA
 - American Osteopathic Association - AOA
 - American Board of Foot and Ankle Surgery - ABFS- ABPS
 - American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)
 - Royal College of Physicians and Surgeons
- Work history containing current employment, as well as explanation of any gaps greater than six months within the last (5) years
- History of professional liability claims resulting in settlements or judgments paid by or on behalf of the health care practitioner in the past 5 years
- A current copy of the professional liability insurance face sheet (evidencing coverage – minimum coverage amount of \$500,000/\$1.5million with excess coverage of
- \$500,000/\$1.5 million) – total coverage should equal \$1million/\$3million. Malpractice insurance may also be listed on the application in lieu of a face sheet as long as the effective date, expiration date, policy number, and limits of liability are included on the application. A Federal Tort Letter is also acceptable insurance.
- Hospital admitting arrangements (for Primary Care Practitioners (PCPs)) with an institution participating with Keystone First CHC, or as an alternative, those health care Providers who do not have hospital privileges, but require them, may enter into a collaboration agreement with a participating health care practitioner(s) who is able to admit. Those practitioners who do not have admitting privileges may also utilize a hospitalist service at a Plan participating hospital.
- CRNP's and CNM's must have collaborative agreements with a Supervising physician who is a Plan participating physician.
- Explanation to any affirmative answers on the “General Questions” section of the application.
- Current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable. CLIA certificate is required for all addresses where the practitioner has a lab in the office where services are being rendered to the Plan Participants.
- Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or other appropriate professional organization.

Practitioner Application

The Plan offers practitioners the Universal Provider Data source through an agreement with The Council for Affordable Quality Healthcare (CAQH) that simplifies and streamlines the data collection process for credentialing and recredentialing. **

Through CAQH, credentialing information is provided to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH.

There is no charge to practitioners to participate in CAQH or to submit applications. The Plan encourages all practitioners to utilize this service.

Submit your application to participate with the Plan via CAQH (www.caqh.org):

- Register for CAQH
- Grant authorization for the Plan to view your information in the CAQH database
- Send your CAQH ID number to the Plan (credapps@keystonefirstchc.com)

** Please note: CAQH credentialing does not apply to HCBS and LTSS Providers. HCBS and LTSS Providers should complete our paper application process.

The Plan's Paper Application Process

- Complete a PA Standard application and attestation that includes the practitioner's signature and current date
- Sign and date a release of information form that grants permission to contact outside agencies to verify or supply information submitted on the applications
- Submit all License, DEA, Board Certification, Education and Training, Hospital Affiliation and other required information with the application, which will be verified directly through the primary sources prior to the credentialing/rec credentialing decision
- Submit a PROMISE™/Medicaid number issued by DHS along with the MMIS/PPID/Service Location number for all addresses where the practitioner will be rendering services to the Plan Participants. If the Medicaid MMIS/PPID number has not yet been received, a copy of the enrollment application must be submitted along with the application.

As part of the application process, the Plan will:

- Request information on health care Provider sanctions prior to making a credentialing or rec credentialing decision. Information from the National Provider Data Bank (NPDB), Health Integrity Provider Data Bank (HIPDB) through Provider Trust, Medichex (Medicaid exclusions) through Provider Trust, HHS Office of Inspector General (Medicare exclusions), System for Awards Management (SAM) through Provider Trust, Federation of Chiropractic Licensing Boards (CIN-BAD), Excluded Parties List System (EPLS) , Social Security Death Master file (SSDMF) through Provider Trust, and Pennsylvania State Disciplinary Action report will be reviewed as applicable.
- Perform primary source verification on required items submitted with the application as required by the National Committee for Quality Assurance (NCQA), State and Federal regulations.

- Performance review of complaints, quality of care issues and utilization issues will be reviewed on a monthly basis by the Quality Management department. A summary of their review will be presented at the Credentialing Committee meeting. A Quality Recredentialing Profile will also be completed for all Practitioners and Providers due for recredentialing and will be presented to the Credentialing Committee as necessary.
- Maintain Confidentiality of the information received for the purpose of credentialing and recredentialing.
- Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized plan employees.

For detailed information on the application process go to For Providers at <https://www.keystonefirstchc.com/providers/index.aspx>.

Presentation to the Medical Director or Credentialing Committee:

Once all information is received and primary source verifications are completed the practitioner's file is presented to either the Medical Director or Credentialing Committee for review and determination.

- All routine (clean) files are presented daily to the Medical Director
- All non-routine (i.e., malpractice cases, license sanctions, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination

After the submission of the application, health care practitioners:

- Have the right to review the information submitted to support their credentialing application, with the exception recommendations, and peer protected information obtained by the Plan.
- Have the right to correct erroneous information. When information is obtained by the Credentialing department that varies substantially from the information the practitioner provided, the Credentialing department will notify the health care Provider to correct the discrepancy. The practitioner will have 10 calendar days from the date of the notification to correct the erroneous information. The practitioner can submit the correction either by email, fax, or phone to the Credentialing department. Corrections received by phone will be documented in the Credentialing database by the Credentialing department.
- Have the right, upon request, to be informed of the status of their credentialing or recredentialing application. The Credentialing department will share all information with the practitioner with the exception of references, recommendations or peer-review protected information (i.e., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the practitioner.
- Have the right to be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision
- Have the right to appeal any credentialing/recredentialing denial within 30 calendar days of receiving written notification of the decision

*To request or provide information for any of the above, the practitioner should contact the Plan's Credentialing department at the following address:

**Attn: Credentialing Department
Keystone First CHC
One International Plaza
Philadelphia, PA 19113
Phone: 1-800-342-3510, option 1
Fax: 1-877-759-6221**

Facility Requirements

Facility Providers must meet the following criteria:

- The Plan will confirm that the facility is in good standing with all state and regulatory bodies, and has been reviewed by an accredited body as applicable
- If there is no accreditation status results, a current CMS State Survey will be accepted. If the Facility is not accredited and does not have a CMS State Survey, the Plan's Provider Network Management department will schedule a site visit of the facility. Recertification of facilities must occur a minimum of every 36 months.
- The following types of facilities are credentialed and recertified:
 - Hospitals (acute care and acute rehabilitation)
 - Skilled Nursing Facilities
 - Skilled Nursing Facilities providing sub-acute services
 - Nursing Homes
 - Sub-Acute Facilities
 - Comprehensive Outpatient Rehabilitation Facilities
 - Home Health Agencies
 - Hospice
 - Ambulatory Surgical Center (ASC)
 - Durable Medical Equipment
 - Home Infusion
 - Dialysis Centers
 - Free Standing Sleep Centers/Sleep Labs
 - Free Standing Radiology Centers
 - Diabetic Education Programs
 - Portable X-ray Suppliers/Imaging Centers

The following information must be submitted with the credentialing application:

- A current copy of the facility's unrestricted license not subject to probation, suspension, or other disciplinary action
- A current copy of the facility's malpractice coverage and history of liability
- A current copy of the accreditation certificate or letter or current CMS State Survey, if applicable (if the facility is not accredited and has not had a CMS State Survey, the Plan's Provider Network Management department will schedule a site visit of the facility)
- The facility must submit a PROMISe™/Medicaid number issued by DHS under which service will be rendered
- The facility must submit an active Medicare number if applicable
- The facility must submit a Group NPI number

Facility Application

Facilities must:

- Complete the facility application with signature and current date from the appropriate facility officer. A facility application must be completed for each location where the Provider renders services to Keystone First CHC Participants. Supporting documents noted above must be provided for each location.
 - **Note:** A parent facility with branch locations is required to submit one application listing all addresses. A copy of one license, accreditation or CMS State Survey, and malpractice insurance is also required. Proof that additional locations are branch locations must also be provided (this is usually documented on the Accreditation Certificate or CMS State Survey).
- Attest to the accuracy and completeness of the information submitted to the Plan
- Submit documentation of any history of disciplinary actions, loss or limitation of license, Medicare/Medicaid sanctions, or loss, limitation, or cancellation of professional liability insurance

The Plan will:

- Verify the facility's status with state regulatory agencies through the State Department of Health
- Request information on facility sanctions prior to rendering a credentialing or recredentialing decision, by obtaining information from the National Practitioners Data Bank (NPDB)/Medicheck (Medicaid exclusions), HHS Office of Inspector General (Medicaid/Medicare exclusions) through Provider Trust, and System for Award Management (SAM) through Provider Trust
- Maintain Confidentiality of the information received for the purpose of credentialing and recredentialing
- Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized Plan employees

After the submission of the application, Facilities:

- Have the right to review the information submitted to support their credentialing application, with the exception of recommendations, and peer protected information obtained by Keystone First CHC *;
- Have the right to correct erroneous information. When information is obtained by the Credentialing department that varies substantially from the information the Provider provided, the Credentialing department will notify the health care Provider to correct the discrepancy. The Provider will have 10 business days to correct the erroneous information;
- Have the right, upon request, to be informed of the status of their credentialing or recredentialing application. * The Credentialing department will share all information with the Provider with the exception of references, recommendations or peer-review protected information (i.e., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the Provider.
- Have the right to be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision; and,
- Have the right to appeal any credentialing/recredentialing denial within 30 calendar days of receiving written notification of the decision.

*To request or provide information for any of the above, the Provider should contact Keystone First CHC's Credentialing department at the following address:

Attn: Credentialing Department Keystone First CHC
200 Stevens Drive
Philadelphia, PA 19113
Phone: 1-800-642-3510, option 1
Fax: 1-877-759-6221

Presentation to the Medical Director or Credentialing Committee:

Once all information is received and primary source verifications are completed the facility file is presented to either the Medical Director or Credentialing Committee for review and determination.

- All routine (clean) files are presented daily to the Medical Director
- All non-routine (i.e., malpractice cases, sanctions, CMS State Survey discrepancies, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination

All Practitioners and Facilities are required to be re-credentialed or recertified at a minimum of every 36 months. All items noted in the Credentialing section are required at the time of recredentialing or recertification, with the exception of work history and education for practitioners. All primary source verifications noted above are conducted at the time of recredentialing and recertification. Presentation to the medical Director or Credentialing Committee occurs for recredentialing files as noted above.

Participant Access to Physician Information

Participants can call Participant Services to request information about network Providers, such as where they went to medical school, where they performed their residency, and if the network Provider is board-certified.

Provider Sanctioning Policy

It is the goal of the Plan to assure Participants receive quality health care services. In the event that health care services rendered to a Participant by a network Provider represent a serious deviation from, or repeated non-compliance with, the Plan's quality standards, and/or recognized treatment patterns of the organized medical community, the network Provider may be subject to the Plan's formal sanctioning process.

Prohibition on Payment to Excluded/Sanctioned Persons

In addition, pursuant to section 1128A of the Social Security Act and 42 CFR 1001.1901, the Plan may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other Federal health care programs.

A Sanctioned Person is defined as any person or affiliate of a person who is (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Pennsylvania Department of Human Services (DHS) Medical Assistance Bulletin (MAB) 99-11-05 requires all Providers who participate in Medicare, Medicaid or any other federal health care program to screen **their employees and contractors, both individuals and entities, before employing or contracting with** them and to rescreen all employees on an on-going monthly basis, to determine if they have been excluded from participation in any of the aforementioned programs. Examples of individuals (as outlined in MAB 99-11-05) that should be screened include, but are not limited to the following:

- An individual or entity who provides a service for which a claim is submitted to Medicaid;
- An individual or entity who causes a claim to be generated to Medicaid;
- An individual or entity whose income derives all, or in part, directly or indirectly, from Medicaid funds;
- Independent contractors if they are billing for Medicaid services;
- Referral sources, such as Providers who send a Medicaid recipient to another Provider for additional services or second opinion related to a medical condition.

All federal health care programs, including Keystone First CHC are prohibited from paying for any items or services furnished, ordered, directed or prescribed by excluded individuals or entities.

For complete details, MAB 99-11-05 is posted on the Provider Center at

<https://www.keystonefirstchc.com/providers/communications/dhs-bulletins-and-news.aspx>.

Resources:

Pennsylvania Medichex List is a data base maintained by DHS that identifies Providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program: <https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/Medichex-List.aspx>.

List of Excluded Individuals/Entities (LEIE) is a data base maintained by HHS- OIG that identifies individuals or entities that have been excluded nationwide from participation in any federal health care program. An individual or entity included on the LEIE is ineligible to participate, either directly or indirectly, in the MA Program. Although DHS makes best efforts to include on the Medichex List all federally excluded individuals/entities that practice in Pennsylvania, Providers must also use the LEIE to ensure that the individual/entity is eligible to participate in the MA Program:

<https://oig.hhs.gov/exclusions/index.asp>.

The System for Award Management (SAM) is an official website of the U.S. government to search for entity registration and exclusion records: <https://sam.gov/content/home>.

Upon request of the Plan, a Provider will be required to furnish a written certification to the Plan that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a Sanctioned Person.

A Provider is required to immediately notify the Plan upon knowledge that any of its contractors, employees, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that a Provider cannot provide reasonably satisfactory assurance to the Plan that a Sanctioned Person will not receive payment from the Plan under the Provider Agreement, the Plan may immediately terminate the Provider Agreement. The Plan reserves the right to recover all amounts paid by the Plan for items or services furnished by a Sanctioned Person.

All sanctioning activity is strictly confidential.

Informal Resolution of Quality-of-Care Concerns

When the Plan Quality Review Committee (Quality Improvement Committee, Medical Management Committee or Credentialing Committee) determines that follow-up action is necessary in response to the care and/or services begin delivered by a network Provider, the Committee may first attempt to address and resolve the concern informally, depending on the nature and seriousness of the concern.

- The Chairperson of the reviewing Committee will send a letter of notification to the network Provider. The letter will describe the quality concerns of the Committee, and what actions are recommended for correction of the problem. The network Provider is afforded a specified, reasonable period of time appropriate to the nature of the problem. The letter will recommend an appropriate period of time within which the network Provider must correct the problem

The letter is to be clearly marked: Confidential: Product of Peer Review
- Failure to conform thereafter is considered grounds for initiation of the formal sanctioning process.

Formal Sanctioning Process

In the event of a serious deviation from, or repeated non-compliance with, the Plan's quality standards, and/or recognized treatment patterns of the organized medical community, the Plan Quality Improvement Committee or the Chief Medical Officer (CMO) may immediately initiate the formal sanctioning process.

- The network Provider will receive a certified letter (return receipt requested) informing him/her of the decision to initiate the formal sanctioning process. The letter will inform the network Provider of his/her right to a hearing before a hearing panel.
- The network Provider's current Participant panel (if applicable) and referrals and/or admissions are frozen immediately during the sanctioning process.

Notice of Proposed Action to Sanction

The network Provider will receive written notification by certified mail stating:

- That a professional review action has been proposed to be taken
- Reason(s) for proposed action
- That the network Provider has the right to request a hearing on the proposed action
- That the network Provider has 30 days within which to submit a written request for a hearing, otherwise the right to a hearing is forfeited. The network Provider must submit the hearing request by certified mail, and must state what section(s) of the proposed action s/he wishes to contest
- Summary of rights in the hearing
- The network Provider may waive his/her right to a hearing

Notice of Hearing

If the network Provider requests a hearing in a timely manner, the network Provider will be given a notice stating:

- The place, date and time of the hearing, which date shall not be less than thirty (30) days after the date of the notice
- That the network Provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the CMO of the Plan and/or upon the advice of the Plan's Legal department
- A list of witnesses (if any) expected to testify at the hearing on behalf of the Plan

Conduct of the Hearing and Notice

- The hearing shall be held before a panel of individuals appointed by the Plan
- Individuals on the panel will not be in direct economic competition with the network Provider involved, nor will they have participated in the initial decision to propose Sanctions
- The panel will be composed of physician Participants of the Plan's Quality Committee structure, the CMO of the Plan, and other physicians and administrative persons affiliated with the Plan as deemed appropriate by the CMO of the Plan. The Plan CMO or his/her designee serves as the hearing officer
- The right to the hearing will be forfeited if the network Provider fails, without good cause, to appear

Provider's Rights at the Hearing

The Network Provider has the right:

- To representation by an attorney or other person of the network Provider's choice
- To have a record made of the proceedings (copies of which may be obtained by the network Provider upon payment of reasonable charges)
- To call, examine, and cross-examine witnesses
- To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law
- To submit a written statement at the close of the hearing
- To receive the written recommendation(s) of the hearing panel within 15 working days of completion of the hearing, including statement of the basis for the recommendation(s)
- To receive the Plan's written decision within 60 days of the hearing, including the basis for the hearing panel's recommendation

Appeal of the Decision of the Plan's Peer Review Committee

The network Provider may request an appeal after the final decision of the Panel

- The Plan's Quality Improvement Committee must receive the appeal by certified mail within 30 days of the network Provider's receipt of the Committee's decision; otherwise, the right to appeal is forfeited
- Written appeal will be reviewed, and a decision rendered by the Plan's Quality Improvement Committee (QIC) within 45 days of receipt of the notice of the appeal

Summary Actions Permitted

The CEO, President of PA Managed Care, the Executive Vice President and Chief Operating Officer, and/or the CMO, can take the following summary actions without a hearing:

- Suspension or restriction of clinical privileges for up to 14 days, pending an investigation to determine the need for professional review action
- Immediate revocation, in whole or in part, of panel participation or network Provider status subject to subsequent notice and hearing when failure to take such action may result in imminent danger to the health and/or safety of any individual. A hearing will be held within 30 days of this action to review the basis for continuation or termination of this action

External Reporting

The CMO will direct the Credentialing department to prepare an adverse action report for submission to the National Practitioner Data Bank (NPDB), and State Board of Medical or Dental Examiners if formal Sanctions are imposed for quality-of-care deviations and if the Sanction is to last more than 30 days, and as otherwise required by law. (NOTE: NPDB reporting is applicable only if the Sanction is for quality-of-care concerns.)

If Sanctions against a network Provider will materially affect the Plan's ability to make available all capitated services in a timely manner, the Plan will notify DHS of this issue for reporting/follow-up purposes.

Utilization Management Program

The Utilization Management (UM) program description summarizes the structure, processes and resources used to implement the Plan's programs, which were created in consideration of the unique needs of its Enrollees and the local delivery system. All departmental policies and procedures, guidelines and UM criteria are written consistent with DHS requirements, the National Committee for Quality Assurance (NCQA), Pennsylvania's Act 68 and accompanying regulations, and other applicable State and federal laws and regulations. Where standards conflict, the Plan adopts the most rigorous of the standards.

Annual Review

Annually, the Plan reviews and updates its UM and policies and procedures as applicable. These modifications, which are approved by the Plan's Medical Management Committee, are based on, among other things, changes in laws, regulations, DHS requirements, accreditation requirements, industry standards and feedback from health care Providers, Participants and others.

Mission and Values

The Plan's UM Program provides an interactive process for Participants that generally assesses whether the physical health care services they receive are Medically Necessary and delivered in a quality manner. Behavioral health services are provided through a separate arrangement between DHS and Behavioral Health Managed Care Organizations. The Plan UM Program promotes the continuing education of, and understanding amongst, Participants, participating physicians and other healthcare professionals.

UM Program techniques that are used to evaluate medical necessity, access, appropriateness and efficiency of services include, but are not limited to, the following programmatic components: intake, Prior Authorization, concurrent review, discharge planning and alternate service review, DME review. The UM Program also generally seeks to coordinate, when possible, emergent, urgent and elective health care services. Participants are assisted by the UM Program in obtaining transitional care benefits such as transitional care for new Participants/covered persons and continuity of coverage for Participants/covered persons whose health care Providers are no longer

participating with the Plan. The UM Program also outlines the responsibility for oversight of entities to whom the Plan delegates Utilization Management functions.

Criteria Availability

The Plan has adopted clinical practice guidelines for use in guiding the treatment of Participants, with the goal of reducing unnecessary variations in care. The clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace, the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual.

The following complete clinical practice guidelines are available upon request by calling the Provider Services department or by visiting the Provider Center of our website at <https://www.keystonefirstchc.com/providers/resources/clinical-resources.aspx>.

A and B Recommendations	Hypertension
Asthma	Obesity - Children and Adults
Attention Deficit/Hyperactivity Disorder	Opioid Addiction
Bipolar Disorder	Opioid Prescribing
Bright Futures Periodicity Schedule	Oppositional Defiant Disorder
Caring for Adult Patients with Suicide Risk	Postpartum Care
Chronic Obstructive Pulmonary Disease	Post-Traumatic Stress Disorder
Depression	Prenatal Care
Diabetes	Preventative Care - Children, Adolescents, and Adults
General Anxiety Disorder	Schizophrenia
Heart Failure	Sickle Cell Disease
HIV/AIDS	Substance Use
Hyperlipidemia	Suicidal Behavior

The Plan will provide its Utilization Management (UM) criteria to network Providers upon request. To obtain a copy of the Plan's UM criteria:

- Call the UM department at **1-800-521-6622**
- Identify the specific criteria you are requesting
- Provide a fax number or mailing address

You will receive a faxed copy of the requested criteria within 24 hours or written copy by mail within 5 business days of your request.

Please remember that the Plan has Medical Directors and Physician Advisors who are available to address UM issues or answer your questions regarding decisions relating to Prior Authorization, DME, home health care and Concurrent Review. Call the Medical Director Hotline at: **1-877-693-8480**.

Additionally, the Plan would like to remind health care Providers of our affirmation statement regarding incentives:

- UM decision-making is based only on appropriateness of care and the service being provided
- The Plan does not reward health care Providers or other individuals for issuing denials of coverage or service
- There are no financial incentives for UM decision makers to encourage underutilization

Hours of Operation

A toll-free number (**1-800-521-6622**) is available for Providers to contact the Plan's UM staff. The UM department is available to answer calls during normal business hours, 8:30 a.m. - 5:00 p.m. Translation services are available as needed.

After business hours and on weekends and holidays, health care Providers are instructed to contact the On-Call Nurse through the Plan's Participant Services number 1-855-332- 0729. After obtaining key contact and Participant information, the Participant Service Representative pages the on-call Nurse. The on-call Nurse contacts the health care Provider and when applicable, the Participant, as needed, to acquire the information necessary to process the request. The on-call Nurse will call the on-call Physician Reviewer to review the request, if necessary. The on-call Nurse is responsible to contact the requesting health care Provider or Participant with the outcome of their request.

Utilization Management Inpatient Stay Monitoring

The Utilization Management (UM) department is mandated by the Department of Human Services to monitor the progress of a Participant's inpatient hospital stay. This is accomplished by the UM department through the review of appropriate Participant clinical information from the Hospital.

Hospitals are required to provide the Plan, within two (2) business days from the date of a Participant's admission (unless a shorter timeframe is specifically stated elsewhere in the Provider Manual), all appropriate clinical information that details the Participant's admission information, progress to date, and any pertinent data.

As a condition of participation in the Plan Network, Providers must agree to the UM department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the Plan Medical Director. As part of the concurrent review process and in order for the UM department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the Plan must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

Timeliness of UM Decisions

Several external standards guide the Plan's timeline standards. These include NCQA, DHS Community HealthChoices standards, Pennsylvania's Act 68 and accompanying regulations, and other applicable state and federal laws and regulations. Where standards conflict, the Plan adopts the more rigorous of the standards. Table 1 identifies the Plan's timeliness standards.

Table 1: Timeliness Of UM Decisions – Excludes Pharmacy

Case Type	Decision	Initial Notification	Written Confirmation*
Urgent Precertification	24 hours from receipt of request**	24 hours from receipt of request	2 business days after decision is made
Non-Urgent Precertification	2 business days from receipt of the request**	2 business days from receipt of the request	2 business days after decision is made
Concurrent Review	1 business day from receipt of the request**	1 business day from receipt of the request	2 business days after decision is made
Retrospective Review***	30 calendar days from receipt of the records	30 calendar days from receipt of the records	2 business days after decision is made

* Written confirmation is provided for all cases where coverage for the requested service is partially or completely denied.

** The timeframes for decisions and notification may be extended if additional information is needed to process the request. In these instances, the Participant and requesting health care Provider are notified of the required information in writing (not applicable to retrospective review).

*** Retrospective Review requests are to be received no later than 180 days from the date of service.

Lack of timely notification may result in a Denial of Services. For information on appeal rights, please see "Provider Dispute/Appeal Procedures; Participant Complaints, Grievances and Fair Hearings" in Section VIII of the Manual.

Denial and Appeal Process

Medical necessity denial decisions made by a Medical Director, or other physician designee, are based on the DHS definition of Medically Necessary, in conjunction with the Participant's benefits, applicable MA laws and regulations, the Medical Director's medical expertise, medical necessity criteria, as referenced above, and/or published peer-review literature. At the discretion of the Medical Director, in accordance with applicable laws, regulations or other regulatory and accreditation requirements, input to the decision may be obtained from participating board-certified physicians from an appropriate specialty. The Medical Director or physician designee makes the final decision. Prior authorization is not a guarantee of payment for the service(s) authorized. The Plan reserves the right to adjust any payment made following a review of the medical record and determination of medical necessity of the services provided. Additionally, payment may also be adjusted if the Participant's eligibility changes between when the authorization was issued and the service was provided. Upon request of a Participant or Network Provider, the criteria used for making Medically Necessary decisions is provided, in writing, by the Medical Director or physician designee.

Physician Reviewer Availability to Discuss Decision

If a practitioner wishes to discuss a medical necessity decision, the Plan's physician reviewers are available to discuss the decision with the practitioner. A call to discuss the determination is accepted from the Practitioner:

- Up to 5 business days after the Participant's discharge date, whichever is later
- Up to 5 business days after a determination for a Prior (Pre-Service) request has been rendered
- Up to 5 business days after a determination of a retrospective review has been rendered, whichever is later.

A dedicated reconsideration line with a toll-free number has been established for practitioners to call at **1-877-693-8480**. A physician reviewer is available at any time during the business day to interface with practitioners. If a practitioner is not satisfied with the outcome of the discussion with the physician reviewer, then the practitioner may file a Formal Provider Appeal. For information on the types of issues that may be the subject of a Formal Provider Appeal, please refer to Section VIII.

Denial Reasons

All denial letters include specific reasons for the denial, the rationale for the denial and a summary of the UM criteria. In addition, if a different level of care is approved, the clinical rationale is also provided. These letters incorporate a combination of NCQA standards, DHS requirements and Department of Health requirements. Denial letters are available in other preferred languages and formats upon request. This service is available through the cooperation of Participant Services and Utilization Management.

Appeal Process

All denial letters include an explanation of the Participant's rights to appeal and the processes for filing appeals through the Plan Complaint and Grievance Process and the DHS Fair Hearing Process. Participants contact the Participant Service Unit to file Complaint and Grievance appeals where a Participant advocate is available to assist Participants as needed.

Evaluation of New Technology

When the Plan receives a request for new or emerging technology, it compiles clinical information related to the request and reviews available evidence-based research and/or DHS technology assessment group guidelines. The Plan Medical Directors make the final determination on coverage.

Evaluation of Participant & Provider Satisfaction and Program Effectiveness

Not less than every two years, the UM department completes an analysis of Participant and network Provider satisfaction with the UM program. At a minimum, the sources of data used in the evaluation include the annual Participant satisfaction survey, Participant Complaints, Grievances and Fair Hearings, and Provider Network surveys and complaints.

To support its objective to create partnerships with physicians, the Plan actively seeks information about network Provider satisfaction with its programs on an ongoing basis. In addition to monitoring health care Provider complaints, the Plan holds meetings with network Providers to understand ways to improve the program.

Monthly, the Department reports telephone answering response, abandonment rates and decision time frames.

Section X: Special Needs & Care Management



Integrated Health Care Management (IHCM)

The Integrated Health Care Management (IHCM) program is a population-based health management program that utilizes a blended model that provides comprehensive care management and disease management services to the highest risk health plan Participants. The primary focus is on coordination of resources for those Participants expected to experience adverse events in the future. The IHCM Program provides specialized services, which support and assist Participants with medical, behavioral and/or social issues that impact their quality of life and health outcomes. Identified issues/diagnoses that would result in a referral to the IHCM Program include, but are not limited to:

- Multiple diagnoses (3 or more major diagnoses)
- Pregnancy
- Participants with dual medical and behavioral health needs
- Participants with behavioral health diagnoses needing assistance with referral to a Behavioral Health Managed Care Organization (BH-MCO) or special help with access to medical care
- Participants with a Special Need
- Participants with Chronic Diseases including:
 - Heart Failure
 - Diabetes
 - Asthma
 - COPD
 - Coronary Artery Disease
 - Sickle Cell
 - HIV
 - Hemophilia

The primary method of service for the IHCM Program is telephonic outreach, assessment, and intervention. The IHCM staff makes outreach calls to the Participant, and/or Participant representative, as indicated, and collaborates with the PCP and Specialist to develop a treatment plan.

Complex Care Management (CCM)

The Complex Care Management (CCM) program is a blended model that provides comprehensive care management and disease management services to the most complex adult with several co-morbidities. These Participants may also need disease management education for Cardiovascular Disease, Diabetes, Asthma or COPD. Participants are identified for CCM through many sources, including practitioner referrals and referrals from internal and external sources.

For more information and/ or to refer Participants to the Complex Care Management program call: **1-800-573-4100.**

Disease State Management (DSM)

Participants identified as high-risk receive targeted education and fact sheets on their disease as well as engagement into our Complex Care Management program. Care Managers address goals and develop a plan of care with input from the Participant and the physician(s).

Participants assessed to be low risk receive information via mailings with access to a Care Manager as necessary.

For more information and/ or to refer Participants for Disease State Management call: 1-800-573-4100.

The Bright Start® Maternity Program for Pregnant Participants

The Bright Start Maternity Program is a focused collaboration designed to improve prenatal care for pregnant Participants. The Bright Start Maternity Program assesses, plans, implements, teaches, coordinates, monitors and evaluates options and services required to meet the individual's health needs using communication and available resources to promote quality and cost-effective outcomes. The design of the Bright Start Maternity Program allows for collaboration between the Care Manager, the Participant, the Obstetrician, and the BHMCO for assessment and interventions to support management of behavioral/social health issues.

The Bright Start Maternity Program is designed to improve birth outcomes and reduce the incidence of pregnancy-related complications through early prenatal education and intervention. The program provides focused, collaborative services designed to improve prenatal care for pregnant Participants. The Plan developed this comprehensive prenatal risk reduction program in an effort to decrease the poor obstetrical outcomes of our pregnant population.

Program Goals:

- Early identification of pregnant Participants (utilizing laboratory and pharmacy data) and accurate contact information
- Improve health outcomes for neonates and parent(s)
- Facilitate access to needed services and resources
 - Dental Screenings
 - Behavioral Health Screenings
- Screening for symptoms of prenatal or post-partum depression (PHQ-9 and Edinburgh Postnatal Depression Scale)
 - Focused education to empower the Participant to adopt healthy behaviors and adhere to prescribed medical treatments
- Build collaborative relationships with community-based agencies that specialize in services for maternal-child health
- Encourage early prenatal care and continuum of care through post-partum period by increasing awareness through Participant education, Provider education and community alliances
- Assess and address healthcare disparities in pregnant women

Participants enrolled in the Bright Start Maternity Program receive a variety of interventions depending upon the assessed risk of their pregnancy. Care Managers play a hands-on role, as

necessary, in coordinating and facilitating care with the Participants' physicians and home health care agencies. They also outreach to ensure Participant follow-up with medical appointments, identify potential barriers to getting care, and encourage appropriate prenatal behavior.

All Participants:

- Receive educational material about pregnancy, e.g., nutrition, warning signs of trouble (such as bleeding/excessive spotting, decreased fetal activity, etc.), preparing for delivery, and how to access a Plan Care Manager for any questions/issues.
- Receive an outreach call after delivery to complete a post-partum survey.
- Receive assistance on decisions regarding breastfeeding vs formula; what is right for the Participant.
- Receive care management interventions by a Care Manager.

Bright Start Maternity programs designed to positively impact birth outcomes:

- Breast Pump program
- Postpartum visit coordination

For more information and program details visit the dedicated Bright Start Maternity page on the Provider Center at <https://www.keystonefirstchc.com/providers/resources/index.aspx> to refer Participants to the Bright Start Maternity Program call 1-800-521-6867.

Postpartum Home Visit Program

Purpose

The postpartum home visit is offered to all Participants who deliver a baby. The purpose of the program is to ensure the Participant receives the appropriate clinical assessment, education and support for a healthy transition from the hospital to home.

All Participants and newborns receive a clinical nursing visit within one (1) week of discharge from the hospital.

- All deliveries (vaginal or cesarean) are eligible for up to two (2) home visits.
- If complications are identified during the home visit, it is the responsibility of the Home Visit Provider to request the authorization of additional home visits or other services
- When a detained baby is discharged more than one (1) week from birth, an authorization is required to receive a home visit.

Postpartum Home Nursing Visit

The postpartum home visit includes a physical, psychosocial and environmental assessment with individualized education, counseling and support.

- Visit timeframes: Complete both visits between day 7 through 84 days post-delivery.

Requesting a Postpartum Home Visit

Network Providers should contact their facility's Discharge Planner to request a postpartum home visit for their patient or contact the Bright Start department for assistance at **1-800-521- 6867**.

Outreach & Health Education Programs

The Plan develops innovative programming in an effort to increase Participant health screening compliance in the community setting while also providing disease management/prevention education. The goal of the Plan's Community Health Education Programs is to increase Participants' knowledge of self-management skills for selected disease conditions and address social determinants of health. The health education programs focus on prevention in order to help Participants improve their quality of life. The Plan's Community Outreach team targets Plan Participants who are non-compliant for HEDIS measures in an effort to facilitate health screenings, provide education, close care gaps, and re-connect them with their PCPs. The Community Outreach team works in collaboration with the Care Management unit to achieve these desired outcomes. The Community Outreach team facilitates health and wellness opportunities for Participants through educational materials, health education programs, and participates in community events both as a sponsor and active participant.

Tobacco Cessation

The tobacco cessation program offers Participants a series of educational classes easily accessible within their communities. The program offers targeted outreach to Participants who are pregnant or who have chronic conditions such as asthma, diabetes, cardiovascular disease or other serious medical conditions, encouraging these Participants to enroll in tobacco cessation classes. For more information go to the Department of Health website:

<https://www.health.pa.gov/topics/programs/tobacco/Pages/Tobacco.aspx>.

Breast Cancer Screening and Outreach Program (BCSOP)

BCSOP is an outreach program developed to increase Participants' awareness of the importance of a mammography screening and to encourage female Participants age 50 and older to have regularly scheduled mammograms. The Plan establishes partnerships with community organizations. Designated outreach staff contacts Participants by phone or mail, to schedule mammography screenings, remind the Plan Participants of appointments, and reschedule appointments if necessary. At the time of the screening, Participants are educated about breast self-exam and instructed to contact their doctor for the results of the screening. All results are sent to the PCP for follow-up.

Domestic Violence Intervention

The Plan is participating in a collaborative domestic violence education program with the Department of Human Services (DHS) and other Community HealthChoices Managed Care Organizations. There has been a growing recognition among health care professionals that domestic violence is a highly prevalent public health problem with devastating effects on individuals and families. Health care Providers can play an important role in identifying domestic

violence. Routine screening for domestic violence increases the opportunity for effective intervention and enables health care Providers to assist their patients, and family Participants who are victims.

The clinical model known as RADAR was developed by the Massachusetts Medical Society to assist clinicians in addressing domestic violence and is an excellent tool for assisting health care Providers in the identification of and intervention with possible domestic violence victims. The acronym "RADAR" summarizes action steps physicians should take in recognizing and treating victims of partner violence.

Routinely screen about partner violence.

Ask directly about violence with such questions as "At any time, has a partner hit, kicked, or otherwise hurt or frightened you?" Interview the patient in private at all times.

Document information about "suspected domestic violence" or "partner violence" in the patient's chart.

Assess the patient's safety. Is it safe for her to return home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.

Review options with the patient. Know about the types of referral options (e.g., shelters, support groups, legal advocates).

You can help your patients by referring them to www.ndvh.org or have them contact the National Domestic Violence Hotline, where all calls are free and confidential.

National Domestic Violence Hotline

1-800-799-7233 (SAFE)

1-800-787-3224 (TTY for the Deaf)

Help is available in English, Spanish and other preferred languages.

For a list of where to get help for a patient, please see the Appendix.

[Pennsylvania Coalition Against Domestic Violence](#)

The services provided to domestic violence victims include crisis intervention; counseling; going along to police, medical, and court appointments; and temporary emergency shelter for victims and their dependent children. Prevention and educational programs are also provided to lower the risk of domestic violence in the community.

1-800-932-4632 (in Pennsylvania)

Alzheimer's Disease and Other Dementias

Local and national resources that can be used by Providers and individuals living with Alzheimer's disease and other dementias, their families, and caregivers to better understand these diseases and make care decisions together can be found at

<https://www.keystonefirstchc.com/providers/resources/index.aspx>.

The Provider's Role

Network Providers can help to identify and refer Participants who are at high risk for particular diseases and disorders to the appropriate program.

Call the Outreach & Health Education Program Staff at 1-800-521-6007:

- With questions about any of the health education programs
- With requests for outreach services

Specialists as PCPs

Specialists can serve as PCPs for Participants. The Plan Participants may contact the Special Needs Unit or Service Coordinator to request designation as a "Special Needs Participant" to utilize a specialist as PCP. Care Managers or Service Coordinators will work with the Participant and the Plan's staff to identify an appropriate Specialist. The Specialist must have expertise in the treatment of the medical condition of the Participant.

To accommodate these Participants, the Plan's Special Needs Unit or Service Coordinator will contact the requested Specialist and obtain their verbal agreement to provide specialty care services, as well as primary care services. The Specialist will be informed that the final approval is subject to meeting credentialing requirements and office accessibility standards. Upon approval, this information will be forwarded to the Provider Network Management and Participant Services departments. The Plan's Provider Network Management department will negotiate a contract with specialists who meet the Plan's Credentialing criteria, and who wish to function as a PCP for a Participant(s) with Special Needs. The specialist will be set-up in our Provider Network database as a "Specialist as PCP". The Participant will then be assigned to the "Specialist as PCP" panel.

Section XI: Participant Rights and Responsibilities



Participant Rights & Responsibilities

Keystone First CHC and its network of Providers do not discriminate against Participants based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.

Keystone First CHC Participants have the following rights and responsibilities.

Participant Rights

Participants have the right:

- To be treated with respect, recognizing their dignity and need for privacy, by Keystone First CHC 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 Keystone First CHC, 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 Keystone First CHC's approval.
- To get information that they can easily understand and talk to their Providers about their treatment options, risks of treatment, and tests that may be self-administered without any interference from Keystone First CHC.
- 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 their records.
- To ask for a second opinion.
- To file a Grievance if they disagree with Keystone First CHC's decision that a service is not medically necessary for them.
- To file a Complaint if they are unhappy about the care or treatment they have received.
- To ask for a Department of Human Services (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 Keystone First CHC 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, Keystone First CHC, and network Providers treat them.
- To create an advance directive. Participants can see their Participant Handbook for more information.
- To make recommendations about the rights and responsibilities of Keystone First CHC's Participants.

- To know and get information about:
 - Keystone First CHC and its health care Providers.
 - Their Participant rights and responsibilities.
 - Their benefits and services.
 - The cost of health care.
- To talk with their health care Provider about:
 - Their treatment plans, regardless of cost or benefit coverage.
 - The kinds of care they can choose to meet their medical needs, in a way they understand.
- To take an active part in the decisions about their health care, including the right to refuse treatment. Their decision to do so will not negatively affect the way they are treated by Keystone First CHC, its health care Providers, or DHS.
- To voice complaints about and/or appeal decisions made by Keystone First CHC and its health care Providers.
- To be given an opportunity to make suggestions for changes in Keystone First CHC policies and procedures.

Participant Responsibilities

Participants need to work with their health care and long-term services and supports (LTSS) Providers. Keystone First CHC needs Participants' help so that they get the services and supports they need.

These are the things Participants should do:

- 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 Keystone First CHC coverage, including all covered and non-covered benefits and limits.
- Use only network Providers unless Keystone First CHC approves an out-of-network Provider, or they have Medicare.
- Be referred by their PCP to see a specialist when the specialist is not one on the self-referral list.
- Respect other patients, Provider staff, and Provider workers.
- Make a good-faith effort to pay their co-payments.
- Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.
- Let Keystone First CHC and their health care Providers know of any changes that may affect their membership, health care needs, or benefits. Some examples include, but are not limited to, the following:
 - They are pregnant.
 - They have a new baby.
 - They have a special medical condition.
 - They change their PCP.

- Their family size changes.
- Their address or phone number changes.
- They have other health insurance.
- They move out of the country or state that they live in now.
- Work with Keystone First CHC and our health care Providers. This means they should follow the guidelines given to them about Keystone First CHC and they should follow their health care Provider's instructions about their care. This includes:
 - Making appointments with their health care Provider.
 - Canceling appointments when they cannot make their appointments.
 - Calling Keystone First CHC when they have questions.
- Talk with their health care Provider to agree on goals for their treatment, to the degree they are able to do so.
- Talk with their health care Provider so they can understand their health problems, to the degree they are able to do so.

Patient Self-Determination Act

The Patient Self-Determination Act is a Federal law recognized in the Commonwealth of Pennsylvania. It states that competent adults have the right to choose medical care and treatment. A Participant has the right to make these wishes known to his/her PCP and other Providers as to whether he/she would accept, reject or discontinue care under certain circumstances.

A Participant should prepare an advance directive to maintain his/her rights in a situation where he/she may not be able to tell his/her health care Provider what is/is not wanted. Once the Participant has prepared an advance directive, a copy should be given to his/her PCP. The health care Provider should be aware of and maintain in the Participant's medical record a copy of the Participant's completed advance directive. Participants are not required to initiate an advance directive or proxy and cannot be denied care if they do not have an advance directive.

An **Advance Directive** is only used when the Participant is not able to make decisions about his/her treatment, such as if the Participant is in a coma.

There are two kinds of documents that can act as an advance directive in the Commonwealth of Pennsylvania:

Living Will

A living will is a written record of how the Participant wishes his/her life to be sustained in the event he/she is unable to communicate with a health care Provider. This document should outline the type of treatments the Participant would or would not want to receive.

Durable Health Care Power of Attorney

This legal document names the person the Participant assigns to make medical treatment decisions for him/her in case he/she cannot make them for himself/herself. This person does not have to be an attorney.

If Participants have questions about the Patient Self-Determination Act and Advance Directives, refer them to Participant Services at **1-855-332-0729**.

Section XII: Regulatory Provisions



Access to & Financial Responsibility for Services

Participant's Financial Responsibilities

If the Plan notifies the health care Provider and/or the Participant that a service will not be covered, and the Participant chooses to receive that service or treatment, the Participant can be billed for such services. The Plan Participants may be directly billed for non-covered services provided they have been informed of their financial responsibility prior to the time services are rendered. The Participant's informed consent to be billed for services must be documented. It is suggested that the health care Provider obtain a signed statement of understanding of financial responsibility from the Participant prior to rendering services.

As outlined in the Pennsylvania Department of Human Services Medical Assistance bulletin 99- 99-06 entitled "Payment in Full", the Plan strongly reminds all Providers of the following point from the bulletin:

Providers requiring Medicaid recipients to make cash payment for Medicaid covered services* or refusal to provide medically necessary services to a Medicaid recipient for lack of pre-payment for such services are illegal and contrary to the participation requirements of the Pennsylvania Medical Assistance program.

***Covered services include products, office visits, urine drug screens, counseling referrals, etc., used to treat opioid dependence.**

Additionally, the Pennsylvania Code, 55 Pa. Code § 1101.63 (a) statement of policy regarding full reimbursement for covered services rendered specifically mandates that:

- All payments made to Providers under the MA program plus any copayment required to be paid by a recipient shall constitute full reimbursement to the Provider for covered services rendered.
- A Provider who seeks or accepts supplementary payment of another kind from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment.

To review the complete MA Bulletin 99-99-06, "Payment in Full", visit the Provider Center at <https://www.keystonefirstchc.com/providers/communications/dhs-bulletins-and-news.aspx>.

Services Provided by a Non-Participating Provider

The Plan's Provider Services department will make every effort to arrange for the Participant to receive all necessary medical services within the Plan's Network of Providers in collaboration with the recommendations of the PCP. Occasionally, a Participant's health care needs cannot be met through the Plan's Network of Providers. All services by Non-Participating Providers (except Emergency Services, Family Planning Services through the Plan, tobacco cessation counseling and Medicare covered services by a Medicare health care Provider) require Prior Authorization from the Plan's Utilization Management department. Unauthorized services

rendered by Non-Participating Providers are not compensable and may become the financial responsibility of the Plan's Participant if the Participant chooses to receive services or treatment by the Non-Participating Provider.

To comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of Providers (Code of Federal Regulations: 42CFR, §455.410), all Providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made. This applies to non-participating out-of-state Providers as well.

Additionally, all Providers, including those who order, refer or prescribe items or services for Keystone First CHC Participants, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02) outlining all requirements can be accessed on the Keystone First CHC Provider website at

<https://www.keystonefirstchc.com/providers/communications/dhs-bulletins-and-news.aspx>.

Keystone First CHC will use the NPI of the ordering, referring or prescribing Provider included on the rendering Provider's claim to validate the Provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering Provider will be denied if it is submitted without the ordering/prescribing/referring Provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA Provider.

Enroll by visiting: <https://www.dhs.pa.gov/providers/Providers/Pages/PROMISE-Enrollment.aspx>.

Services Provided Without Required Referral/Authorization

Except for certain services, and network Providers for which specific prepayment arrangements have been made, e.g., lab services and certain PCP services, the Plan requires Prior Authorization of certain health care treatment and services rendered to its Participants. Health care Providers should refer to Section III of the Manual titled "Referral and Authorization Requirements" for this information. Participants should also be referred to the Participant Handbook for a listing of those services that require a referral or Prior Authorization. The Plan is not obligated to provide reimbursement for services that have not been appropriately authorized.

Services Not Covered by the Plan

The Plan is a Pennsylvania Medical Assistance Managed Care Organization, and as such, has a benefit structure that closely resembles the Pennsylvania Medical Assistance fee-for-service program. The Plan is not responsible for reimbursing for services, treatments, or other items that are outside of the covered benefit structure of the Plan. If the Plan notifies the health care Provider and/or the Participant that a service will not be covered, and the Participant chooses to receive that service or treatment, the Participant can be billed by the health care Provider for such services provided that the Participant has been informed of his/her financial responsibility prior to the time services are rendered. Health care Providers should refer to Section I of the Manual titled "Participant Copayment Schedule" or call the Plan's Provider Services department at **1-800-521-6007** with questions about covered/non-covered services. Participants should also be referred to

the Plan's Participant Handbook or speak with a Plan Participant Services Representative by calling **1-855-332-0729** when questions arise about services that are or are not covered by the Plan.

Important Note: The Plan is prohibited from making payment for items or services to any financial institution or entity located outside of the United States or its territories

Participant Accessibility to Providers for Emergency Care

No Prior Authorization for Emergency Services

The Plan does not require Prior Authorization or pre-approval of any Emergency Services.

The Plan PCP and Specialist Office Standards (see Section VII of this Manual) require network Providers to provide Medically Necessary covered services to the Plan Participants, including emergency and/or consultative specialty care services, 24 hours a day, 7 days a week. Participants may contact their PCP for initial assessment of medical emergencies.

In cases where Emergency Services are needed, Participants are advised to go to the nearest Hospital Emergency Room (ER), where ER staff should immediately screen all the Plan Participants and provide appropriate stabilization and/or treatment services.

Care Out of Service Area

The Plan Participants have access to Emergency Services when traveling anywhere in the United States. Although not required, Participants are encouraged to contact their PCP to report any out-of-area Emergency Services received.

Important Note: The Plan is prohibited from making payment for items or services to any financial institution or entity located outside of the United States or its territories

Compliance with the HIPAA Privacy Regulations

In addition to maintaining the Corporate Confidentiality Policy, the Plan is required to comply with the Privacy Regulations as specified under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The Plan complies with all provisions stipulated in the HIPAA Privacy Regulations, including, but not limited to, the following:

- Designated a Privacy Officer who is responsible for the directing of on-going activities related to the Plan's programs and practices addressing the privacy of Participant's protected health information (PHI)
- Developed a centralized Privacy Office, which is responsible for the day-to-day oversight and support of Privacy-related initiatives conducted at the Plan.

- Issue copies of the Plan’s Notice of Privacy Practices to newly enrolled Participants and existing Participants of the Plan, which describes how medical information is used and disclosed, as well as how it can be accessed.
- Established and/or enhanced processes for our Participants to exercise their rights under these regulations, such as requesting access to their PHI, or complaining about the Plan’s privacy practices.

Allowed Activities under the HIPAA Privacy Regulations

The HIPAA Privacy Regulations allow covered entities, including health care Providers and health plans (such as the Plan), the ability to use or disclose PHI about its Participants for the purposes of Treatment, Payment and/or Health plan Operations (TPO) without a Participant's consent or authorization. This includes access to a Participant's medical records when necessary and appropriate.

“**TPO**” allows a health care Provider and/or the Plan to share Participants' PHI without consent or authorization by establishing these purposes as follows:

“**Treatment**” includes the provision, coordination, management, consultation, and referral of a Participant between and among health care Providers.

Activities that fall within the “**Payment**” category include, but are not limited to:

- Determination of Participant eligibility
- Reviewing health care services for medical necessity and utilization review
- Review of various activities of health care Providers for payment or reimbursement to fulfill the Plan’s coverage responsibilities and provide appropriate benefits
- To obtain or provide reimbursement for health care services delivered to Participants

“**Operations**” includes:

- Certain quality improvement activities such as Care Management and care coordination
- Quality of care reviews in response to Participant or state/federal queries
- Response to Participant Complaints/Grievances
- Site visits
- Administrative and financial operations such as conducting Health Plan Employer Data And Information Set (HEDIS) reviews
- Participant services activities
- Legal activities such as audit programs, including fraud and abuse detection to assess compliance with compliance programs

While there are other purposes under the Privacy Regulations for which the Plan and/or a health care Provider might need to use or disclose a Participant's PHI, TPO covers a broad range of information sharing.

For more information on HIPAA and/or the Privacy Regulation, please visit the Provider Center at <https://www.keystonefirstchc.com/providers/index.aspx> and click on the HIPAA Page or contact the Provider Services department at **1-800-521-6007**.

Contact Information

Listed below are general contact addresses for accessing the Plan, DHS, and other related organizations. For information about additional organizations, contact Provider Services at **1- 800-521-6007** or Participant Services at **1-855-332-0729**.

Keystone First Community HealthChoices
200 Stevens Drive
Philadelphia, PA 19113

Department of Human Services
Office of Long-Term Living
P.O. Box 8052
Harrisburg, PA 17105
1-800-753-8827

Department of Human Services
Bureau of Managed Care Operations
Commonwealth Tower, 6th Floor
P.O. Box 2675
Harrisburg, PA 17105

Pennsylvania Health Law Project
Lafayette Building, Suite 900
437 Chestnut St.
Philadelphia, PA 19106
Phone: 1-215-625-3663
Fax: 1-215-625-3879
Toll-free line 1-800-274-3258 TTY line, 1-866-236-6310
Email at staff@phlp.org.

Disabilities Law Project
The Philadelphia Building
1315 Walnut St., Suite 400
Philadelphia, PA 19107-4798
1-215-238-8070 (Voice)
1-215-789-2498 (TDD)
1-215-772-3126 (Fax)

Office of the State Long-Term Care Ombudsman
Pennsylvania Department of Aging
555 Walnut Street, 5th Floor
Harrisburg, PA 17101-1919
1-215-783-8975

Office of Maternal & Child Health
1101 Market Street
9th Floor
Philadelphia, PA 19107
1-215-685-5225
1-215-685-5257 (fax)

Cultural Responsiveness

Cultural Responsiveness, as defined by the Pennsylvania Department of Human Services (DHS), is 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 healthcare delivery to diverse populations.

In addition, DHS Office of Minority Health defines Cultural Humility as a reflective process of understanding one's biases and privileges, managing power imbalances, and maintaining a stance that is open to others in relation to aspects of their cultural identity that are most important to them.

DHS Office of Minority Health strategies for practicing cultural humility include:

- Practicing self-reflection, including awareness of your beliefs, values, and implicit biases
- Recognizing what you don't know and being open to learning as much as you can
- Being open to other people's identities and empathizing with their life experiences
- Acknowledging that the patient is their own best authority, not you
- Learning and growing from people whose beliefs, values, and worldviews differ from yours

Further, Section 601 of Title VI of the Civil Rights Act of 1964 states that:

No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

In addition, Section 1557 of the Affordable Care Act (ACA) prohibits discrimination in health care based on race, color, national origin, sex (includes gender identity and sexual orientation), age, disability in health programs and activities receiving federal funds.

Racial, ethnic, linguistic, gender, sexual orientation, gender identity and cultural difference must not present barriers to Participants' access to and receipt of quality services. Providers should

demonstrate willingness and the ability to make necessary accommodations in providing services, to employ appropriate language when referring to and speaking with people with disabilities, and to understand communication, transportation, and scheduling, structural, and attitudinal barriers to accessing services.

Discriminatory actions against those of Limited English Proficiency (LEP), Low Literacy Proficiency (LLP) or sensory impairment can be seen as discrimination on the basis of national origin. Therefore, these Medical Assistance recipients must be allotted equal access to all services and benefits of the Plan.

Recipients of federal financial assistance would include the Pennsylvania Medical Assistance Program, and by extension, Medical Assistance Managed Care Organizations, i.e., the Plan and its network Providers.

As a participant in the Pennsylvania Medical Assistance program, all practitioners and other health care Providers must take responsible steps to provide meaningful access to language service assistance as defined by this section of the Civil Rights Act of 1964. Language services include verbal interpreter services and written translation services in Participant's preferred language or formats.

In order to be in compliance with federal law and state contractual requirements, the Plan and its network Providers have an obligation to provide language services to LEP and LLP Participants and to make reasonable efforts to accommodate Participants with other sensory impairments.

If a Plan Participant requires or requests translation services because they are either non-English speaking, or of LEP, or of LLP, or if the Participant has some other sensory impairment, the health care Provider has a responsibility to make arrangements to procure translation services for those Participants, and to facilitate the provision of health care services to such Participants.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations (such as health care Providers) must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/ health care Provider relationship

Providers are required to:

- Provide written and oral language assistance at no cost to Plan Participants with limited-English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters, upon request.
- Advise Participants that translation services are available through Keystone First CHC if the Provider is not able to procure necessary translations services for a Participant.
- Make available auxiliary aids and services, such as alternative formats and sign language interpreters, free of charge, when necessary for effective communication.
- Provide Participants verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.
- Post and offer easy-to-read Participant signage and materials in the languages of the common ethnic groups in the Provider’s service area.
- Vital documents, such as patient information forms and treatment consent forms, must be made available in Participant’s preferred languages and formats.
- Use top 15-language taglines in large-sized communications, such as outreach publication or written notices. *
- Discourage Participants from using family or friends as oral translators.
- Display notice of individual’s rights that includes information about LEP communication help.

***As determined by DHS, the top 15 written non-English languages in Pennsylvania are:**

Albanian	Chinese (simplified/Mandarin)	Nepali
Arabic	French	Portuguese (Brazil)
Bengali	Gujarati	Russian
Burmese	Haitian Creole	Spanish
Cambodian (Khmer)	Korean	Vietnamese

- **For complete details and guidelines refer to PA DHS MA Bulletin 99-17-11 on the Provider Center at <https://www.keystonefirstchc.com/providers/communications/dhs-bulletins-and-news.aspx>.**

Note: The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a Participant has been made aware of his/her right to receive free interpretation and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

Therefore, if a Plan Participant requires interpretation or translation services, the health care Provider has a responsibility to provide these services for such Participants.

The Plan contracts with a competent telephonic interpreter service Provider. We have an arrangement to make our corporate rate available to participating network Providers. For information on using the telephonic interpreter service, contact Provider Services at **1-800-521-6007**.

Additionally, under the Culturally Linguistically Appropriate Standards (CLAS) of the Office of Minority Health, Plan Providers must:

- Provide effective, understandable, and respectful care to all Participants in a manner compatible with the Participant's cultural health beliefs and practices of preferred language/format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area.
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services.
- Establish written policies to provide interpretive services for Plan Participants upon request.
- Routinely document preferred language or format, such as Braille, audio, or large type, in all Participant medical records.

We have a dedicated Cultural Responsiveness [webpage](#) with multiple resources and training opportunities that address subjects such as: Cultural Humility, Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Cultural Responsiveness Training, Servicing Participants with LEP and best practices when using language services. They can be accessed on the Keystone First CHC Provider website at www.keystonefirstchc.com → [Providers](#) → [Resources](#) → [Culturally Competent Care](#). The Plan has a Cultural Responsiveness Plan. Providers may request a copy by contacting Provider Services at **1-800-521-6007**.

The Plan's Corporate Confidentiality Policy

The policy states that during the course of business operations, Confidential Information and/or Proprietary Information, including Participant Protected Health Information (PHI), may become available to The Plan Associates, Consultants and Contractors. The Plan's use and disclosure of Participant PHI is regulated pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations. The Plan's use and disclosure of PHI is also impacted by applicable state laws and regulations governing the Confidentiality and disclosure of health information.

The Plan is committed to safeguarding Confidential Information and Proprietary Information, including ensuring the privacy and security of Participant PHI, in compliance with all applicable laws and regulations. It is the obligation of all The Plan's Associates, Consultants and Contractors to safeguard and maintain the confidentiality of Confidential and Proprietary Information, including PHI, in accordance with the requirements of all applicable federal and state statutes and regulations as well as the provisions of The Plan's Confidentiality Policy and other Plan policies and procedures addressing Confidential and Proprietary Information, including PHI.

All Confidential Information and Proprietary Information, including PHI, will be handled on a need-to-know basis. The Plan's Confidentiality Policy and other Plan policies and procedures are adopted to protect the Confidentiality of such information consistent with the need to effectively conduct business operations without using or disclosing more information than is necessary, for example, conducting research or measuring quality through the use of aggregated data wherever possible.

No Associate, Consultant or Contractor is permitted to disclose Confidential Information or Proprietary Information pertaining to the Plan or a Participant to any other Associate, Consultant or Contractor unless such a disclosure is consistent with The Plan's Confidentiality Policy.

Both during and after an Associate's association with the Plan, it shall be a violation of the Plan's Confidentiality Policy to discuss, release, or otherwise disclose any Confidential Information or Proprietary Information, except as required by the Associate's employment relationship with The Plan or as otherwise required by law. It is also a violation of the Plan's Confidentiality Policy for any Associate to use Confidential Information or Proprietary Information for his/her own personal benefit or in any way inconsistent with applicable law or the interests of the Plan. To the extent that a violation of the Plan's Confidentiality Policy occurs, the Plan reserves the right to pursue any recourse or remedy to which it is entitled under law. Furthermore, any violation of the Plan's Confidentiality Policy will subject the Associate(s) in question to disciplinary action, up to and including termination of employment.

The following information is provided to outline the rules regarding the handling of confidential information and proprietary information within the Plan.

Confidential information and proprietary information includes, but is not limited to the following:

- Protected Health Information
- Medical or personal information pertaining to Associates of the Plan ("the Company") and/or its Customers
- Accounting, billing or payroll information, and data reports and statistics regarding the Company, its Associates, Participants, and/or Customers
- Information that the Plan is required by law, regulation, agreement or policy to maintain as confidential
- Financial information regarding the Company, its Participants, network Providers and Customers, including but not limited to contract rates and fees
- Associate personnel and payroll records
- Information, ideas, or data developed or obtained by the Plan, such as marketing and sales information, marketplace assessments, data on customers or prospects, proposed rates, rating formulas, reimbursement formulas, health care Provider payment rates, business of the Plan and/or its Customers
- Information not generally known to the public upon which the goodwill, welfare and competitive ability of the Plan and/or its Customers depend, information regarding product plans and design, marketing sales and plans, computer hardware, software, computer systems and programs, processing techniques, and general outputs
- Information concerning the Plan's business plans
- Information that could help others commit Fraud or sabotage or misuse the Plan's products or services

Procedure

1. Associates, Consultants and Contractors may use Confidential or Proprietary Information and may disclose Confidential or Proprietary Information internally within the Plan only as necessary to fulfill the responsibilities of their respective position.
2. Confidential Information which is specific to an Associate or health care Provider may not be released by the Plan to another party, except as permitted or required by law or regulation, without first obtaining the written consent of that individual. PHI may not be disclosed, other than as permitted or required by law or regulation, or for purposes of treatment, payment or health care operations, without first obtaining a written Authorization as required by HIPAA, or other form of consent as may be required by state law. If an individual is unable to make his/her own decision regarding consent, a legal guardian or other legally authorized representative must provide written consent or an Authorization on the individual's behalf.
3. Associates, Consultants or Contractors, may not disclose Confidential or Proprietary Information to persons or organizations outside the Plan, unless otherwise required by law or regulation or approved by the Legal Affairs department. Associates, Consultants or Contractors may not make any direct or indirect communication of any kind with the press or any other media about the business of the Plan without express written approval from the Communications department.
4. Information that pertains to the Plan's operations may be disclosed to the Plan's general partners, Independence Blue Cross and Blue Cross Blue Shield of Michigan, d/b/a the Plan, on a need to know basis; provided, however, that Confidential Information and Proprietary Information belonging or pertaining to a Customer may be disclosed ONLY to representatives of that Customer.
5. Any Associate, Consultant or Contractor who is approached with an offer of Confidential Information including PHI or Proprietary Information to which he/she should not have access and/or which was improperly obtained must immediately discuss the matter with his/her supervisor, an attorney in the Legal Affairs department, the Chief Compliance Officer or the Internal Auditor.
6. All Associates, Consultants and Contractors must review and familiarize themselves with all departmental or any other Plan policies and procedures applicable to Confidentiality issues arising within the course of performing their job duties.
7. Each Associate's, Consultant's, and Contractor's level of access to the information maintained in the Plan's computer system is determined by the Information Services department, based upon the individual's department and job duties. Associates are to access and distribute data electronically only in accordance with instructions given by the Information Services or the Corporate Compliance departments. All Associates, Consultants and Contractors are required to comply with the Information Services policies and procedures regarding security and access to data, electronic mail and other information systems.
8. Associates, Consultants and Contractors must also follow reasonable Confidentiality restrictions imposed by previous employers and not use or share that employer's confidential information with the Plan.
9. All Consultants/Contractors, including those who are Participants of the Plan committees, will sign a confidentiality and non-disclosure agreement for the protection of confidential information and proprietary information.

10. All agreements with network Providers, Consultants and Contractors will include Confidentiality provisions that are consistent with this Policy and Procedure and that require, at a minimum, that the Provider/Subcontractor comply with all federal and state statutes and regulations regarding the disclosure of Confidential Information and otherwise maintain the Plan's Confidential Information and Proprietary Information as Confidential. The material elements of this policy and procedure will be communicated to participating network Providers via the Plan's network Provider agreements and network Provider manuals. To the extent that a health care Provider, Consultant or Contractor is a Business Associate pursuant to HIPAA, such health care Provider, Consultant or Contractor must execute a Business Associate agreement governing the Business Associate's use and disclosure of Protected Health Information as required by HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Act.
11. The Legal Affairs and/or Corporate Compliance department should be contacted whenever issues of Confidentiality and/or disclosure of Confidential Information or Proprietary Information arise which are not clearly addressed in the Plan's Confidentiality Policy or other Plan policies and procedures.
12. The Chief Compliance Officer will report to the Compliance and Privacy Committee, all Participant, health care Provider and Associate complaints regarding Confidentiality as well as the resolution of such complaints. The Compliance and Privacy Committee will determine if operational practices should be altered to prevent or reduce the risk of future concerns.

Provider Protections

The Plan shall not exclude, discriminate against or penalize any health care Provider for its refusal to allow, perform, participate in or refer for health care services when the refusal of the health care Provider is based on moral or religious grounds. The health care Provider must make information available to Participants, prospective Participants and the Plan about any such restrictions or limitations to the types of services they will/will not make referrals for or directly provide to the Plan Participants, due to religious or moral grounds.

Health care Providers are further protected in that no public institution, public official or public agency may take disciplinary action against, deny licensure or certification or penalize any person, association or corporation attempting to establish a plan, or operating, expanding or improving an existing plan, because the person, association or corporation refuses to provide any particular form of health care services or other services or supplies covered by other health plans, when the refusal is based on moral or religious grounds. The Plan will not engage in or condone any such discriminatory practices.

The Plan shall not discriminate against or exclude from the Plan's Provider Network any health care Provider because the health care Provider advocated on behalf of a Participant in a Utilization Management appeal or another dispute with the Plan over appropriate medical care, or because the health care Provider filed an appeal on behalf of a Plan Participant.

The Plan does not have policies that restrict or prohibit open discussion between health care and the Plan Participants regarding treatment options and alternatives. The Plan encourages open communication between health care Providers and our Participants with regard to all treatment options available to them, including alternative medications, regardless of benefit coverage limitations

Section XIII: Medical Assistance Manual & Regulations



The Plan is providing links to the Medical Assistance Manual regulatory provisions so that network Providers always have the most current regulatory requirements. Below is a link to Chapter 1101 (General Provisions) of the Medical Assistance Manual. You should consult an official publication or reporting service if you want to be assured you have the most up-to-date version of these regulations.

MEDICAL ASSISTANCE MANUAL
CHAPTER 1101. GENERAL PROVISIONS

PRELIMINARY PROVISIONS

Sec.

1101.11. [General provisions.](#)

Medical Assistance Regulations

Below are links to the remainder of the Department of Human Services' Medical Assistance Regulations including the regulations pertaining to specific Provider types.

<http://www.pacode.com/secure/data/055/partIII/toc.html>

Links are to:

[Communicable and Noncommunicable Diseases \(Chapter 27\)](#)

[MA Program Payment Policies \(Chapter 1150\)](#)

[Ambulance Transportation \(Chapter 1245\)](#)

[Ambulatory Surgical Center Services and Hospital Short Procedure Unit Services \(Chapter 1126\)](#)

[Birth Center Services \(Chapter 1127\)](#)

[Certified Registered Nurse Practitioner Services \(Chapter 1144\)](#)

[Chiropractors' Services \(Chapter 1145\)](#)

[Clinic and Emergency Room Services \(Chapter 1221\)](#)

[Dentists' Services \(Chapter 1149\)](#)

[Family Planning Clinic Services \(Chapter 1225\)](#)

[Funeral Directors' Services \(Chapter 1251\)](#)

[General Provisions \(Chapter 1101\)](#)

[Health Maintenance Organization Services \(Chapter 1229\)](#)

[Healthy Beginnings Plus Program \(Chapter 1140\)](#)

[Home Health Agency Services \(Chapter 1249\)](#)

[Hospice Services \(Chapter 1130\)](#)

[Inpatient Hospital Services \(Chapter 1163\)](#)

[Inpatient Psychiatric Services \(Chapter 1151\)](#)

[Medical Supplies \(Chapter 1123\)](#)

[Midwives' Services \(Chapter 1142\)](#)

[Nursing Facility Care \(Chapter 1181\)](#)

[Nursing Facility Services \(Chapter 1187\)](#)

[Optometrists' Services \(Chapter 1147\)](#)
[Outpatient Drug and Alcohol Clinic Services \(Chapter 1223\)](#)
[Outpatient Laboratory Services \(Chapter 1243\)](#)
[Outpatient Psychiatric Services \(Chapter 1153\)](#)
[Pharmaceutical Services \(Chapter 1121\)](#)
[Physicians' Services \(Chapter 1141\)](#)
[Podiatrists' Services \(Chapter 1143\)](#)
[Portable X-ray Services \(Chapter 1230\)](#)
[Renal Dialysis Services \(Chapter 1128\)](#)
[Rural Health Clinic Services \(Chapter 1129\)](#)
[Shared Health Facilities \(Chapter 1102\)](#)
[Targeted Case Management Services \(Chapter 1247\)](#)

Section XIV: Appendix



Forms and Required Notices and Information

The items listed below can be accessed at: <http://www.keystonefirstchc.com/provider/manual-forms/index.aspx>

1. Hospital Notification of Emergent Admissions Form
2. Universal Pharmacy Prior Authorization Form (for a complete listing of Drug-Specific Order Forms, please visit <https://www.keystonefirstchc.com/providers/manual-forms/index.aspx>)
3. Observation Billing Guidelines 4.CMS Hospital Acquired Conditions
4. Policy for Billing Medical Assistance Recipients for Missed Appointments (MA Bulletin 99-10-14)
5. Provider Reference Guide
6. Long-Term Services and Supports (LTSS) Provider Change Form 8. Medical Provider Change Form
7. Claims Project Submission Form
8. Enrollee Consent Form
9. Domestic Violence Resources
10. Claims Filing Guide
11. Sterilization Consent Form (MA 31)
12. Physician Certification for an Abortion (MA 3)
13. Recipient Statement Form (MA 368 and MA 369)
14. Provider Claim Refund Form